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	03/06/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on observation, record review, staff interview, and policy review the facility failed to provide range of motion services to improve or maintain functioning in all extremities for 1 out of 1 residents reviewed (Resident #11). The facility reported a census of 29 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #11 indicated a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated intact cognition. The MDS documented diagnoses of symptoms and signs involving the musculoskeletal system (include muscle weakness, joint pain, limited range of motion, tremors, and gait disturbance), reduced mobility, and spasmodic torticollis (neck muscles contract involuntarily). It further recorded the resident did not receive active or passive range of motion (ROM) restorative nursing in the prior 7 calendar days. Resident #11's Care Plan initiated of 03/29/24 revealed he had a self care performance deficit due to fatigue and required assistance of 1 staff for bathing, dressing, and personal hygiene. He required the assistance of 2 staff for bed mobility and a standing lift for transfers. A focus area for pain, dated 10/10/24 included an intervention to observe and report a decrease in functional abilities or a decrease in ROM. The Care Plan did not include treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Review of an occupation therapy discharge summary with dates of service from 1/6/25 - 1/30/25 revealed the resident received hands on care focused on bilateral upper extremity strength, safety and independence with functional mobility, transfers, ADL (activities of daily living) completion, activity tolerance, balance, reaching, and cardiopulmonary tolerance. A restorative program was not indicated and a functional maintenance program was discussed regarding cardiopulmonary tolerance activity with the facility exercise bike (brand name removed). Documentation included the resident's wish to return home and improve transfers and ambulation. A review of the physical therapy discharge summary with dates of services from 1/3/25 - 1/30/25 documented improvements in transferring from sitting to standing with the use of a standing lift (brand name removed). Neither a restorative program nor a functional maintenance program was established. On 03/03/25 at 1:11 PM observed the resident in his recliner in his room with his eyes closed. The blinds were drawn and he was listening to the television. (continued on next page)

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident #11 on 03/04/25 at 8:52 AM again observed his blinds closed and his door was partially closed. He stated he didn't know if he would participate in range of motion with staff but they didn't ask. He didn't like the option of group exercise because he liked to be in his room. On 03/05/25 at 02:40 PM Staff B, Occupational Therapy (OT) indicated the resident participated in therapy in January and returned to baseline. She reported the activities staff encouraged him to participate in group activity and he regularly refused. She stated he had actually been in therapy multiple times, always returned to baseline, then declined again. While meeting with Staff F, MDS Coordinator on 03/06/25 at 09:46 AM, she stated the facility did not have a staff member specifically designated for restorative therapy, confirmed it was not in the resident's Care Plan, and there was no formal program to ensure residents maintained functioning. If there was a concern about decline, they just screened for Part B therapy services. During an interview on 03/06/25 at 10:26 AM Staff A, Physical Therapy (PT) stated the facility did not have a formal restorative program. He stated he offered the resident could come in to use the exercise bike and acknowledged the resident preferred to stay in his room. The facility provided an undated policy titled Restorative Nursing Policy and Procedure that documented it was the policy of the facility to provide restorative nursing which promoted the resident's ability to adapt and adjust to living as independently and safely as possible. Restorative nursing focused on achieving and/or maintaining optimal physical, mental, and psychological function of the resident. The restorative nurse, RNA (restorative nursing assistants), along with the IDT (interdisciplinary team) would determine what programs would be initiated for the residents. Residents would be screened using the restorative assessment in the electronic health record to identify candidates for programs and included resident who required programs to maintain their current level of functioning.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 48452 Based on observation, resident interview, staff interview, and record review the facility failed to provide trauma informed care for 1 of 5 residents reviewed (Resident #15). The resident arrived at the facility on 2/17/25 with diagnoses of PTSD (Post Traumatic Stress Disorder), anxiety, adjustment disorder, and depression and was not assessed for potential triggers that could cause re-traumatization. The facility reported a census of 29 residents. Findings include: The Minimum Data Set (MDS) for Resident #15 documented diagnoses of adjustment disorder with depressed mood, PTSD, depression, and anxiety disorder. The MDS included a Brief Interview for Mental Status (BIMS) score of 11/15 which indicated moderately impaired cognition. Resident #15's Care Plan indicated the resident had current thoughts of suicide, the primary care provider was notified, and the resident was seen by psych. The resident had no active plans as of 2/24/25. Interventions included face to face consults with the primary provider and psych, monitoring and documenting behaviors, and social service visits with the resident. Another focus area documented the resident had depression disease process. Interventions included administering medications and monitoring for side effects, monitor/record/report risk for harm to self, and monitor/record/report risk for harm to others. The Care Plan did not address anxiety, adjustment disorder, or PTSD. The Care Plan did not include mental health triggers, medications, examples of side effects to watch for, behaviors, or non-pharmacological interventions to address these diagnoses. A Progress Note dated 2/21/2025 at 10:34 PM revealed the resident was seen by her provider that day for a psychiatry appointment with new orders to: 1. Continue Duloxetine 90 mg daily. 2. Continue Seroquel 25 mg po at HS (by mouth, at bedtime) for insomnia, nightmares, anxiety, depression, and history of hallucinations. Patient is at risk for decompensation if not continued. 3. Start Buspar 5 mg po daily in AM (by mouth in the morning). Signed and noted. A Progress Note titled Daily Skilled Note dated 3/3/25 at 10:00 PM documented the resident had the following indicators of a mood issue: Yells out at times. The resident had the following behavioral issues: Yells out at times. Additional comments: none. The note did not include the reason the resident was yelling out or how the staff responded to her needs. A Progress Note titled Daily Skilled Note dated 3/4/25 at 11:54 PM documented the resident had the following indicators of a mood issue: Crying at times. Speech inaudible. The resident had the following behavioral issues: crying. Additional comments: none. The note did not include the reason the resident was crying, why her speech was inaudible, or how the staff responded to the crying. On 03/03/25 at 01:37 PM the surveyor observed the resident in her room. She was in her wheelchair, staring ahead. She did not initially respond to the surveyor's knock, then shook her head and looked up. Resident #15 confirmed her PTSD diagnosis and said she thought they (staff) knew about it. She did not want to discuss it further at that time. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 03/05/25 at 10:19 AM the resident again confirmed her mental health diagnoses. She did not think facility staff had asked about her mental health diagnoses or what caused her to feel anxious. She stated she felt anxious and depressed when she thought about not going home, about wanting to be done with therapy, and about things that happened to her. The resident stated she did not want to hurt herself. She reported changes in her health were hard and made her sad. When asked if she thought her mental health was being managed, she shrugged. An interview with Staff C, Certified Nursing Assistant (CNA) on 03/05/25 at 01:35 PM revealed Resident #15 could get 'really down.' She would walk or stand for some staff and not others, had poor mental health, and did not like being there. During a follow up interview on 03/06/25 at 08:42 AM Staff C stated she was never told about triggers to watch for related to the resident's PTSD and mental health. On 03/06/25 at 09:46 AM Staff F, MDS Coordinator stated it was her fault that the diagnoses, medications, and PTSD triggers did not get into Resident #15's Care Plan. When asked, she stated she didn't see it when the resident came in, and saw the diagnoses later in a doctor's note. At that time she added the information to the diagnoses list but not to the Care Plan. When asked who was responsible for asking a resident about their PTSD triggers, she stated the social worker would ask about that. During an interview with Staff E, Life Enrichment/Social Services on 03/06/25 at 10:14 AM she stated the surveyor should ask the MDS Coordinator who was responsible for asking about mental health triggers, behaviors, and interventions.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 48452 Based on observation, record review, interviews, and policy review the facility failed to ensure psychotropic medications were used only to treat documented conditions for 1 of 5 residents reviewed for unnecessary medications (Resident #25). The facility did not respond to the pharmacist's request to document resident behaviors or implement non-pharmacological interventions to help reduce anxiety. The facility reported a census of 29 residents. Findings include: The Minimum Data Set (MDS) for Resident #25 dated 01/21/25 included documentation that the resident was unable to complete the Brief Interview for Mental Status (BIMS) due to long and short term memory problems and severely impaired daily decision making. Diagnoses on the MDS included non-Alzheimer's dementia, anxiety disorder, and depression. Resident #25's Care Plan included a focus area dated 10/10/24 indicating she was at risk for falls, wandering, poor decision making, and forgetting her walker due to dementia. A focus area dated 11/25/24 documented the resident had dementia with behavior disturbance. An intervention dated 1/20/25 directed staff to administer Olanzapine as ordered and to monitor/document for side effects and effectiveness. An intervention dated 11/25/24 directed staff to give Buspirone as ordered and to monitor/document side effects and effectiveness. An intervention revised 1/6/25 documented pharmacy review per protocol. A focus area dated 10/10/24 indicated the resident had a mood problem, depression, and anxiety. Staff were directed to monitor/document/report to the doctor as needed ongoing signs and symptoms of depression unaltered by antidepressant medications including but not limited to slowed movement, agitation, disrupted sleep, fatigue, changes in cognition, unrealistic fears, attention seeking, anxiety, and constant reassurance. The resident's Medication Administration Record (MAR) for March documented the resident received Alprazolam .25 MG for anxiety, Escitalopram 10 MG for depression, Mirtazapine 15 MG for depression, Olanzapine 2.5 MG for psychotic disorder, and Buspirone 30 MG for depression. Another order for PRN (as needed) Alprazolam .25 MG for anxiety for 90 days was included. Alprazolam, Escitalopram, and Mirtazapine were not addressed in the Care Plan. Triggers for PRN medications were not addressed in the Care Plan. The MAR included orders to observe for depressive behaviors, anxious behaviors, clinical worsening, suicidality, unusual changes in behavior, and side effects related to antidepressant and antianxiety medications. Staff were directed to document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings every shift effective 10/1/24. These sections were marked with a check mark and did not follow the directed protocol for monitoring. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/03/25 at 12:19 PM observed Resident #25 eating in the dining room. She crossed and uncrossed her legs 6 times in 1 minute, and the right leg over her left knee repeatedly bounced. The resident's arms were folded and shook. She stood up and sat down twice, once walking around her walker to get to the door, about 15 feet. On 03/04/25 at 1:01 PM the resident was seated in the common area of her neighborhood at a table. No staff were in the area. The resident stood up and walked toward her room without her walker. She walked about 30 feet before a CNA saw her and assisted her back to the chair. A progress note titled Consulting Pharmacy Note dated 2/25/2025 at 04:59 PM documented the resident's monthly medication review was completed. The facility was asked to add behavior notes to support the use of psych medications, and to include non-pharmacological methods attempted to help reduce anxiety. Between this note and 3/5/25 the progress notes did not show behavior monitoring or non-pharmacological interventions. Resident #25's electronic health record included a section labeled Tasks. Under heading of Behavior Monitoring 2 there were 0 responses documented over the prior 30 days. During an interview with Staff F, MDS Coordinator on 03/06/25 at 09:46 AM she stated they tried to include behavior monitoring in the care plans as soon as possible so it was included on the point of care (POC) screen the Certified Nursing Assistants (CNAs) saw. She stated all departments could enter information in the care plan. It was typical for nurses to enter orders for behavior monitoring, to chart as a progress note, and potentially include monitoring in the MAR depending on the resident's needs. On 03/06/25 at 10:35 AM the Director of Nursing stated behavior monitoring should be on the POC if triggering from the care plan, and could also be in the progress notes. She reported that all residents need behavior monitoring for instances such as confusion or changes in condition. A facility policy titled Medication Regimen Review revised 6/1/24 documented the consultant pharmacist would conduct reviews and make recommendations based on information made available in the resident's health record. The facility should ensure the pharmacist had access to physician/prescriber progress notes, nursing notes, medication administration records and any other documents which might assist the consultant pharmacist in making a professional judgment as to whether irregularities exist in the medication regimen. The facility should inform the pharmacist of any physical and/or mental conditions of the resident which were likely to affect his/her medication therapy outcome.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on observation, kitchen record review, interview, and policy review the facility failed to store food according to professional guidelines and to clean dishes under sanitary conditions during 1 of 2 kitchen observations. Dry storage and the refrigerator contained expired, unlabeled, and undated items. Dishwasher sanitizer logs were not maintained and the sanitizer sink did not register chemical content. The facility reported a census of 29 residents. Findings include: During the initial kitchen observation on [DATE] from 09:57 AM to 10:24 AM the surveyor observed the following: a. 16 - 1 pound boxes of baking soda that expired in [DATE] b. sliced cheese wrapped in saran wrap without a label or open date c. opened, undated 5 pound container of cottage cheese d. clear plastic bins of vegetable soup, tomato paste, and pickles covered with saran wrap dated [DATE] (11 days prior) e. clear plastic bin of chicken gravy, undated f. dishwasher chemical logs recorded concentration testing until [DATE] g. staff tested the dishwasher chemical with a test strip that did not register the chemical h. the sanitizing sinks for bigger items also did not register the sanitizing chemical with a different test strip The facility Certified Dietary Manager (CDM) participated in the observation and tour. She stated she took over the facility kitchen the week before from a contracted provider and was aware there was a lot of work they still had to do. She reported she talked to staff during her initial tour about labeling and dating items. The CDM indicated she expected items in the refrigerator and dry storage to be labeled with a date of receipt and an open date. She preferred lids to saran wrap for freshness, and would generally keep items stored that way ,d+[DATE] days, certainly no longer than 7 days. She stated the dishwasher test strip was probably not the right one and they would have to look at that. While reviewing additional paperwork with the surveyor, the CDM was unable to locate additional dishwasher chemical testing documentation. During a subsequent conversation on [DATE] at 12:40 PM the CDM reported she had found additional expired items that had to be thrown away. An undated policy titled Dish Machine Operation documented Dining Services staff should check the dials to ensure the wash and rinse cycles were achieving proper temperature, and if a chemical sanitizer was used, check the concentration using the correct test tape for the type of sanitizer in use. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An undated policy titled Food Storage (Dry, Refrigerated, and Frozen) documented all food items would be labeled. The label must include the name of the food and the date it should be sold, consumed, or discarded. Food that passed the expiration date should be discarded, and food prepared in the facility should be discarded after 7 days.