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	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Meadows Senior Living & Health Care	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, and facility policy review the facility failed to ensure residents had a dignified dining experience for Resident #13 and four additional residents. The facility reported a census of 29 residents.Findings Include: Review of Resident #13's Quarterly Minimum Data Set, dated [DATE] revealed a Brief Interview for Mental Status score of 10 out of 15, which indicated moderate cognitive impairment. The MDS further revealed diagnosis of unspecified dementia without behavioral disturbance and Diabetes Mellitus. On 3/26/26 at approximately 6:45 AM, an observation was made of residents brought to the dining table by Staff K Certified Nursing Assistant (CNA). Five residents were observed at the table by 7:00 AM. Several residents including Resident #13 were heard repeatedly asking for something to drink. Resident #13 repeatedly asked for coffee and was told by Staff F it would be a little bit. Other residents were heard asking for water or a snack and wondering where their breakfast was. Staff F repeatedly responded to residents ok or it would be a little bit. On 3/26/26 at 7:30 AM Resident #13 queried about any concerns he had with meals. He advised they always brought (residents) out here so early and then had to sit and wait a long time. Resident #13 explained asked staff for coffee and they told the resident he had to wait. He explained there was no reason he couldn't have something to drink, even water. Resident #13 explained he was not in prison. The other four residents at the table also spoke up and explained if they had to sit there so long they would at least like something to drink. On 3/26/26 at 7:40 AM, observation revealed Staff K prepared drinks for the residents and placed them on a serving tray in the kitchenette area. After the drinks were prepared, Staff K stood in the kitchenette area and did not serve the residents their drinks. Approximately 10 minutes later Staff K was queried and explained waited to closer to the time the meal was served to pass out the beverages. When asked for clarification, Staff K shared if they gave the residents their drinks too soon, they would drink them and want more and would drink several if they were allowed to. Then the residents would have to go to the bathroom more often and would have to change their briefs. Staff K explained then would run out of briefs. When asked if the facility ran out of briefs often Staff K responded, not really. On 3/26/26 at 1:15 PM Staff L, Registered Nurse (RN) was queried about when the residents were brought out to the dining area for their meals. Staff L explained typically residents were brought out for meals closer to the meal time then what the CNA did that morning. Staff L advised she did not know why the residents were brought out for breakfast so early that morning and if they were going to be brought out that early, they should have been offered something to drink and a snack. On 3/26/26 at 1:30 PM, Staff C, CNA explained breakfast was usually at 8:00AM and residents started coming out around 7:20 AM. On 3/26/26 at 1:32 PM, Staff B, CNA explained breakfast was around 8 AM. Residents come out to the dining room about 7:20 AM to be ready by 7:45 AM. Per Staff B, the residents were provided drinks while they waited. Staff B was not aware of running out of briefs. On 3/26/26 2:24 PM the Director of Nursing (DON) explained she had observed staff bring residents to the dining room between 7:30 and 7:45 AM. The DON explained 6:30 AM was too early for residents to be in the dining room for breakfast unless it was the resident's request. Per the DON, it was her expectation that residents be offered a drink within five minutes. The (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON further explained she ordered all of the briefs and they had never run out.On 3/26/26 at approximately 3:15 PM the Administrator explained it was the resident's preference what time they were brought out for breakfast. He explained unless the residents had requested, 6:30 AM would be too early to be brought out for dining. He further explained it was his expectation the resident was given something to drink right away. Per the Administrator, earlier this week dietary staff approached him with concerns of residents being brought out for meals too early. When queried, the Administrator explained the facility staff would never withhold a resident from beverages unless they had a beverage restriction. He was not aware of the facility ever running out of briefs. A review of the facility policy titled Resident Rights Policy, dated 12/24 revealed, Each resident residing in this community has the right and will be afforded the right to a dignified existence, self determination, and communication. Each resident will have autonomy and choice, to the maximum extent possible, about how each resident wish to live his/her everyday life and receipt of care, subject to the community's policies and procedures as long as those policies do not violate any requirement.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review, staff interviews and facility policy review the facility failed to notify the physician of change in resident transfer status and pain in left ankle for 1 out of 1 resident reviewed with injury of unknown origin (Resident #25). The facility identified a census of 29 residents. Findings include:Review of the Minimum Data Set for Resident #25 dated 12/5/25 revealed a Brief Interview for Mental Status score of 15 out of 15 which indicated intact cognition. The MDS noted Resident #25 needed supervision or touching assistance for sit to stand transfers and toilet transfers. The MDS listed diagnoses of hypertension (high blood pressure), end stage renal disease, and diabetes. Review of the facility nurse progress notes from 2/13/26 through 2/15/26 lacked any documentation of left ankle pain or change in transfer status or ability to bear weight. The progress notes failed to reveal any physician notification. Review of the progress notes from dialysis on 2/16/26 for Resident #25, with no time indicated, revealed she arrived today with a complaint of much pain in left ankle and unable to stand on it. A Progress Note from dialysis Advanced Registered Nurse Practitioner noted on 2/16/26 at 8:02 AM revealed Resident #25 presented to dialysis with left ankle medial and lateral malleolar pain. It is exquisitely tender in nature. We can barely touch it. She denies any trauma. Review of a written statement dated 2/25/26 at 1:54 PM by Staff H, Licensed Practical Nurse (LPN) revealed she worked 6:00 PM to 6:00 AM on 2/15/26. During the shift Staff H was made aware Resident #25 requested 2 person assist with her transfer due to not being able to bear weight on her left leg. Later in the shift Resident #25 requested pain medication for a rating of moderate pain. Resident #25 requested assistance from two staff from a recliner to wheelchair to have breakfast. On 3/25/26 at 12:43 PM, Staff G, LPN confirmed she worked on day shift 6:00 AM to 6:00 PM on 2/14/26 in Resident #25's unit. Resident #25 had been complaining for a couple of days, she had a sore on her leg and she complained that her leg hurt. Normally she would transfer with one and she would hold onto and use the grab bar and transfer. She was not letting go of the transfer bar that day. Staff G didn't recall if she was bearing weight 100% or not. Staff G didn't transfer her very often. Staff G knew she had been complaining of pain for a couple days prior to that. Staff G explained usually, would document pain assessments in a progress note, if it was unusual. Staff G did not recall if gave her (resident) pain medication that day and it would be on the medication administration record. Staff G thought she was on scheduled Tylenol. Staff G looked at the whole knee down and thought along the lines of cellulitis, when the pain increased [Staff G] thought more cellulitis. Per Staff G, asked her (resident) to do a range of motion but she refused but that was not uncommon for Resident #25 to get upset with a lot of questions. Staff G further explained did pass it along to the nurse on the next shift that resident was having pain. Per Staff G, should have charted in the progress note anything that was out of the normal for the resident. On 3/25/26 at 3:47 PM of Staff E, CNA revealed she worked the evening shift 2:00 PM to 10:00 PM and Resident #25 requested more assistance with transfers. Resident #25 reported to Staff E, CNA it was hard for her to put weight on her left leg. She spoke with a coworker about it and normally Resident #25 did not require extra help and she requested more help that night. Staff E explained let the nurse know and she was going to talk to her about it. She could not recall who the nurse was that night. On 3/25/26 at 2:29 PM Staff F, Certified Nursing Assistant (CNA) revealed she worked 6:00 PM to 6:00 AM on 2/15/26. Staff F assisted Resident #25 in the bathroom and Resident #25 said she could not put any weight on her leg, so had to get a second person. A lot of times she would do it on her own and other times she would need assistance from one staff member, it would depend on how she was feeling. The nurse knew about the situation because she had to help with transfers that night and Resident #25 wasn't able to bear weight. On 3/26/26 at 11:40 AM Staff D, Registered Nurse (RN) revealed if change in status of resident transfer status and complaints of pain staff should notify the physician and potentially have evaluation at the emergency room or attempt to get a physician appointment. On 3/26/26 at 1:33 PM the Director of Nursing (DON) (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported with condition changes for residents, staff should notify the on-call nurse, DON, and the on-call physician. The DON revealed Resident #25 was alert and oriented, and the resident should have been talked to about if she wanted follow up and staff should have offered her choices. The facility provided a policy dated 12/2024 titled Significant Condition Change and Notification which stated the purpose was to ensure the resident's family and/or representative and medical practitioner were notified of resident changes such as those listed below: -An accident or incident, with or without injury, that has the potential for needed medical practitioner intervention. -A significant change in the resident's physical, mental or psychosocial status. Sudden onset of shortness of breathMobility changesAbnormal, unusual or new complaints of pain

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and the Medicare Claims Processing Manual the facility failed to provide a resident with form CMS-10055 (Centers for Medicare & Medicaid Services) at the end of therapy services when the resident planned to remain in the building for one of three residents reviewed for Beneficiary Notice (Resident #20). The facility reported a census of 29 residents.Findings include:A review of Resident #20's Minimum Data Set, dated [DATE] revealed he admitted to the facility on [DATE]. The resident ended his therapy and Medicare stay on 11/07/2025. His Brief Interview for Mental Status score was 11/15, which indicated moderate cognitive impairment.On 3/26/26 the facility was asked to provide documentation of the resident's CMS 10055 (Advance Beneficiary Notice of Non-Coverage or ABN) and CMS 10123 (Notice of Medicare Non-Coverage or NOMNC) forms.A document titled Notice of Medicare Non-Coverage (NOMNC, CMS 10123) dated 11/07/2025 documented the end of Resident #20's skilled services. It was signed by his power of attorney on 11/05/2025. The facility did not provide a CMS-10055. During an interview with the Administrator on 3/26/26 at 2:18 PM he stated he was unable to say if the facility completed the CMS 10055 for discharging residents. He indicated social services completed them.On 3/26/26 at 2:25 PM Staff I, Social Services stated she was not completing the CMS 10055 with any residents discharged from skilled services or therapy who remained in the facility. She indicated she was not aware they needed it. Chapter 30 of the Medicare Claims Processing Manual documented that the ABN form CMS 10055 was issued in order for a Skilled Nursing Facility (SNF) to transfer financial liability to an original Medicare beneficiary for items or services that Medicare was expected to deny payment (entirely or in part).

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on clinical record review, staff interviews, and facility policy review, the facility failed to document targeted behaviors and provide non-pharmacological interventions prior to the use of an as needed antianxiety medication for 1 of 5 residents reviewed for unnecessary medications (Resident #9). The facility reported a census of 32 residents.Findings include:The Minimum Data Set assessment for Resident #9 dated 3/5/26 identified a Brief Interview for Mental Status score of 8 out of 15, indicating moderate cognitive impairment. The MDS identified a PHQ-2 (Patient Health Questionnaire, a screening tool used to assess the frequency of depressed mood) score of 0, which indicated no depression. The MDS documented the resident displayed no behavioral symptoms, hallucinations or delusions during the look back period. The MDS documented diagnoses that included non-Alzheimer's Dementia, anxiety, and depression. The Care Plan for Resident #9 dated 3/2/26 identified a focus area of depression and anxiety related to dementia. It directed staff to monitor, document and report signs and symptoms of depression and to administer medications as ordered. No targeted behaviors for antianxiety medication were documented on the Care Plan. The Medication Administration Record (MAR) for March 2026 documented Resident #9 received an order on 3/4/26 for Alprazolam (Xanax, an antianxiety medication), with instruction to give 1 tablet of 0.5 mg (milligram) every six hours as needed. The order was 14 days long. Between 3/4/26 and 3/18/26, eight doses were administered. A new order was written with a start date of 3/19/26. Between 3/19/26 and 3/25/26, an additional seven doses were administered.A Health Status Note dated 3/4/26 at 4:59 PM documented that the resident's daughter notified the facility that the resident had been calling family members during overnight hours. The daughter reported that the resident had been using alprazolam prior to admission and requested the facility inform the physician of this. The note further documented staff notified the physician and that was when the alprazolam order was initially prescribed. Daily Skilled Nursing Notes, documented twice daily, were reviewed for 2/27/26 through 3/20/26. The standardized form included an area to note if the was resident experiencing any cognitive concerns/behaviors. On 2/28/26, 3/2/26, and 3/5/26 it was documented the resident had confusion. On 3/11/26 it was documented the resident yelled at times. On 3/12/26 it was documented the resident was pleasantly confused and on 3/19/26 the resident experiencing moderate to severe confusion. A review of eMAR (electronic MAR) notes revealed that no behaviors or non-pharmacological interventions were documented prior to administration of any of the doses of the PRN (as needed) alprazolam.On 3/25/26 at 2:53 pm, the Director of Nursing (DON) explained, via email, that her expectation and the facility's practice was for the staff to document on the eMAR if the resident displayed behaviors and if so, to enter a detailed progress note outlining the specific behaviors, contributing factors, and interventions implemented. The DON also stated re-education had been provided to nursing staff. The email additionally documented that the expectation of the facility was that non-pharmacological interventions were attempted and documented prior to the administration of PRN (as needed) psychotropic medications. Further education regarding this was also provided to the nursing staff. In a separate email on 3/26/26 at 8:42 am, the DON stated no targeted behaviors for the use of alprazolam were on the Care Plan for Resident #9. She stated the facility had no documentation as to what the alprazolam was treating as Resident #9 was a recent admission to the facility. On 3/26/26 at 11:16 am, Staff B, Certified Nurse Aide (CNA) Resident #9 would at times pick at a scab on the right side of her head but she was not aware of any other behaviors she exhibited. She stated the resident did get more confused later in the day. Staff C, CNA stated that in the evenings, Resident #9 got more anxious and would roll back and forth in her wheelchair. She said if the resident was in her room and her call light was attached to her wheelchair (so she could locate it if needed), this would agitate the resident. She said if the resident became agitated, staff would bring her out of her room and talk with her which would usually help calm her (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	down. She felt Resident #9 got bored and enjoyed having company. She stated she would report any behaviors to the nurse to document. She stated as a CNA she was unable to document behaviors on all residents, explaining behavior documentation was only shown for some of the residents in the CNA charting. On 3/26/26 at 11:32 am, Staff D, Registered Nurse (RN) stated Resident #9 normally did not have any anxious behaviors when she was on duty. She stated the resident was very confused when she was first admitted . The facility was a new environment and the resident would often climb out of bed or out of her chair but she was no longer doing that. She also stated Resident #9 did pick at the scab on her head from a fall earlier in her stay. She stated if Resident #9 was displaying anxious behaviors, it should be documented in progress notes if giving the PRN medication. The facility policy Psychotropic Medication Use, dated 2/2025 included the following documentation: Residents will only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to:AntipsychoticsAntidepressantsAntianxiety Hypnotics The policy further revealed, Staff will complete the Psychoactive Medication Review assessment on admission, when any new psychotropic medication is ordered, with a change of condition, and quarterly. This assessment will be completed for any medication prescribed to manage behaviors .Residents who are admitted from the community or transferred from a hospital and who are already receiving psychotropic medications will be evaluated for the appropriateness and indications for use. The interdisciplinary team will: Review PASRR screening (preadmission screening for mentally ill and intellectually disabled individuals), if appropriate; or Re-evaluate the use of the psychotropic medication at the time of admission to consider whether the medication can be reduced, tapered, or discontinued per regulation.Complete the Psychotropic Medication Review assessment in the EHR (electronic health record).Based on assessing the resident's symptoms and overall situation, the medical practitioner will determine whether to continue, adjust, or stop existing psychotropic medication. No Psychoactive/Psychotropic Medication Review was located in Resident #9's Electronic Health Record

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review, staff interviews, and facility policy review the facility failed to assess and intervene for a resident with a fall which resulted in a fracture (Resident #1) and for a major injury of unknown origin (Resident #25) for 2 out of 2 residents reviewed with injuries. The facility reported a census of 29 residents. Findings include:1. Review of the Minimum Data Set for Resident #25 dated 12/5/25 revealed a Brief Interview for Mental Status score of 15 out of 15 which indicated intact cognition. The MDS noted Resident #25 needed supervision or touching assistance for sit to stand transfers and toilet transfers. The MDS listed diagnosis of hypertension (high blood pressure), end stage renal disease and diabetes. Review of the nurse progress note 2/16/26 at 1:48 PM revealed Resident #25 went to the emergency department related to left ankle pain. The progress note dated 2/16/26 at 6:03 PM revealed Resident #25 had a tibial fracture on left leg. Resident #25 needed to be completely non weight bearing and wear a boot to move around. Review of the progress notes from dialysis on 2/16/26, no time documented, revealed the resident arrived that day with a complaint of pain in left ankle and was unable to stand on it. A progress note from the dialysis Advanced Registered Nurse Practitioner noted on 2/16/26 at 8:02 AM revealed Resident #25 presented to dialysis with left ankle medial and lateral malleolar pain. It was exquisitely tender in nature. We can barely touch it. She denies any trauma. Review of the facility nurse progress notes from 2/13/26 through 2/15/26 from the facility failed to reveal any documentation of left ankle pain or change in transfer status or ability to bear weight. Review of an incident report dated 2/15/25 at 10:00 PM revealed Resident #25 went to dialysis this AM and requested to be sent to the emergency room for ankle pain. Facility notified of fracture to left ankle. Resident #25 stated she had been assisted by a staff member when her leg got caught between staff members legs and her ankle twisted. A progress note from 2/16/26 6:37 PM revealed vital signs stable and fistula within desired limit after dialysis and the emergency room. The progress notes did not have any assessments on the left lower extremity or pain level. A written statement by Staff G, Licensed Practical Nurse (LPN)on 2/18/26 revealed on the evening of 2/14/26 Resident #25 complained of pain to the left lower leg. The resident does have a dressing change for a skin tear and she removed the dressing to assess for any signs and symptoms of infection. After supper during a transfer to the toilet Resident #25 did not want to stand on the left leg. She refused to use the easy stand and was assisted to the toilet by pivot on right leg and staff holding her by a gait belt. Staff G reported to the nurse at 6:00 PM who relieved her about the pain and to watch for signs and symptoms of infection. A major injury form signed on 2/18/26 revealed the resident had diffuse osteopenia and likely osteoporosis. Per the form, the resident had a diaphyseal fracture. The ankle mortise was noted to be intact (socket of the distal tibia and fibula). The section completed by the Physician, designee, or extender noted the resident had an excellent prognosis with recovery within 3 to 6 months without surgery. Treatment included non-operative management with boot and ortho follow up and evaluation. Review of a written statement dated 2/25/26 at 1:54 PM by Staff H, Licensed Practical Nurse (LPN) revealed she worked 6:00 PM to 6:00 AM on 2/15/26. During the shift Staff H was made aware Resident #25 requested 2 persons to assist with her transfer due to not being able to bear weight on her left leg. Later in the shift Resident #25 requested Tylenol (pain medication) for a rating of moderate pain. Resident #25 requested assistance from two staff from a recliner to wheelchair to have breakfast. No further complaints of pain or discomfort during the remainder of the shift. A written statement by Staff F, Certified Nursing Assistant (CNA) revealed on 2/15/26 sometime between 7:30-8:00 PM went to Resident #25 bathroom and the resident told her she could not put any weight on her left leg. Resident #25 requested to get another person to help. Resident #25 did not say (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was in pain, only that she could not put weight on it. On 3/25/26 at 12:20 PM, the Director of Nursing (DON) stated she did fill out the incident report for Resident #25 after the ankle injury. The resident could not specify when the transfer occurred or who it was with initially Resident #25 stated she thought it was a male and then after she changed her statement and said she could not recall. On 03/26/26 at 11:40 AM, Staff D, Registered Nurse (RN) stated if a resident had a change in status for transfers and complaints of pain she would complete an assessment. Staff D would see if the resident could bear weight, would check the resident range of motion and assess where pain was located. Staff D would check the resident's pulse and circulation and notify the physician. Staff D explained they would document the assessment in the progress notes, and if they returned with a fracture from the emergency room, would need to do circulation checks, and make sure pain was controlled, and follow any restrictions. On 3/26/26 at 1:33 PM, the DON revealed she was notified of the left ankle fracture for Resident #25 after she did not return from dialysis. The DON stated it occurred during a transfer and her leg hit something or got caught between staff member legs. The nurse should have documented in the progress notes or incident report. The nurse should do a proper assessment. After she returned from the emergency room and the information the nurse had of the fracture, she should have done a baseline assessment and documented a pain assessment. 2. The MDS for Resident #1 dated 1/31/26 documented diagnoses of dependence on renal dialysis with stage 5 chronic kidney disease, heart failure, and respiratory failure. The BIMS score of 12 out of 15 indicated moderately impaired cognition. The MDS documented the resident was dependent for toileting hygiene and needed partial to moderate assistance with toilet transfers. Resident #1 did not wander or reject care. The resident's Care Plan, with a readmission date of 1/26/26, documented the resident was at risk for falls related to gait/balance problems. Another focus area documented the resident had an ADL (Activities of Daily Living) self care performance deficit and required assistance of 1 for transfers and toileting. During an interview with Resident #1 on 3/23/26 at 1:40 PM, she stated she had been in and out of the hospital since December, one of them for a femur fracture. She reported she fell in her bathroom by her toilet. She asked the CNA to hold her longer, stated they didn't, and then she fell. She felt afraid before the fall and the break caused her pain. An Incident Report dated 2/01/26 at 11:30 PM documented the resident was assessed post fall and complained of right leg pain that ranged from 8 to 10. The resident was assessed for injuries and assisted to bed via full body lift. Vital signs were taken as well as neuros (neurological checks). All appeared to be intact. Per the Incident Report, the resident had no injuries, including skin tears, punctures, and hematomas. The list did not include range of motion assessment. The resident was alert to person, place, situation, and time. The Health Status Note dated 2/02/26 at 12:47 AM documented the resident lost her footing on her right leg and fell to the floor. The CNA stated she was assisting the resident when her right leg gave out and she lost her balance. The resident hit her arm on the floor. The CNA denied the resident hit her head. The resident placed her hand on the right side of her head and stated she hit her head. The resident was very vocal about experiencing pain to the right leg. The resident was hoyered into bed by the nurse and the aide. Peri cares were completed during this time. The resident accepted Tylenol 500 mg (milligram). Vitals and neuros were 'intact' and the resident did not complain of additional pain thereafter. This progress note did not include an attempt to assess range of motion or discussion regarding sending the resident to the emergency room. Per the note, the on-call Provider was notified, (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	03/26/2026

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as well as the DON and resident's responsible party. The Daily Skilled Nurse's Note dated 2/2/26 at 12:02 PM revealed the resident had decreased movement to the right lower extremity, had a fall last evening, and had extreme pain noted to the right lower extremity. Review of the resident's February 2026 Medication Administration Record (MAR) revealed Tylenol 500 mg was administered to the resident on 2/1/26 at 11:43 PM for pain score of 8, on 2/2/26 at 5:45 AM for pain score of 6, and at 6:45 AM for pain score of 10. A document titled Dialysis Communication Form dated 1/02/26 (additional dates indicated it should have been 2/02/26) documented Resident #1 had a fall on 2/01/26 at 11:30 PM, complained of right leg pain, and took a pain medication that morning. Dialysis records dated 2/02/26 indicated the resident was sent to the ER by ambulance and was unable to bear weight. An additional page documented the resident left dialysis 1 hour and 29 minutes early due to pain. The resident reported to dialysis staff that the facility did not offer to send her to the ER. A progress note labeled Health Status Note dated 2/02/26 at 12:55 PM documented the resident was sent to the emergency room (ER) from dialysis for right lower extremity pain. A note on 2/04/26 labeled IDT (Interdisciplinary Team) Fall Note documented the Director of Nursing (DON), Staff I, Social Services, and the Dietary Manager met to review the fall. It indicated the resident was assisted by 1 staff member, a gait belt, and the bathroom grab bar when her right leg gave out and she fell to the floor. General weakness contributed to the fall, and the cause was determined to be related to recent infections (pneumonia and a urinary tract infection). A hospital encounter note dated 2/04/26 at 6:19 PM indicated the resident presented with an acute right femur fracture after a ground level fall and was transferred to this location from another ER due to history of end stage renal disease. On admission, the resident was awake. She confirmed the history of present illness of falling at the facility. At (current) time, the resident reported feeling generally achy all over. She denied pain specifically in the right leg. During an interview with Staff B, CNA on 3/25/26 at 1:15 PM, she reported Resident #1 told her Staff A, CNA 'dropped her' and was crying because of pain in her right leg. When asked if the resident complained about any other pain, Staff B reported the resident did not complain about pain in her arm or head or any other pain. When asked if the resident was scared, Staff B said it didn't seem like it. During an interview on 3/25/26 at 3:11 PM, Provider J, Dialysis nurse stated that the resident was in horrible pain in her right leg. Resident #1 told her that her leg gave out and she hit her head on the toilet. Provider J reported the resident screamed out in pain. The resident told them the facility did not assess her leg before sending her to dialysis or offer to send her to the ER, telling her dialysis would do it. Provider J observed the resident's right leg was swollen, warm to the touch, inverted, and definitely not straight. She was unable to determine if the damage occurred at the time of the fall, during the night, or during transportation and said the injury was pretty obvious. On 3/25/26 at 4:33 PM, Staff A stated that when she answered the resident's room call light, the resident was already at the grab bar in the bathroom so she helped her on the toilet. While the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was on the toilet, Staff A got her bed ready. She then pulled the toilet chair to the grab bar so the resident could stand up. Staff A said Resident #1 stood fine, said she was ready, and then her right leg just gave out. It looked like she just collapsed on it. Her left leg was straight out in front of her and her right knee was bent but in front of her. She stated it happened really fast and didn't look broken. Staff A confirmed the resident said she hit her head but Staff A didn't see that happen. The resident complained that her leg hurt while she was on the floor. The nurse helped Staff A with the full body lift, and they got Resident #1 into bed. She saw the nurse complete the neurological assessment and vitals, but it was after they put the resident in bed. She did not see her assess for range of motion. Staff A stated the resident still complained of pain when she was in bed. At 1:10 PM on 03/26/26 the Director of Nursing (DON) stated the nurse completing the initial assessment on Resident #1 was an agency nurse and she was not sure what her assessment entailed. The nurse texted the DON at midnight even though it was facility policy to call, so she wasn't aware of the fall until morning when she arrived at 6:00 AM to cover a shift. It was at that time she was notified of the resident's complaints of pain. The DON was not sure what information was provided to the nurse practitioner because it was not documented. She stated the resident was tearful when she saw her that morning, complained of pain that was at a 10, and took pain medication. She was not sure if the medication was effective because the resident went to dialysis. The resident reported to the DON that her leg gave out, and the DON believed that the CNA didn't let go too fast but rather the resident was already falling because her leg gave out. The DON reported she offered to send the resident to the ER twice because she was not her normal self, but the resident wanted to go to dialysis. She reported that she called dialysis who said they would provide her treatment and then send her to the ER. The facility provided a policy titled Significant Condition Change and Notification dated 12/2024. The policy directed documentation will include an assessment of the resident's current status as it related to the change in condition. Charting will be done each shift for 72 hours for residents with a change of condition. A change of condition is reviewed by DON or designee for the continued need for additional documentation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews the facility failed to provide enhanced barrier precautions to prevent the spread of infections for 2 out of 4 residents (Resident # 7) with a catheter and (Resident # 11) with an open wound. The facility identified a census of 29 residents. Findings include: 1.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had an indwelling catheter.The Care Plan for Resident #7 with a revision date of 3/16/26 revealed the resident had an indwelling foley catheter. Resident #7's Care Plan directed staff to position the catheter bag and tubing below the level of the bladder and away from the entrance room door. The Care Plan failed to direct staff to use enhanced barrier precautions with the use of the catheter. On 3/26/26 at 11:25 AM Staff C, Certified Nursing Assistant (CNA) emptied the foley catheter for Resident #7 in her room. She did not utilize any personal protective equipment and failed to utilize enhanced barrier precautions. No supplies were outside of the room and no sign posted on the door to notify staff to use enhanced barrier precautions. 2. Review of the MDS dated [DATE] for Resident #11 revealed she had a Stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough). Review of Resident #11's Care Plan with a revision date 3/5/26 revealed a Stage 2 pressure ulcer to the coccyx on 2/19/26. The Care Plan failed to direct staff to use enhanced barrier precautions for Resident #11. On 3/26/26 at 7:47 AM observed the Assistant Director of Nurse (ADON) provided wound care to Resident #11's buttocks. The ADON completed the dressing change but failed to don personal protective equipment or utilize enhanced barrier precautions. There was no sign outside Resident #11 door and no supplies for personal protective equipment. On 3/26/26 at 11:36 AM Staff D, Registered Nurse (RN) stated enhanced barrier precautions should be used when a resident has an open wound, any colostomy, dialysis port, or tube feeding. On 3/26/26 at 1:46 PM, the Director of Nursing (DON) revealed enhanced barrier precautions should be utilized for multi drug resistant organisms (MDRO), anyone with a dialysis port, catheter, colostomy, chronic wounds and tube feedings. Enhanced barrier precautions should be utilized to protect the resident from infections. Per the DON, even if the wound was covered, should still use enhanced barrier precautions. Staff would know if they were on enhanced barrier precautions by a sign posted on the resident's door. The DON explained had recently done staff education for enhanced barrier precautions. The ADON and DON were responsible for putting the signs on doors. The facility provided an undated policy titled Infection Prevention and Control Manual-Enhanced Barrier Precautions which directed that enhanced barrier precautions were recommended for residents with any of the following:Infection of colonization with a MDRO or A wound or indwelling medical device, even if the resident is not known to be infected or colonized with a MDRO. Indwelling medical devices include central venous catheters, urinary catheter, feeding tubes, tracheostomies/ventilators. High contact resident care activities where a gown and gloves should be used include: Bathing/showeringTransferring residents from one position to another (for example, from bed to wheelchair)Providing hygieneChanging bed linensChanging briefs or assisting with toiletingCaring for or using an indwelling medical devicePerforming wound care.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review the facility failed to screen residents for eligibility of the pneumococcal vaccine for 2 of 5 residents reviewed (Resident #7 and Resident #13). The facility reported a census of 29 residents.Findings Include: 1. The admission Minimum Data Set (MDS) assessment tool, dated 3/2/26 revealed Resident #7 admitted to the facility on [DATE]. The MDS revealed the resident had severely impaired cognition for daily decision making. The admission MDS documented the resident received a Influenza vaccine outside the facility, was not up to date with pneumococcal vaccination, and was not offered a pneumococcal vaccine. The Immunization Consent Form for Resident #7 dated 10/24/24 documented the resident received a Covid vaccine and Influenza vaccine. There was no documentation of a pneumococcal vaccine.The Immunization Consent Form for Resident #7 dated 10/16/25 documented the resident received an Influenza vaccine. The was no documentation of a pneumococcal vaccine.2. The Quarterly MDS assessment tool dated 2/01/26 listed diagnosis for Resident #13 which included unspecified dementia without behavioral disturbance and diabetes mellitus. The MDS listed his BIMS score was 10 out of 15, indicating moderate impairment. Resident #13 admitted to the facility on [DATE]. The Immunization Consent Form for Resident #13 dated 11/13/25 documented the resident received a Covid vaccine and Influenza vaccine. There was no documentation on a pneumococcal vaccine. The MDS also documented the resident was up to date on pneumococcal vaccination.Documentation from the pharmacist dated 1/13/26 revealed the resident qualified for Prevnar 20. During an interview on 3/26/26 at 2:01 PM, the Director of Nursing (DON) and Infection Control Preventionist was queried on the expectation of residents being vaccinated for pneumococcal and she advised, all resident vaccination history should be electronically entered into the Immunizations Section of the resident's EHR (electronic health record) within 48 hours of their admission. The DON queried she was unable to provide further vaccination documentation on either resident and both should have been offered the pneumococcal vaccination and if refused a declination and verification of education should be in the resident's EHR. The DON advised there had been a lot of staff turn over and there was no staff assigned to entering vaccinations.The Facility Policy titled Infection Prevention and Control Manual dated 2019 documented the following: It is the policy that this facility's Infection Prevention and Control Program (IPCP), is based upon information from the Facility Assessment and follows national standards and guidelines to prevent, recognize and control the onset and spread of infection whenever possible.