STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165605	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kennybrook Village	200 SW Brookside Drive Grimes, IA 50111

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, staff interview, and policy review, the facility failed to serve food within appropriate temperature ranges for one of one meals observed. The facility reported a resident census of 39.Findings include:On 1/21/26 at 12:05 PM, a lunch food check revealed the following preservice temperatures:Chicken parmesan - 142.3 deg FSpaghetti noodles - 149 deg FVegetables - 177 deg FBread - 153.4 deg FSpaghetti sauce - 173.6 deg FBeef pot pie - 161 deg FChicken noodle soup - 196 deg FMechanical soft (MS) chicken parmesan - 159.1 deg FMechanical soft (MS) beef pot pie - 173 deg FPureed chicken parmesan - 189 deg FPureed noodles - 175.8 deg FPureed bread - 179 deg FPureed vegetables - 154.5 deg FAt 1:06 PM, the food temperatures revealed the MS chicken parmesan temperature was 125.2 deg F and the Pureed chicken parmesan temperature was 126.3 deg F which indicated they did not maintain a safe temperature of at least 135 deg F throughout lunch service. All other food items' post-service temperatures exceeded 135 deg F.At 1:10 PM, the Dietician stated the MS and pureed foods are routinely placed on the steam table but the facility had to place them in the warming oven due to the number of items being served for lunch.On 1/22/26 at 1:47 PM, the Dietary Manager (DM) stated staff should have checked the food temperatures periodically since it was being served from a warming location that was different than usual.A policy titled Preventing Foodborne Illness - Food Handling revised October 2018 indicated the facility recognized that the critical factors implicated in foodborne illness are:Poor personal hygiene of food service employees;Inadequate cooking and improper holding temperatures;Contaminated equipment; andUnsafe food sources.A policy titled Food Preparation and Service revised October 2018 indicated the danger zone for food temperatures is between 41 deg F and 135 deg F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness.

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 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. Based on observation, staff interview, and policy review, the facility failed to maintain sanitary practices by touching food with contaminated, gloved hands during food service for one of one meal services observed. The facility reported a census of 39 residents.Findings include:On 1/20/2026 at 11:17 AM, a continuous meal service observation revealed Staff A, Culinary Aide (CA) placed his right oven mitt covered thumb inside the pan of peas and directly touched the food.At 11:34 AM, Staff A put on gloves, packed up a food thermometer, grabbed the temperature logbook, placed them both on the back counter, and returned to serving resident food. During service, he grabbed Tostitos chips with the same gloved hands and put them on a resident's plate.At 11:46 AM, Staff B, CA put on gloves, handled plates, ladles, and scoops then returned to serving resident food. During food service, she grabbed Tostitos chips with the same gloved hands and put them on a resident's plate. She did it four (4) times.At 11:15 AM, Staff A stated he received Infection Prevention training upon hire in March 2025. He confirmed hand hygiene and proper glove use were included in the training. He stated he was not aware his thumb touched the peas and admitted he should have changed his gloves before touching the Tostitos chips.On 1/22/26 at 1:47 PM, the Dietary Manager (DM) stated staff should have been more aware of food handling equipment when handling food items and staff should've used appropriate equipment to serve food, such as tongs.A policy titled Food Preparation and Service revised October 2018 directed staff to adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. It also indicated bare hand contact with food is prohibited. Gloves must be worn when handling food directly. However, gloves can also become contaminated and/or soiled and must be changed between tasks.

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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 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, clinical record review, staff interviews, and policy review the facility failed to maintain infection control practices for 2 of 3 residents reviewed (Resident #35 and Resident #4). The facility failed to ensure use of Enhanced Barrier Precautions (EBP) when required for Resident #35 and failed to perform hand hygiene and infection control practices during wound care for Resident #4. The facility reported a census of 39 residents. Findings include: 1.The Minimum Data Set (MDS) for Resident #35, dated 12/31/2025, included diagnoses of Non-Alzheimer's Dementia and pressure- induced damage of sacral region (buttocks). The MDS identified the resident was dependent on staff for transfers. The MDS identified the resident had a Stage 2 pressure ulcer (partial thickness loss of skin presenting as a shallow open ulcer). The MDS indicated the resident had a BIMS score of 5, indicating severe cognitive impairment. The Care Plan with initiated date of 10/24/25 for Resident#35 documented a Deep Tissue Injury (IDT) to the buttock. Observation on 1/20/2026 at 12:41 PM, Staff C, Certified Nurse Aide (CNA) and Staff D, CNA entered Resident #44's room, applied gloves only and transferred the resident from the wheel chair to the recliner with a stand-up lift. Interview on 1/20/2026 at 1:15 PM, Staff E, Licensed Practical Nurse, stated Resident #35 had a wound on her right buttock. Interview on 1/21/2026 at 11:15 AM, Staff F, stated Resident #35 is on EBP for a wound and need to wear gown and gloves with transfers, cares, and bedding changes for the resident. Interview on 1/21/2026 at 11:23 AM, Staff G stated need to wear gown and gloves for cares or transfers with Resident #35, as the resident has an EBP sign posted outside her door. Interview on 1/22/2026 at 10:38 AM, the Infection Preventionist stated Resident #35 is on EBP due to her wound and expectation for staff to wear gown and gloves when transferring the resident. The facility Enhanced Barrier Precautions policy dated 3/7/2024, directed EBP are used in conjunction with standard precautions and expand the use of personal protective equipment to donning of gown and gloves during high-contact resident care activities. EBP are indicated for residents with wounds. 2. The MDS dated [DATE] for Resident #4 documented a BIMS score of 2, indicating severe cognitive impairment. The MDS included diagnoses of heart failure, renal insufficiency, respiratory failure and pressure ulcer of the sacral region, stage 3. The MDS indicated the resident was at risk of developing pressure ulcers/injuries and had unhealed pressure ulcers/injuries. The Order Summary Report for Resident #4 documented the following physician orders; Start date 1/20/26 left forearm, clean with wound cleanser, apply a single layer of Xeroform to open wound, cover with a gauze roll one time a day and as needed for abrasion. Start date 1/6/26 Right forearm clean with wound cleanser of choice, apply a single layer of Xeroform to open wound, cover with gauze roll one time a day for skin tear, and as needed. Right shin clean with wound cleanser, apply a single layer of Xeroform to open wound, cover with gauze roll one time a day for abrasion and as (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed. During a continuous observation 1/22/2026, beginning at 11:30 AM, Staff H, LPN, completed wound care for Resident #4 for both forearms and the right shin. Staff H sanitized hands before getting the supplies ready, washed her hands and then donned a gown and gloves. The supplies were placed on a barrier. Staff H began with wound care for Resident #4's right forearm. Taking a pair of scissors, Staff H cut the old dressing off of the resident's right forearm, placed the scissors on the barrier and removed the dressing and pad. Staff H removed her gloves, did not sanitize hands, retrieved a gauze pad and cleaned the wound with wound cleanser, there was blood on the gauze and a spot of blood on Staff H's glove. Staff H removed her gloves, did not sanitize her hands and placed new gloves on her hands. Staff H used the same scissors she had used to cut the old gauze off of the resident's arm, without sanitizing the scissors, to cut the Xeroform to fit the wounds on the right forearm and placed the Xeroform on the wounds. Staff H put a clean pad over the Xeroform and wrapped the wound with a clean gauze roll. Staff H washed hands and put on new gloves. Staff H then began wound care for the left forearm. Staff H used the same scissors, without sanitizing them before or after, to cut the old gauze off and removed the gauze and pad and Xeroform. Staff H changed her gloves and cleaned the wound with wound cleanser. Staff H removed her gloves, did not sanitize her hands, and placed a new pair of gloves on her hands. Staff H used the same scissors to cut the Xeroform to fit the wound and applied this to the wound and covered with a pad. Staff H then used the same scissors to cut a piece of gauze from the roll and wrapped this around the wound. Staff H removed her gloves and washed her hands. Staff H put on a new pair of gloves and then began wound care for the resident's right shin. Staff H used the same scissors, without sanitizing before or after, and cut the old gauze off of the right shin. Staff H removed the old pad and old Xeroform from the wound. Staff H removed her gloves, did not sanitize hands, placed new gloves on and cleaned the wound with wound cleaner. Staff H used these same gloved hands to open the lid of the trash can, touching the trash can, then using the same gloved hands, continued to clean the wound. Staff H changed gloves, she did not sanitize her hands. Staff H used the same scissors, without cleaning them before or after, to cut a section of the Xeroform from the package to fit over the wound. The Xeroform was placed on the wound and a clean pad over the wound. Staff H used the same scissors to cut a strip of clean gauze to wrap around the wound. During an interview 1/22/2026 at 12:15 PM, the Director of Nursing (DON) stated an expectation the scissors are cleaned/sanitized between clean and dirty use and for staff to use appropriate hand hygiene with sanitizing hands between clean and dirty and changing gloves, and sanitizing after touching a dirty surface such as a trash can lid. Review of the facility policy Handwashing/Hand Hygiene, revised August 2024, documented indications for hand hygiene included after contact with blood, body fluids or contaminated surfaces, before moving from work on a soiled body site to a clean body site on the same resident and immediately after glove removal. The use of gloves does not replace handwashing/hand hygiene.