STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165618	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Meadows	5300 Grand Meadow Drive Asbury, IA 52002

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34821 Based on observations, staff interviews and facility policy review the facility failed to secure and supervise access to 2 out of 2 hot steam table surfaces. This failure resulted in the ability of eight cognitively impaired and independently mobile residents to access the areas that held the steam tables, therefore causing an Immediate Jeopardy to the health, safety, and security of the residents. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of February 15, 2024 on April 17, 2024 at 3:10 p.m. Facility staff removed the Immediate Jeopardy on April 17, 2024 through the following actions: a. The meals will be served in the Bistro common dining room. b. All meals will be served in this location until the barriers can be placed between resident care areas and the kitchen serving area where the steam tables are located. c. The two steam tables were disabled from use to prevent any cognitively impaired residents in the units from possibly getting burned. d. The keys that turn the steam tables on have been removed from the households. e. Education to staff will be provided verbally and on paper using [NAME] Manor's protocol for communication which includes email, text, Alerts & Messages in Matrix, and signage. The scope was lowered from J to D at the time of the survey after ensuring the facility implemented their removal plan. The facility also failed to investigate or do a root cause analysis for a fall with injury for 1 out of 3 falls. The facility reported a census of 30 residents. Findings include: 1. The Minimum Data Set (MDS) Assessment for Resident #23 dated 4/6/24, included diagnoses of non-traumatic brain dysfunction, anemia, and depression, The MDS's Brief Interview for Mental Status score of 1 out of 15 indicated severely impaired cognition. The MDS identified her independent with ambulation and transfer with an assistive device. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165618	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Meadows	5300 Grand Meadow Drive Asbury, IA 52002

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Care Plan for Resident #23 dated 2/22/24, identified impaired decision making related to dementia. The Care Plan directed she will continue to walk independently with the front wheeled walker. The Certified Nurses Aid (CNA) Resource list undated, identified six residents at risk for elopement. The Registered Nurse Consultant (RNC) provided his Consultant Summary undated, Environmental Rounds failed to identify the hot steam table top hazard or the broken barrier gate to the B wing kitchenette. On 4/15/24 at 11:30 AM, as Staff K, Certified Nurses Aid opened the lids of the steam table, steam filled the air above the steam table. On 4/15/24 at 2:00 PM, Resident #23 opened another resident room door and wandered in. Resident #18 directed her out. On 4/15/24 at 2:30 PM, Resident #23 wandered the halls and the dining room (DR). Staff were not always in the area Resident #23 wandered. Two other residents also wandered in the DR. On 4/16/24 at 10:02 AM, the B wing kitchenette, failed to provide staff in the area and failed to ensure a barrier across the opening to the kitchenette, the lower part of the wall held a bracket that may have held a gate. On 4/16/24 at 10:30 AM, Resident #23 wandered the halls and the DR in the B wing. Staff not always present to supervise in the area she wandered. On 4/16/24 at 10:30 AM, in the B wing kitchenette the surface of the steamtable felt very hot to the touch. The entrance to the kitchenette lacked a barrier gate. On 4/16/24 at 11:23 AM, the Staff J, CNA left the kitchenette area while three residents sat in the DR at the tables. On 4/16/24 at 11:26 AM, Staff M, Licensed Practical Nurse (LPN), walked through the area and passed by 3 residents that sat in the DR. Two residents sat in their wheel chairs and one independently ambulatory resident sat in a DR chair. Staff M went into the hall. On 4/16/24 at 11:32 AM, Staff J, directed Resident #23 and Resident #14 into the DR area to sit for the meal. The Staff J left the area. On 4/16/24 at 11:47 AM Staff M, LPN told the CNA she needed so go chart something, they both left the DR kitchenette area leaving the residents unsupervised. On 04/16/24 at 12:08 PM, the staff opened the lid from the steam table and the steam rolled up from the steam table. On 04/16/24 at 1:09 PM, Resident #23 wandered the hall and walked right by the open kitchen area and talked to a woman at the table, she pulled up the chair and sat down. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165618	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024
NAME OF PROVIDER OR SUPPLIER Grand Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 Grand Meadow Drive Asbury, IA 52002	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/16/24 at 1:12 PM, Resident #10 wandered out and around the tables in the B wing. On 4/16/24 at 1:14 PM, the kitchenette failed to have staff in the area. Food remained on and in the steam table. The steam table checked and it felt hot to the touch. On 04/17/24 at 9:11 AM, the steam tables in the B wing were turned on, the tops felt hot to the touch. On 4/17/24 at 9:53 AM, the top of the steam table in the B wing remained hot to the touch. On 4/17/24 at 1:13 PM, the top of the last steam table well remained hot to touch. On 4/17/24 at 1:20 PM, the facility thermometer used to temp the food in the C wing, placed the thermometer on the surface of the steam table lid and it showed a temperature of 160.3 degrees. Facility staff failed to be in the area to supervise residents. On 4/17/24 at 1:40 PM the Environmental Services Director checked the surface temperature of the steam table top in the C wing and confirmed it was 160 degrees. He then went to the B wing and checked the surface temperature of the steam table top, it reflected a temperature of 155 degrees. On 4/17/24 at 8:45 AM, Staff I, CNA reported three residents in the B wing wandered daily. On 4/17/24 at 1:15 PM, Staff K, CNA reported she worked here for 2 years. She revealed the barrier gate to the B wing kitchenette used to be in place because of a resident who used to go into the kitchenette, but after he passed away it broke months ago and the facility removed it. On 4/17/24 at 1:27 PM, Staff H, Registered Nurse (RN) reported the C wing held seven wandering confused residents. She stated they use the barrier gate at times on the day shift. She revealed the nursing department turned the steam tables on in the morning leave them on for the morning and try to turn them off after lunch at some point. On 4/17/24 at 1:40 PM, the Environmental Services Director reported if a staff isn't in the kitchenette, then the barrier gate needed to be in place. He report the gate in B wing broke a few weeks ago and he failed to have the parts to fix it at this time. He confirmed the surface of the steam table tops were too hot to touch and may result in a burn. On 4/22/24 at 02:25 PM, the Environmental Services Director reported he completed a walk though of the units daily and looked for potential hazards. On 4/23/24 at 9:52 AM the Administrator reported that Environmental Services used an online work order system that staff, residents, or families may submit a request. She continued to report at their daily morning meeting a discussion is held for any maintenance needs and follow up on emails/requests over the past day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165618	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Meadows	5300 Grand Meadow Drive Asbury, IA 52002

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/23/24 at 12:28 PM, the Administrator reported she noticed the kitchenette barrier gate in B wing failed to work, but later thought the staff fixed it. She reported her expectation is the staff supervised the steam table area while the stream tables were on and hot. She stated she expected the staff kept the gait closed. The Administrator revealed the Environmental Service Director obtained a work order to fix the B wing gait in February. The facility provided a Work Order dated 2/15/24, reported the gate to keep resident out of the kitchen broke. The facility provided an undated list that identified each resident BIMS and mobility status, the list revealed 8 independently mobile cognitively impaired residents. The facility Equipment Safety policy dated 2013, at point #9 directed that equipment should not be left on when unattended. The Foodwarmers Installation & Operation Manual dated 6/2017, revealed at page 5 General Operation Instruction point #1 All food service equipment should be operated by trained personal. #2 Do not allow your customers to come in contact with any surface labeled caution hot. Page 11 included a Warning: Steam can cause serious burns. Always wear some type of protective covering on your hands and arms when removing lids or pans. Lift the lids or pans in a way that will direct escaping steam away from your face. 37072 2. The MDS for Resident #138 dated 9/26/23 revealed a BIMS score of 10 which indicates moderate cognitive impairment. The MDS indicated the resident needed substantial assist of staff for transfers and toileting. A incident report dated 9/14/23 at 11:25 PM revealed Resident #138 was found sitting on the floor in front of the bathroom in his room. The walker was near by. Resident was assisted to bed with a mechanical lift and assist of 2 staff. An 8 centimeter by 7 centimeter red area noted to right hip. No external or internal rotation of both lower extremities. The Progress Note dated 9/15/23 at 8:46 AM revealed the resident had increased pain with movement. A physician order was obtained for a portable X ray. The Progress Note dated 9/15/23 7:09 PM revealed the X ray of the right hip showed an irregularity of the cortex of the right hip. The Progress Note dated 9/16/23 at 1:04 AM revealed the nurse spoke with the hospital and Resident #138 was admitted with a fractured right hip. On 04/16/24 at 12:12 PM during an interview with corporate nurse he stated they are unable to locate any investigation or root cause analysis completed after the fall for Resident #138. He stated when the new administrator was hired they found things were not being completed or missing. He stated they spoke to the Director of Nursing at the time of the fall who is also still employed at the facility and she had no recollection of the incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165618	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Meadows	5300 Grand Meadow Drive Asbury, IA 52002

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/18/24 at 2:45 PM Staff G, Registered Nurse (RN) stated Resident #138 got up out of his bed or chair and he fell right before the bathroom in his room. He was toileted before the incident and had been in bed before he got up by himself and fell . On 04/18/24 at 2:53 PM Staff H, RN stated at the time of Resident #138 fall with fracture, I was the Director of Nursing. I am not aware of an investigation or root cause analysis for it. When a fall occurs there should be an investigation and try to determine why the resident fell and then put interventions in place to prevent further falls. I do not recall anything about Resident #138's fall. It would have been the responsibility of the DON. On 04/22/24 at 2:38 PM the current DON stated the responsibility of the investigating for falls would be with the DON but the Administrator has been doing them since he started at the facility. He will be responsible for investigating falls. The facility provided a policy last reviewed 7/18/2017 titled Falls Policy, the policy failed to direct staff to complete an investigation or root cause analysis after a fall. The policy did have a procedure to complete a fall risk assessment within 24 hours of admit, quarterly, and with any significant change and after any fall. Review intrinsic and extrinsic risk factors. Intrinsic risk factors may include: cardiovascular problems, neurological problems, orthopedic problems, psychological and cognitive factors, medications, pain, sleep disorders and incontinence. For extrinsic risk factors, observe how the resident: transfers, ambulates, used the bathroom handrails, and uses assistive devices such as walkers or canes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165618	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024
NAME OF PROVIDER OR SUPPLIER: Grand Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE: 5300 Grand Meadow Drive Asbury, IA 52002	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 49976 Based on observation, policy review, and staff interview the facility failed to keep garbage cans covered near food preparation surfaces to provide a sanitary cooking environment. The facility reported a census of 30 residents. Findings include: During an observation of the kitchen on 4/15/24 at 10:00 AM the trash can next to the meat slicer was found with the lid on the floor and trash in the can. The trash can directly contacting the food preparation counter was also without a lid and trash was present in the can. At 2:18 PM the trash can next to the food preparation counter was uncovered with canned fruit exposed in a bowl next to the trash can. On 4/16/24 at 9:50 AM both trash cans were found without lids. The trash can contacting the food preparation counter had a soiled plastic sheet overflowing out of the can. During an interview on 4/17/24 at 9:16 AM Staff A, Dietary Services Manager explained his expectation is for trash cans to be covered when not in use. During food preparation they can be left open to avoid staff touching lids when working with food, but should otherwise remain covered. He further explained he expected all facility policies to be followed. The policy titled Pest Control directed staff to dispose of garbage quickly and correctly. They are to keep garbage containers clean, in good condition, and tightly covered in all areas (indoor and outdoor). Staff must clean up spills around garbage containers immediately. They must wash, rinse, and sanitize containers regularly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165618	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024
NAME OF PROVIDER OR SUPPLIER Grand Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 Grand Meadow Drive Asbury, IA 52002	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 34821 Based on staff interviews, facility record review, and facility policy review the facility failed to ensure an effective Quality Assurance Performance Improvement (QAPI) process to address previously identified quality deficiencies, resulting in repeated deficiencies cited on the current survey and cited in previous surveys. The facility reported a census of 30 residents. Findings include: The Centers for Medicare and Medicaid Services (CMS) 2567 form dated 9/13/22, reflected deficiencies identified for accidents and hazards. The CMS 2567 form dated 2/28/23, reflected deficiencies identified for accidents and hazards. The CMS 2567 form dated 9/14/23, reflected deficiencies identified for accidents and hazards. During the current recertification, complaint, and facility reported incident survey dated 4/23/23, the team identified the same deficiency, Accident and Hazards (F689). On 4/22/24 at 3:19 PM, the Registered Nurse Consultant (RNC) reported he's worked on the accidents and hazards in the building, however he failed to know if the previous team worked on that citation. On 4/23/24 at 12:30 PM, the Administrator reported she monitors and audits the effectiveness of the QAPI process and she confirmed the concern related to the pattern of deficiencies at F689. The facility provided the QAPI Plan dated 12/1/22, that included feedback, data systems, and monitoring that stated the facility will put into place systems to monitor care and utilize data from various sources. It directed it will include tracking, investigating, and monitoring adverse events every time they occur, and actions implemented through the Plan, Do, Study, Act (PDSA) cycle of improvement to prevent recurrence.