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	02/26/2026

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 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** Based on observations, clinical record review, resident interviews, staff interviews and facility policy review, the facility failed to provide services and treatment to increase range of motion and to prevent further decrease in range of motion for 2 of 2 residents reviewed for limited range of motion (Resident #40 and Resident #44). The facility reported a census of 52 residents. Findings include: 1. The Minimum Data Set, dated [DATE] documented Resident #40 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident had diagnoses to include stroke and hemiplegia (a form of paralysis affecting one side of the body) affecting the left side. The MDS indicated a functional limitation in range of motion in the look back period with an impairment on one side in both the upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot). The Care Plan for Resident #40, with a revision date of 8/27/24, included a problem area of resident had a history of Cerebral Vascular Accidents (CVA/stroke) with left sided weakness, with a goal of resident will be free from complications of CVA: DVT (Deep vein thrombosis), contractures (painful tightening and shortening of muscles, tendons, skin, or tissues, often replacing elastic tissue with stiff, fibrous tissue that limits joint movement), aspiration, pneumonia and dehydration through the next review date. Interventions for staff included administer medications as ordered by the physician, allow sufficient time to communicate needs and PT (physical therapy)/OT (occupational therapy)/ST (speech therapy) as ordered. During an observation 2/23/26 at 4:35 PM, Resident #40 had a contracture of her left hand, the left hand was closed with fingers curled into the palm, no padding or device was placed on or in the hand. Resident #40 demonstrated an ability to partially open her left hand with her right hand, observed indentations to the palm of the left hand from the resident's fingernails digging into the skin. During an interview 2/23/26 at 4:40 PM, Resident #40 stated she had a stroke in December of 2024, which resulted in left sided paralysis. Resident #40 stated she could not open her left hand due to contracture and stated the facility did not put anything in her hand to help keep it open or to prevent her fingernails from digging into her skin. Resident #40 stated she currently does not receive therapy for the contracture in her left hand. Resident #40 stated she has placed Kleenex in the palm of her left hand at times, for relief and to keep her fingernails from digging into her skin. During an interview and observation 2/24/26 at 9:22 AM, Resident #40 had placed some Kleenex in her left palm. Resident #40 stated placing the Kleenex into her palm felt better so her fingernails did not dig into her hand. Resident #40 stated she had to put something in the palm of her left hand (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the facility did not do this, or offer this. Review of the Electronic Health Record (EHR) for Resident #40 revealed no orders or interventions in place for the contracture of the resident's left hand. During an interview 2/25/26 at 11:33 AM, Staff H, Advanced Registered Nurse Practitioner (ARNP) stated she had been a provider for Resident #40 since October of 2025. Staff H stated the resident has a left hand contracture. Staff H recommended a splint for the resident's left hand, however believed the resident's insurance would not pay for the splint. Staff H stated she talked to the resident about putting a washcloth in her hand or a foam block, however there is not an order for this. Staff H stated the contracture has not gotten worse since October of 2025, however a splint would be beneficial. The resident is currently receiving OT due to a new wheelchair, not for the splint or contracture. During an interview 2/25/26 at 12:25 PM, Staff G, Occupational Therapist (OT), stated he started working with Resident #40 recently on wheelchair safety for an electric wheelchair. Staff G stated he has not provided OT for the resident regarding her hand or contracture and has not evaluated her for a splint for the contracture for her hand. During an interview 2/25/26 at 3:45 PM, the Director of Nursing (DON), stated there is not a current order for a splint for Resident #40. The DON did not know if the resident had a splint before, or what interventions were put in place previously to address the contracture in her hand. Inquired what steps should be taken or could be taken for a resident with a contracture in their hand, the DON stated from a nursing standpoint a washcloth should be put in their hand and wash their hand twice a day. The DON stated these interventions should be in the care plan for the resident and acknowledged they are not in the care plan for the resident, or in the task section of the EHR. 2. The MDS for Resident #44, dated 2/6/26, includes diagnoses of stroke and hemiplegia (paralysis on one side of the body). The MDS identified the resident had an impairment in range of motion (ROM) for the upper and lower extremities on one side of the body and had a BIMs of 15, indicating no cognitive impairment. Observation on 2/23/26 at 1:15 PM, Resident #44's four fingers on her left hand were curled and pushing into the palm of her left hand, with her thumb remaining out, no padding between fingers and palm of hand. Interview on 2/23/26 at 1:16 PM, Resident #44 stated she had contractures of her left hand due to strokes and is unable to open her left fingers independently. Additionally, the resident stated she does sometimes use gauze under her fingers but she does not receive any restorative exercise for her hand as not able to receive therapy due to her insurance, and does not have a splint for the hand. Resident #44's Order Summary Report dated 2/25/26, revealed a physician's order dated 1/12/26, resident to be fitted for and receive a hand splint for left hand related to contracted fingers. Interview on 2/25/26 at 11:38 AM, Staff H stated she spoke with Staff G and Staff G stated insurance would not cover a splint for Resident #44. Additionally, Staff H stated the resident always has a strong offensive odor from her left hand. Interview on 2/25/2026 at 12:25 PM, Staff G stated Resident #44's insurance won't pay for an evaluation, so he has not completed an evaluation or provided any treatment for the resident and the facility has to give the go ahead that some kind of funding is in place before Staff G can do the evaluation. Interview on 2/25/26 at 2:58 PM, the DON stated was (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unsure what has been done since the order was received for the splint, not sure what else has been done to prevent further contracture of the resident's hand, and will have to check on it. Interview on 2/25/26 at 3:05 PM, the Director of Clinical Services stated the facility should pay for the resident's splint. Interview on 2/25/2026 at 4:00 PM, the DON stated he spoke with the Administrator (ADM) and the ADM approved for therapy to see Resident #44, was not sure why the order was not followed, and his expectation for orders to be followed. Facility Prevention of Decline in ROM policy, undated, revealed the following: a. Residents who exhibit limitations in ROM, initially and thereafter, will be referred to the therapy department for a focused assessment of ROM.b. Based on the comprehensive assessment the facility will provide intervention, exercises and/or therapy to maintain or improve ROM.c. The facility will provide treatment and care in accordance with professional standards of practice which includes appropriate services (specialized rehabilitation, restorative, maintenance), appropriate equipment (braces or splints), and assistance as needed for ROM.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on clinical record review, pharmacy record review, staff interviews, and facility policy review the facility failed to ensure accurate control and accountability of scheduled controlled narcotic medication for 1 (Resident # 34) of 3 residents reviewed. The facility reported a census of 52 residents. Findings include:The Minimum Data Set (MDS) for Resident #34, dated 11/28/25, documented diagnoses of Diabetes, depression, and primary insomnia (inability to fall or stay asleep). The MDS documented a Brief Interview of Mental Status score of 15, indicating no cognitive impairment, and the resident received a hypnotic medication. Resident #34's Medication Administration Record (MAR), dated 12/1/25 - 12/31/25, revealed a physician's order for Ambien (hypnotic medication) 5 milligrams (mg) 1 tablet at bedtime for insomnia. The MAR revealed the medication was administered 12/1/25 and 12/7/25 - 12/29/25 and the medication was not administered 12/2/25-12/6/25 and 12/30/25-12/31/25, due to the resident in the hospital. Resident #34's MAR, dated 1/1/26 - 1/31/26, revealed a physician's order for Ambien 5 mg. 1 tablet at bedtime for insomnia. The MAR revealed the medication was administered 1/2/26 - 1/12/26. Resident #34's Controlled Drug Record, Individual Patient's Narcotic Record form revealed an order for Ambien 5 mg with a quantity of 30 and dispense date of 12/12/25. The form revealed Staff F, Licensed Practical Nurse signed as date received of 12/12 and amount received appeared as 30 with a 1 marked over the 0, changing the amount received to 31. The form documented the first dose administered on 12/20/25 by Staff E, Certified Medication Aide, with 1 pill given and amount remaining of 30 pills. The form continued with the following documentation:12/21- 1 given, 29 remaining12/22 - 1 given, 28 remaining12/23 - 1 given, 27 remaining12/24 - 1 given, 26 remaining12/25 - 1 given, 25 remaining12/26 - 1 given, 24 remaining12/27 - 1given, 23 remaining12/28 - 1 given, 22 remaining12/29 - 1 given, 21 remaining1/2/26 - 1 given, 20 remaining1/3/26 - 1 given, 19 remaining1/4/26 - 1 given, 18 remaining1/5 - 1 given, 17 remaining1/6 - 1 given, 16 remaining1/7- 1 dropped and initialed by 2 staff, 15 remaining1/7- 1 given, 14 remaining1/8 at 6AM - Recount, 12 remaining1/8 at 1 PM- Recount signed by 2 staff, 12 remainingInterview on 2/24/26 at 2 PM, Staff A, Registered Nurse (RN) stated on 1/8/26 around 6 AM, he counted the narcotic medications with Staff I, Licensed Practical Nurse (LPN) who had worked the night shift and there were 1 or 2 pills missing from Resident #34's Ambien pills, not sure how many, but the count was off. Staff A stated he asked Staff I, the nurse who worked the night shift and had the medication cart keys, if Staff I had to waste any of the pills and Staff I said the pills may have popped out of the card on their own. Staff A stated that has happened before when there are a lot of narcotic cards and the drawer is full, it can push a pill out of the bubble pack and the pills can pop out if too full. Staff A stated he checked the drawer and did not find any loose pills. Staff A stated he refused to sign off for the narcotic count for the medication cart and was not going to spend time looking for a little pill that he wasn't going to find anyway. Staff A stated he reported to Staff D, RN who had worked the night shift also, that he was not going to sign for the narcotic count and walked away. Staff A stated when the narcotic count is not correct, suppose to notify the Director of Nursing (DON), but don't know if Staff D notified the DON. Staff A stated he notified the DON when the DON came into work later that day, maybe 8 AM. Staff A stated Staff I just kept stating she didn't know what happened to the medication. Staff A stated he thinks the medication cart keys were passed from Staff D to the Certified Medication Aide that was working that morning, as he did not take the keys. Staff A stated at shift change the 2 nurses count all controlled medications, the number of narcotic cards and bottles present, and sign the facility Controlled Drugs - Count Record form, and when signed the nurses are verifying the count for all medications is correct and the number of narcotic cards and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bottles present. Facility Controlled Drugs-Count Record form dated January 2026, revealed on 1/8/26 at 6 AM Staff A signed as the nurse on, Staff I signed as the nurse off and comments of 31 cards and 2 bottles. The form instructed that signing acknowledges that you have counted the controlled drugs on hand and have found that the quantity of each medication counted is in agreement with the quantity stated on the Controlled Drug Administration Record and record any discrepancies or pertinent notes in comments. Interview on 2/24/26 at 2:45 PM, the DON stated he came into work later on 1/8/26. The DON stated he got a message from Staff D notifying of the discrepancy on the medication cart and nobody was willing to sign for the cart being accurate. The DON stated he notified the Assistant Director of Nursing (ADON) and she followed up to verify the medication count. The DON stated he notified the Administrator and the ADM took over from there. The DON stated he completed a verbal interview with Staff A and Staff D, but did not document the interview or have them write a statement. The DON stated he tried to call Staff I two times to figure out the medication error but she didn't answer or call back. Interview on 2/24/26 at 3:20PM, the ADON stated she was text by the DON of the medication discrepancy, went to check the med count, and found that 1 Ambien pill was unaccounted for, as when she counted the pills #13 was missing from the count sheet as the sheet had documentation of 14 pills remaining and then 12 pills remaining which meant there was only 1 pill missing. The ADON stated she recounted the Ambien pills and documented the number of 12 pills remaining on the count sheet. The ADON stated she tried to contact Staff I as Staff I was passing medications on the cart the previous night. The ADON stated she did not have a photocopy of the medication bubble pack card to verify how many pills were received, how many pills popped out, or number of pills remaining when the recount was completed. Interview on 2/24/26 at 3:35 PM, Director of Clinical Services (DCS) present during previous interview on 2/24/26 at 3:20PM and confirmed if followed the documentation of total # count of pills as documented administered, that the medication discrepancy would be 2 pills short on 1/8/26. The DCS stated it did appear on Resident #34's Controlled Drug Record, Individual Patient's Narcotic Record form for Ambien that the documented amount signed as received looked like 30 written in and then 1 marked over the 0. Interview on 2/24/26 at 3:55PM, Staff D stated the evening before the medication count was off, around 10PM, Staff I stated she dropped an Ambien. Staff D stated she observed the pill and then observed Staff I dispose of the pill in the dissolvable medication waste container. Staff D stated the next morning she did the narcotic count with Staff A and Staff I and the medication count was short by 1 pill and when she asked Staff I what happened, Staff I reported 1 pill was missing. Interview on 2/24/26 at 4:07 PM, Staff J, Pharmacist stated Zolpidem Tartrate (Ambien) 30 pills were dispensed to the facility for Resident #34 on 12/12/26 and will email a copy of the record. Facility's Shipping Manifest form from the pharmacy dated 12/12/25 documented Resident #34 Zolpidem 30 tablets and signed as received by Staff F, LPN on 12/12/25. Interview on 2/25/26 at 5:16PM, Staff F stated when she receives medication from the pharmacy delivery, she counts every card of medications, enters her name for received by and how many pills received while the pharmacy delivery person is there. Staff F stated if the count is off, she notifies the delivery person and also calls the pharmacy and notifies them if the count was not right, if there are more or less pills and the difference. Staff F acknowledged on Resident #34's Controlled Drug Record, Individual Patient's Narcotic Record form for Ambien appears a 1 is marked over the 0, to make the number 31. Staff F stated she documented 30 on the narc count record sheet, not 31 and does not know who marked 1 over the 0. Staff F stated if she needed to change the number, she would mark through the incorrect number, initial and then document the correct number, not just mark over the number. Interview on 2/26/26 at 8:30 AM, Staff E, CMA acknowledged appeared on Resident #34's Controlled Drug Record, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Individual Patient's Narcotic Record form for Ambien on that 1 had been marked over the 0 to make the number 31 received Staff E stated she was the first staff to administer medication and documented 30 pills remaining after 1 given and she believes there was 30 pills remaining after she gave the medication as that is what she documented, but can't remember that far back. Staff E denied markings a 1 over the 0 for the amount received and didn't know who did or when done. Facility Controlled Substances policy revised December 2012, revealed the following:a. Controlled substances must be counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals must sign the designated controlled substance record.b. If the count is correct, an individual resident controlled substance record must be made and record must include quantity received and number on hand. c. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the DON.d. The DON shall investigate any discrepancies in narcotic reconciliation to determine the cause and identify any responsibility parties, and shall give the ADM a written report of findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, pharmacy recommendation, and policy review the facility failed to store and label medications properly in 1 of 2 medication carts reviewed. The facility reported a census of 52 residents. Findings include:Observation on [DATE] at 10:30 AM with Staff C, Registered Nurse (RN) in attendance, in the 100/200 hall medication cart:a. a bottle of Latanoprost eye drops (prescription medication for dry eye syndrome) for Resident #35 with the following labels: needs refrigerated, open date [DATE], and expires 42 days after open with no expired date written in. b. 4 bottles of prescribed eye drops not labeled with open date. c. 9 prescribed inhalers not labeled with open date.Interview on [DATE] at 10:35 AM, Staff C acknowledged the Latanoprost was a medication administered at bedtime which should be refrigerated and she did not know how long eye drops and inhalers were good for after opened, she would have to check. Resident #35's Medication Administration Record dated [DATE] - [DATE], documented the resident had received the Latanoprost every night [DATE] - [DATE]. Interview on [DATE] at 3:15 PM, the Director of Nursing (DON) stated the facility did not have a policy for expiration dates on medications after opening, would follow the pharmacy recommendations. The DON stated expectation for all medications to be labeled when opened with open date and expire date, and medications that are to be refrigerated to be refrigerated, not kept in the medication cart. Facility provided faxed document dated [DATE], signed by the pharmacist, revealed Latanoprost expires 42 days after opening. Facility Medication Storage Policy, not dated, instructed all medications requiring refrigeration are stored in refrigerators at each medication room.

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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. Based on observation, clinical record review, staff interviews, and policy review the facility failed to maintain infection control practices to ensure use of Enhanced Barrier Precautions (EBP) when required and to perform hand hygiene and infection control practices during wound care for 1 (Resident #4) of 2 residents reviewed. The facility reported a census of 52 resident. Findings include:The Minimum Data Set (MDS) for Resident #4, dated 2/6/26, includes diagnoses of peripheral vascular disease (PVD) (narrowing of blood vessels usually affecting the legs and feet) and 1 venous ulcer (wound caused by decreased blood flow). The Care Plan with initiated date 8/8/25, revealed the resident required EBP related to the presence of PVD wound to left lower leg with EBP to be instituted during completion of high contact activities. Observation on 2/23/26 at 3:07 PM, Staff A, Registered Nurse entered Resident #4's room and placed the wound treatment supplies directly on the resident's bed. Staff A applied gloves, did not apply a gown, removed the resident's left sock and leg dressing, and cleansed the scattered open wounds on the left lower leg with wound cleanser. Staff A proceeded with the same gloves on and wrapped the leg/wounds with a medicated dressing, gauze, and Coban (adhesive bandage). Staff A then removed the gloves, washed his hands, and placed wound cleanser and the medicated dressing box back in the treatment cart with other residents' supplies.Interview on 2/23/26 at 4:10 PM, Staff B, Certified Medication Aide, stated the EBP sign on the resident's door was due to wounds on his leg and staff need to wear gown and gloves with all hands-on care with the resident. Facility Enhanced Barrier Precautions policy dated 3/25/24, revealed gloves and gown are applied before performing high-contact resident care activities and an example of high-contact resident care activities requiring the use of gown and gloves included wound care. Interview on 2/26/26 at 1:31 PM, the Director of Nursing stated expectation to change gloves and complete hand hygiene when going from dirty to clean when completing a wound treatment, EBP of gown and gloves worn when completing the treatment, and to place supplies on a barrier.