

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>165301</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>12/02/2025</b>
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NAME OF PROVIDER OR SUPPLIER <b>Great River Care Center</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1400 West Main , Mc Gregor, Iowa, 52157</b>
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F0000	INITIAL COMMENTS  Correction date: _____  The following deficiencies resulted from investigation of facility reported incidents #2659950-I, #2659937-I, #2661423-I, #2674068-I and complaints #2658415-C and #2673894-C conducted from November 5, 2025 - December 2, 2025.  Complaint #2658415-C resulted in a deficiency.  Facility reported incident #2659950-I resulted in a deficiency.  See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F0000		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices  CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents.  The facility must ensure that -  §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is NOT MET as evidenced by:  Based on observation, clinical record review, staff interview, family interview, police officer interview and facility policy review the facility failed to ensure the staff maintained all secured exit doors resulting in 1 of 3 reviewed residents (Resident #1), identified as exit seeking, exiting the facility while a staff member who entered allowed the resident to exit. The staff member failed to notify any nursing and/or management staff. The resident then walked 0.8 miles from the facility down an identified highway on an incline from a bluff and into town. The resident had	F0689	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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
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F0689 SS = SQC-J	<p>Continued from page 1</p> <p>left the facility for approximately 45 minutes before the nursing staff realized he was missing, when the resident's family called the facility and informed the staff. This deficient practice resulted in an Immediate Jeopardy (IJ) to the health, safety, and security of the resident. The facility identified a census of 31 residents.</p> <p>The Iowa Department of Inspections, Appeals, and Licensing (DIAL) notified the facility of the IJ on 11/5/25 at 3:30 PM. The immediacy began on 11/2/25. The IJ was removed per past noncompliance on 11/3/25. The facility removed the IJ through the following actions:</p> <p>*Wander guard placement 11/3/5.</p> <p>*The nursing staff began holding missing resident drills on 11/3/25.</p> <p>*All staff received education on the following policies: missing resident/tenant policy, door alarm response times, prior to their next shift and via a mass text message to all staff.</p> <p>The facility implemented their plan of correction and removed the immediacy on 11/3/25. The scope was lowered from a "J" to a "D".</p> <p>Findings Include:</p> <p>According to a Minimum Data Set (MDS) assessment form dated 10/24/25, Resident #1 had diagnosis that included a non-traumatic brain dysfunction, Hypertension (HTN), Alzheimer's Disease, anxiety, and disorientation. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which signified moderately impaired cognitive skills,</p> <p>Review of Resident #1's Care Plan revealed the following:</p> <p>a. The resident required 24 hour care related to (r/t) Alzheimer's Disease (Initiated 2/13/25).</p> <p>b. At risk for falls r/t pain, weakness and a history of falls. (Initiated 2/13/25). The intervention initiated 9/16/25 revealed, Independent with a front wheeled walker (FWW) for transfers and ambulation.</p> <p>c. Impaired cognition r/t Alzheimer's Disease. (Initiated 2/13/25). The intervention dated 2/13/25 directed staff to cue, reorient and supervise as needed.</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 2</p> <p>A Morse Fall Scale dated 10/22/25 at 8:18 a.m. indicated the resident as at high risk for falls. The resident scored 80 on the assessment. It was noted a score between 46 and 125 indicated high fall risk. Per the Fall Scale, Resident #1 exhibited weak fait, and overestimated or forgot limits related to abilities to ambulate safely.</p> <p>An Elopement Incident Form dated 11/2/25 at 7:20 a.m. included the following information: When housekeeper arrived to work at 7:20 a.m. she opened the front door. Resident was stading at the front door and asked the housekeeper to hold the door open for him. The housekeeper held the door open and the resident went outside. Resident was dressed in jeans, sweater, baseball cap, sock and shoes. Resident does often stand at the front entrance and look out the window, however, never attempted to go outside prior. When staff noticed resident was not in his room, Nurse and all of the present staff searched the building for resident, which included every resident room, and then looked outside to see if he was there. Housekeeper then reported she let the resident out the front door upon her arrival to work. Nurse then called 911. Granddaughter then called right after getting off the phone with the police and reported the resident called her and stated he was downtown. Police arrived back to the facility with the resident. Full head to toe assessment done upon arrival back to facility, No injuries. Denies pain. Fingertips cold to the touch due the temperature outside. Resident had his walker with him and his glasses on.</p> <p>The Resident Description section of the Incident Report revealed, "I just wanted to get away".</p> <p>Review of a Police Report dated 11/12/25 at 7:16 p.m, for incident date 11/2/25 at 8:06 a.m. included the following:</p> <p>On 11/2/25 at approximately 8:06 a.m., the police officer had been dispatched to the report of a person missing from the care center. The officer later identified the missing person as [Resident #1]. Upon speaking to the staff at the care center, they informed him that one of their staff members held the door open for the resident as he left the care center earlier that morning. The staff stated the resident was not supposed to leave the facility unless a family member picked him up. Then staff then notified the officer the resident's daughter had called the care center and told them the resident had been alone at his son's properly at [Address Redacted].</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 4 because he said he was uptight related to (r/t) some of the things around the facility. The resident indicated he exited out the front door and walked down the highway into [City Name] to the vicinity of his son's house. He ended up across the street from his apartment by the church. The resident indicated his son had been working at the time so he had not been home. At that point the police intercepted him and brought him back to the facility. The resident indicated he walked the street or sidewalk whichever he could find on his way into town. The resident confirmed he felt cold when he left and he failed to wear a coat and gloves but he had not fallen.</p> <p>During an interview 11/5/25 at 11:26 a.m., Staff B confirmed she worked 11/2/25, arrived at 5:30 a.m., and entered the facility through the North dining room door at which time she observed the resident positioned at the dining room table. The staff member never observed him again until later that morning as she walked through the dining area. Later that morning staff had not observed him at the dining room table so Staff C, Certified Nursing Assistant (CNA) asked where he was as Staff B indicated she had not known. Staff then got on radio (walkie talkie) and asked if any staff knew the location of the resident. At that point everyone took off down the hallways, resident rooms, outside and through the entire building. The staff returned to the facility around 8 a.m. when the phone rang as the resident's family requested to speak to Staff D, Registered Nurse (RN).</p> <p>During an interview 11/5/25 at 11:41 a.m., Staff C confirmed she worked 11/2/25 from 5 a.m. to 1 p.m. and entered the facility through the North door in the dining room and observed the resident positioned at the dining room table where he sat per norm for the resident. Around 7 a.m. she had been in another resident's room when a call came over the walkie talkie and informed staff the resident had been exit seeking. As she left the resident's room Staff B told her the resident stood by the front door and was exit seeking so Staff C intervened. The resident told her he had been upset because he drank all of his coffee and he wanted more. Staff C redirected him and stated it had been cold outside at which time he responded by, yes you are right so he headed back towards his room. The next thing she knew around 7:50 a.m. to 8 a.m. while she assisted the resident's roommate in their room she noted the resident as not present so she informed Staff D the resident appeared missing. From what she knew, Staff D called the police and all staff looked down each hallway and rooms, one staff went to the assisted living and three staff outside and around the building.</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 5</p> <p>The staff member indicated maybe 10-15 minutes after that event began a police officer arrived without the resident and talked to Staff D then left the facility as a means to locate the resident. At a time unknown she observed the officer return with the resident, who appeared per normal self.</p> <p>During an interview 11/5/25 at 12:32 p.m., Staff D confirmed she worked 11/2/25 from 5 a.m. to 5 p.m. and entered the facility through the front door and felt the resident had been in his room at that time. Just before breakfast around 7:50 ish staff notified her the resident had not been in the dining room anymore. Staff already knew he had been wandering so they searched all the rooms in the facility, outside and the assisting living facility on grounds but no one found him. At approximately 8 a.m. she called 911 and as soon as she got off the phone the granddaughter called and said, you know the resident had not been in the facility rather he was at his son's apartment. The staff member validated they had been aware so she called 911 again and told them where he had been located per the family. The police went straight to the location and brought him back to the facility around 8:30ish with his walker and cell phone. When the staff member got to him he grabbed her hands and his hands were cold but his circulation was good. She then took him to his room and cranked up his heat as she performed a head to toe assessment with no negative outcome other than cold.</p> <p>During an interview 11/5/25 at 12:44 p.m., Staff E, CNA confirmed she worked Sunday morning and entered for her shift through the North side door in the facility however the resident had not been positioned at the dining room table upon her arrival. Staff E proceeded to get people up for the day and as she took residents to the dining area she indicated at approximately 6:30 a.m. the staff member observed the resident as he drank coffee at the dining room table. Later she heard someone paged the resident had been by the front doors looking outside so the staff were aware. Staff E proceeded to get people up and around 8 a.m. when she went up to the front of the building the girls asked if she had observed the resident. At that point, all the staff split up and went through the facility and looked outside. The staff member offered somewhere in her line of looking Staff A said around 7:20-7:30 a.m. she observed him by the front door and that she let him out to get some fresh air. Staff E then informed Staff D who made calls.</p> <p>Staff E confirmed she observed him from a distance when he returned with the police officer and denied having noticed anything abnormal at that time.</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 6</p> <p>During an interview 11/5/25 at 1:55 p.m. Staff F, Dietary explained she worked on 11/2/25, arrived a little after 6:30 a.m., and observed the resident at the dining room table with a cup of coffee. At about 6:45 a.m. the staff member proceeded to set the tables for breakfast and observed him as he ambulated towards the front door. The staff member redirected him and asked him what he planned to do and he stated he wanted to leave. She basically tried to talk to him because he said someone planned to pick him up. She attempted to redirect him but he refused and went back to his room. The staff member had no more contact until he returned back with the police officer.</p> <p>During an interview 11/5/25 at 12:07 p.m., resident's family member offered at 6:45 a.m. the resident initially called her but she failed to answer the phone as she slept. The resident called again at 8:02 a.m. and 8:03 a.m. when she answered and he told her he was at his son's apartment on [Street Redacted] which had been a block and 1/2 down from the church and she thought approximately 0.8 miles away from the facility. This family member then called a granddaughter at 8:06 a.m. who lived approximately 20 minutes from the facility so the granddaughter called the nursing home and the local police department. The police officer picked up the resident and took him back to the facility.</p> <p>An observation 11/5/25 at 12:55 p.m. revealed the elopement pathway consisted of having walked down the highway into town, approximately 0.8 miles and on a busy road/highway.</p> <p>A Missing Resident/Tenant Policy dated 12/21/18 indicated the Purpose as an assurance of prompt and appropriate response by the staff and emergency personnel for maintenance of resident safety.</p>	F0689		