STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165208	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granger Nursing & Rehabilitation Center	2001 Kennedy Street Granger, IA 50109

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49990 Based on resident interview, staff interview, and facility documentation, the facility failed to speak to residents with dignity and respect for 3 of 3 residents reviewed (Resident #12, #13, and #14). The facility reported a census of 40 residents. Findings include: 1. The quarterly Minimum Data Set (MDS) for Resident #12, dated 12/12/2024, documented a brief interview for mental status (BIMS) score of 15, indicating intact cognition. A prior MDS dated [DATE] documented Resident #12 was dependent on staff members for toileting hygiene and required substantial assistance for bed mobility, transfers, and personal hygiene. It further documented her to be continent of bowel. In an interview on 1/9/2025 at 11:14 AM with Resident #12, she stated a staff member identified as Staff A, Certified Nurse's Aide (CNA), who worked night shift had a pattern of rude and unkind behavior. She stated Staff A often made her feel like she is a burden, asking her what she needs in an unkind tone and manner that makes her feel like he could care less about her. She stated he had asked her questions like What do you need now? and had sighed loudly when answering her call lights. She reported she had been made to wait so long for assistance using the restroom at night that she had soiled herself. She stated she had filed grievances with the facility in the past but felt that nothing had been done about the issue. 2. The quarterly MDS for Resident #13, dated 12/19/2024, documented the resident's BIMS score was 15, indicating intact cognition. It further documented she required moderate assistance for personal hygiene tasks. In an interview on 1/6/2025 at 1:07 PM with Resident #13, she stated she had a number of complaints about the facility, her biggest complaint is one of the night CNAs, identified as Staff A, is rude and treats her in a manner that leads her to believe he doesn't care. When she requests something at night he has entered her room asking her What does she need now?. She noted the call lights on the evening shift are also sometimes very slow when Staff A is working. She noted one call light the weekend before the surveyors entered where she waited close to an hour for assistance. She stated she accurately tells time and keeps track through use of a clock in her room. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The quarterly MDS for Resident #14, dated 11/1/2024, documented a BIMS score of 14, indicating intact cognition. It further documented her as requiring moderate assistance for toileting hygiene and dressing, as well as for most transfers. In an interview on 1/6/2025 at 10:14 AM with Resident #14, she stated that several staff are rude and treat her poorly. She mentioned that one gentleman in particular, identified as Staff A, makes her wait long periods of time when she requests help during the night shift. She stated he has made her feel like a piece of garbage. In an interview on 1/6/2025 at 1:24 PM, Resident #5 stated that some of the CNAs are rude to her when answering her call lights. She also stated they don't wear name tags like they're supposed to. In an interview on 1/6/2025 at 2:13 PM with Resident #1, she stated a gentleman who works the night shift is rough with cares and can be rude. In an interview on 1/9/2025 at 11:27 AM with Staff C, Registered Nurse (RN), she stated each resident prefers to be treated in their own way. She stated staff should always treat a resident with dignity and respect, which includes personalizing how you approach them to how they prefer to be addressed and treated. She stated you should assess how a resident is responding to your approach and change if the resident expresses distress or is unhappy. In an interview on 1/9/2025 at 11:35 AM with Staff B, Certified Medication Aide (CMA), stated she was trained to always greet residents in a warm and friendly manner and would never make a resident feel as if she didn't want to help them. She stated cares are expected to be as gentle as possible, and you should talk to the resident during cares to ensure they are comfortable. In an interview on 1/8/2025 at 8:24 AM with the Director of Social Services, she stated that she had received several formal grievances about rude staff and rough cares in the last several months. She stated the residents who reported these issues have a propensity to report many things. She was unsure of any actions taken regarding the grievances and stated the Administrator had the final say. Review of a facility provided document titled Resident Council Meeting, dated 12/30/2024, documented several residents had complained of the call light times on the night shift, as well as rude CNAs who had made statements such as What do you want now, why is your call light on again. Review of a Residential Grievance Form, dated 10/16/2024, documented four residents, including Resident #12 and #13, had complained that staff are rude and don't have common courtesy. It documented the follow up as the RN spoke with staff members and had them sign a customer service pledge. Review of a Residential Grievance Form, dated 12/30/2024, documented Resident #13 had complained to administration about Staff A making her wait an excessively long time for assistance, and when the call light was answered Staff A told her to take her socks off herself as it was good exercise. Resident #13's MDS documented that she required moderate assistance to remove footwear. Follow up on the grievance form failed to address how the issue was handled. Review of a Residential Grievance Form, dated 12/30/2024, documented Resident #12 had requested to be assisted to her recliner, and staff refused, stating they did not have time. The form documented staff were educated about the concern. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Residential Grievance Form, dated 11/26/2024, documented Resident #12 had reported staff using inappropriate tones with her when she requested assistance. It documented a customer service pledge again as the follow up. Review of staffing files for Staff A documented the staff member had received a written warning for allowing a Resident to sit overnight in a brief that was soaked through with urine on 11/17/2024. It further documented Staff A failed to attend a mandatory nursing meeting and did not follow up with the nurse supervisor on 11/15/2024. Review of a facility provided document titled Quality of Life - Dignity, last revised in August of 2009, stated Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Section 2 defined treated with respect as the resident will be assisted in maintaining or enhancing their self worth. Section 7 stated staff shall speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs. In section 11, subsection B it stated residents shall have prompt access to care for toileting assistance.

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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. 46873 Based on clinical record review, staff interview, and instructions of CMS form 10123-NOMNC, the facility failed to provide appropriate Notice of Medicare Non Coverage (NOMNC) to 2 of 3 (Resident #7 and #142) residents reviewed for Beneficiary Notification. The facility reported a census of 40 residents. Findings include: 1. The census portion of the Electronic Health Record (EHR) of Resident #7 revealed the resident began receiving skilled care under Medicare A payer source on 8/5/24 and Medicare continued to pay for her stay through 8/23/24. The facility was unable to provide documentation of Resident #13 receiving a Notice of Medicare Non Coverage (NOMNC) form. The facility did provide a copy of the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN). The SNF Beneficiary Protection Notification Review form documented the resident did not receive a NOMNC due to the resident telling therapy she was done and refused further therapy. 2. The census portion of the EHR of Resident #142 revealed the resident began receiving skilled care under Medicare A payer source on 9/13/24 and Medicare paid for her stay through 10/18/24. The facility was unable to provide documentation of Resident #13 receiving a NOMNC form. The facility did provide a copy of the SNF ABN form. The SNF Beneficiary Protection Notification Review form documented the resident did not receive a NOMNC due to the resident receiving the SNF ABN. On 1/8/25 at 12:17 pm, the Social Services Director stated she has been employed at the facility for eight months. She stated she was only trained to provide the SNF ABN form and was not trained regarding the NOMNC form. On 1/8/25 at 4:20 pm, the Administrator stated the Social Services Director had now received education on the correct forms to use when a resident's Medicare coverage is ending and future discharges will be completed following CMS guidelines. The document titled Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 directs: A Medicare provider or health plan (Medicare Advantage plans and cost plans, collectively referred to as plans) must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services. The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49990 Based on observations, resident interviews, staff interviews, and facility document review, the facility failed to maintain a clean environment free of hazards. The facility reported a census of 40 residents. Findings include: 1. A direct observation on 1/6/2025 at 9:58 AM of the 300 hallway revealed a baseboard heater with a bent/broken safety grate. The grate was bent in such a way that it allowed the surveyor to access the interior of the grate easily with his hand. 2. A direct observation on 1/6/2025 at 10:14 AM revealed that Resident #14's room baseboard heater cover was bent and ineffective at preventing someone from accessing the interior of the heating unit. Resident #14 commented on how it looked trashy. 3. In an interview and direct observation on 1/6/2025 at 1:07 PM with Resident #13, she stated she was unhappy with her room. When asked what she was unhappy about, the resident pointed out the state of the baseboard heater, which had a bent safety grate and appeared to be improperly secured to the unit. The heating fins were fully exposed and could be easily touched. 4. During a direct observation on 1/7/2025 at 2:37 PM of Resident #27, the surveyor noted the baseboard heater safety grate had been completely removed from the baseboard heater just below Resident #27's bed. When asked about it, Resident #27 noted it had been like that since he moved in. Review of clinical records indicated the resident admitted to the facility on [DATE]. In an interview on 1/9/2025 at 11:35 AM with Staff B, Certified Medication Aide (CMA), she stated she had been employed by the facility since approximately 2022, and the baseboard heaters have been in the same condition since she started working at the facility. In an interview on 1/9/2025 at 11:27 AM with Staff C, Registered Nurse (RN), she stated some of the baseboard heaters are in terrible shape and have been for a long time. She noted she does not have a lot of opportunity to notice the baseboard heaters in the resident rooms as she is not often performing resident cares. In an interview on 1/8/2025 at 3:56 PM with the Assistant Director of Nursing (ADON), she stated she had been employed by the facility for several years now. She further stated the baseboard heaters should have been replaced a long time ago, as the condition has worsened significantly over the last year. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/8/2025 at 11:30 AM with the Director of Maintenance, he revealed he has been in that role for approximately a year. He was aware that many of the baseboard heaters had broken safety shields. He has attempted to fix them as he has been made aware of them being broken, but stated he has had issues with staff members reporting the grates when they break or have worn out. He stated the building is older and a number of its systems are in need of significant repair, including the baseboard heaters. He noted the baseboard heater shrouds have been a chronic issue in the facility, and they have been in a state of disrepair since he started in the role. Review of facility provided maintenance logs documented 8 rooms that had a maintenance request placed for the state of the baseboard shrouds on 8/20/2024, with a number of the shrouds only having been repaired in December of 2024. Review of a facility provided document titled Maintenance Service, last revised in December of 2009, stated the maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times, including heating systems.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873 Based on clinical record review, staff interviews and facility policy review, the facility failed to revise the comprehensive Care Plan to accurately reflect the status of 2 of 16 (Resident #24 and #32) residents reviewed. The facility reported a census of 40. 1. The Minimum Data Set (MDS), dated [DATE], of Resident #24 identified a Brief Interview of Mental Status (BIMS) score of 15 which indicated cognition intact. The MDS documented diagnoses that included depression, bipolar disorder, schizophrenia and nicotine dependence. The MDS documented a presence of an open foot lesion to her foot. The Wound Treatment Plan, dated 12/19/24, documented Resident #24 was to wear a walking boot on her right foot and a Controlled Ankle Motion (CAM) boot on her left foot (a medical device used to immobilize the foot and ankle). On 1/7/25 at 1:37 pm, Resident #24 was observed standing at the end of the hallway of the 200 hall, waiting to go outside to smoke. She was wearing a coat, a hat and gloves. She was wearing gripper socks on her feet with no shoes or boots. The State Surveyor questioned Resident #24 and she responded she was not fond of wearing her shoes. At 1:42 pm, Staff C, Registered Nurse (RN) came to join the residents to take them outside for smoking. She asked Resident #24 about her feet and the resident replied it was ok. Staff assisted Resident #24 and two other residents outside to smoke. The outside temperature was documented at 19 degrees at the time of observation. On 1/7/25 at 1:56 am, Resident #24 returned inside and the State Surveyor asked her if it was cold outside. Resident #24 replied it was not bad, and she had faced much worse when she had been homeless and had no protection from the elements except a sleeping bag. On 1/7/25 at 2:56 pm, the Director of Nursing (DON) stated smokers should wear shoes outside. He stated Resident #24 is to wear a boot for walking but has a history of being non compliant. He stated education has been given to her regarding this. The Care Plan of Resident #24 failed to reveal any documentation of Resident #24 wearing a walking boot or a CAM boot. The Care Plan additionally failed to reveal any documentation of Resident #24 being non compliant or receiving any education regarding care of her feet. 2. The MDS of Resident #32, dated 11/29/24, identified the presence of short and long-term memory impairment. The MDS coded the resident to be totally dependent for bed mobility. The MDS coded the presence of a Stage III pressure ulcer. On 1/6/25 at 10:28 am, Resident #32 was observed sleeping in bed. She had a body pillow tucked under her back, under her fitted sheet on her left side, with the resident being propped to lie on her right side. A fall mat was noted on the floor next to her. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/7/25 at 8:38 am, the resident was observed in bed, lying on her back. The fall mat was again observed on the floor, and the body pillow was again on the outside of the bed closest to the door, tucked under the fitted sheet. On 1/7/25 at 2:53 pm, the DON stated the body pillow is used for positioning for the resident. On 1/7/25 at 2:54 pm, the Assistant Director of Nursing (ADON) stated the resident had recently had a pressure ulcer which was now healed. She stated the body pillow was put in place as part of her repositioning schedule to assist in healing the pressure ulcer. On 1/7/25 at 3:17 pm, Staff D, Certified Nurse Aide, stated the resident had a history of rolling out of bed. She stated the pillow helped her to prevent falling but the resident still crossed her leg over it and climbed over it at times. On 1/7/25 at 3:19 pm, Staff E, RN, stated he was not really aware of why the pillow was there. He stated his assumption was to prevent falls but he said that he had seen her move the pillow in bed. He stated staff had told him the resident will still roll over the pillow at times. The Comprehensive Care Plan of Resident #32 identified a Problem Area of Fall Risk, initiated on 8/31/23. The Care Plan documented on 9/11/23 the fall mat next to the bed was removed and non skid strips were added to the floor. The Care Plan failed to document use of the body pillow for positioning. On 1/8/25 at 4:20 pm, the Administrator stated his expectation is for care plans to be kept up to date and to be comprehensive for the resident. The facility policy, Care Plans, Comprehensive Person-Centered identified the following: Point 9: Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. Point 10: When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. Point 11: Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change. Point 12: The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 46873 Based on observation, staff interview, pharmacy interview, drug manufacturer administration instructions, and policy review, the facility failed to assure a medication error rate of less than 5%. Medication errors were observed for Resident #21, Resident #22 and Resident #28. A total of 25 medications being prepared and administered were observed with 4 errors, an error rate of 16%. The facility reported a census of 40 residents. Findings include: Observation of Medication Pass began on 1/8/25 at 7:23 am. Staff B, Certified Medication Aide (CMA) was observed preparing morning medications for Resident #22. 1. Staff B prepared a total of four medications for Resident #22. Among the medications observed, Staff B prepared one tablet of Oxybutynin, (a medication to assist with overactive bladder), 5 milligrams (mg), Extended Release (medications which are modified to release at a delayed or slower rate in the digestive system). Staff B stated Resident #22 needed all of his medications crushed and she placed all of the tablet medications into a plastic sleeve and used a pill crusher to crush them into a fine powder. She mixed this with food and administered the medication to the resident at 7:34 am. 2. Staff B next prepared medications for Resident #21. She prepared eight medications for Resident #21. Among the medications observed were one capsule of Fenofibrate, 43 mg (a cholesterol medication) and one tablet of Senna, 8.6 mg (a laxative). She administered his medications at 7:54 am. When reconciling the observed medication pass against the orders for Resident #21, it was noted the Resident's order for Fenofibrate was 45 mg, rather than the 43 mg the resident received. Additionally, it was noted the resident was to have received Senna-S, a combination tablet of laxative and stool softener medication. He was given only Senna, not the combination medication prescribed. 3. On 1/8/25 at 8:00 am, the Assistant Director of Nursing (ADON) was observed administering insulin for Resident #28. The ADON performed hand hygiene and donned gloves. After verifying the correct medication for the resident, she placed an insulin pen needle on his Basaglar KwikPen insulin. She turned the dose knob of the pen to 2 units and held the pen with the needle pointing down and pushed the dose knob in. The ADON failed to follow the manufacturer instructions for the KwikPen of priming the pen with the needle facing up and noting the insulin to be at the tip of the needle. She then verified the scheduled dose and turned the dose knob to 22 units as ordered. She verified with Resident #28 where he wished for the insulin to be administered. She assisted with pulling his shirt up above his abdomen and cleansed the area with an alcohol swab. She guided the insulin needle and administered the insulin, holding the pen in place for approximately 1 second, failing to continue to hold the dose knob in and slowly counting to five before removing the needle per manufacturer instructions (this step is to ensure the full dose of insulin is delivered and doesn't leak out from the injection site immediately after insertion). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A pharmacist representative from the facility's contracted pharmacy stated in an email on 1/8/25 at 9:57 am that Oxybutynin ER cannot be crushed. She also stated the incorrect dosage of Fenofibrate was entered into the computer and sent to the facility and the pharmacy would be contacting the prescriber to verify the dosage. On 1/9/25 at 10:33 am, the Director of Nursing (DON) stated it was incorrect for Resident #22's oxybutynin to be crushed. He additionally stated his expectation for staff administering medications is to triple check the medication label against the Medication Administration Record (MAR) prior to administering the medication. When asked about the expected procedure for administering insulin through an insulin pen, he stated the steps are to - Perform hand hygiene and place gloves on - Remove the cap from the pen and disinfect the top of the pen with an alcohol swab before placing a needle - Open a needle and place it on the pen - Prime the needle with 2 units of insulin - Dial the pen to the correct dosage - Disinfect the skin of the resident with an alcohol swab - Administer the insulin and hold the pen/needle in place for 10 seconds before removing. The facility policy, Administering Medications, revision date April 2019, documented the following in Point 10: The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administering the medication before giving the medication.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 49990 Based on facility records and staff interviews, the facility failed to have a clinically qualified nutrition professional who met the required qualifications of a Certified Dietary Manager or a full time Registered Dietician. Findings Include: On 1/8/2025 at 1:46 PM, the Dietary Manager stated she did not have certification as a dietary manager. She stated she had completed courses to obtain certification, but the classes would not officially finish until 1/15/2025. An email provided by the Registered Dietician on 1/8/2025 at 2:53 PM stated she was only physically in the building one day a week. In an interview on 1/8/2025 at 2:42 PM with The Administrator, he stated the Registered Dietician is in the building one day a week. A review of facility records indicated the Dietary Manager did not hold any certifications in food safety, had not yet taken the test to be a Certified Dietary Manager, and had not been in the role of a Dietary Manager for two years or more.

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Granger Nursing & Rehabilitation Center	2001 Kennedy Street Granger, IA 50109

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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 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. 49990 Based on observation, staff interview, and policy review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. The facility reported a census of 40 residents. Findings include: During a direct observation on 1/6/2025 at 12:16 PM the Dietary Manager opened a package of crackers with ungloved hands. She made direct contact with the crackers before giving them to the resident. During a direct observation on 1/6/2025 at 12:18 PM the Dietary Manager served a plate of food to a resident and held the plate by the top with her thumbs. She made direct contact with ungloved hands with what appeared to be French fried potatoes on the plate. Hand hygiene was not performed after having assisted the previous resident. In a direct observation on 1/8/2025 at 12:21 PM, Staff G, Certified Nurse Aide (CNA), was seen touching the interior of a divided plate with bare hands while serving food to a resident. In a direct observation on 1/8/2025 at 12:22 PM and lasting until 12:25 PM, Staff H, Certified Medication Aide (CMA), was seen touching the tops of plates while serving food to several residents. She also unwrapped silverware for several residents, gripping the bowl of a spoon and tongs of a fork, with ungloved hands. She did not perform hand sanitation at any time during the observation. In a direct observation on 1/8/2025 at 12:24 PM, Staff I, CMA, was observed serving food to residents with her thumbs on top of the plate. In an interview on 1/8/2025 with Staff F, Dietary Cook, she explained that when serving residents during dining service staff should avoid contact with the top of the plate or interior surfaces of things like cups and bowls, they should never touch the serving ends of dining utensils, and you should wash your hands frequently when serving multiple residents and after making any direct contact with a resident. In an interview on 1/8/2025 at 1:46 PM with the Dietary Manager, she admitted she was worried she had touched the tops of the plates during dining service. She acknowledged that her expectations are that staff should never touch the tops of plates or the interior of bowls, nor should they ever touch the serving surfaces of forks and spoons. She stated staff should never make direct contact with food, and if they do the food item should be replaced. In an interview on 1/8/2025 at 3:56 PM with the Assistant Director of Nursing (ADON), she stated her expectations for Certified Nurses Aides and Certified Medication Aides who are assisting in dining service include never making direct contact with a resident's food, not touching the tops of plates or interior of items like bowls, and frequent hand hygiene. She added that staff should not touch a surface where a resident's food or mouth would make contact. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165208	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granger Nursing & Rehabilitation Center	2001 Kennedy Street Granger, IA 50109

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility provided document titled Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices, last revised in November of 2022, it stated in section 6 all employees will wash hands before coming into contact with any food surfaces, as often as necessary when changing tasks, and when engaging in other activities that contaminate the hands. In section 8 it stated contact between food and bare (ungloved) hands is prohibited. Review of a facility provided document titled Dish & Utensil Handling with an unknown last reviewed date stated Fingers will not be placed in or at the lip of contact surfaces of cups, glasses, and/or flatware.