STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525486	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grancare Nursing Center	1555 Dousman St Green Bay, WI 54303

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 record review, the facility did not ensure food was stored and prepared in a safe and sanitary manner. This practice had the potential to affect all 48 residents residing in the facility.The reach-in coolers and freezers contained expired and/or undated items.During an observation of food service, [NAME] (CK)-K touched serving dishes, trays, plates, and utensils with gloved hands. CK-K then left the steam table and opened a package of cups. CK-K then returned to the steam table and picked up a food item with the same gloved hands.Findings include:During an initial kitchen tour that began at 8:36 AM on 1/5/26, Dietary Manager (DM)-J stated the facility follows the Wisconsin Food Code.Undated/Expired Foods:The 2022 Wisconsin Food Code documents at 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking: (A) Except when packaging food using a reduced oxygen packaging method as specified under S 3-502.12, and except as specified in (E), (F), and (H) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature and time combination of 5 degrees Celsius (C) (41 degrees Fahrenheit (F)) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1 .(2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety .(D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: .(3) Marking the date or day the original container is opened in a food establishment with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section .Disposition: (A) A food specified under 3-501.17 (A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17 (A), except time that the product is frozen; (2) Is in a container or package that does not bear a date or day.During an initial kitchen tour that began at 8:36 AM on 1/5/26, Surveyor and DM-J observed the following expired items in the reach-in cooler:~ Two bags of baby carrots with use-by dates of 1/4/26~ Two bags of baby carrots with use-by dates of 12/12/25~ One unlabeled bag of grapes that contained what appeared to be moldSurveyor and DM-J observed the following items in the reach-in cooler that did not contain a delivery date, open date, and/or use-by date:~ Three bags of carrots~ One bag of cabbage~ Two heads of lettuce~ Two bags of tomatoes~ Three cucumbers~ One bin of oranges~ One bin of apples~ Five bell peppers~ One bag of 6 lemons~ Eight egg trays with 30 eggs in each tray~ One bag of hot dogs removed from the original packaging~ Three 3 pound bags of chicken breastsSurveyor and DM-J observed the following items in the reach-in freezer that did not contain a delivery date, open date, and/or use-by date:~ Nine bags of green beans~ Nine bags of cauliflower~ Six bags of hot dog buns~ Eight loaves of bread ~ Seven bags of whipped topping ~ Sixteen cartons of whipped topping~ Six bags of broccoli~ One box of 48 strawberry sundaes~ One box of 48 vanilla ice cream cupsSurveyor and DM-J observed the following undated items in the dry storage area:~ One tub of sugar~ One bucket of flourDuring a tour of the unit refrigerators on 1/5/26 at 10:20 AM, Surveyor observed the following undated items in the Caring Drive refrigerator: ~ Nine (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	containers of prune juice concentrate ~ One open bottle of ketchup~ Five Snack Pack pudding packs~ A half container of vanilla ice creamDuring a tour of the unit refrigerators on 1/5/26 at 11:30 AM, Surveyor observed the following undated items in the Grand Ave refrigerator:~ Fourteen 4 ounce canisters of prune juice concentrate ~ Thirty-six 4 ounce canisters of grape juice concentrate ~ One undated container of resident food Surveyor observed the following undated items in the refrigerator on the therapy unit:~ Six 4 ounce canisters of prune juice concentrate ~ Fourteen 4 ounce canisters of grape juice concentrateDuring the initial kitchen tour that began at 8:36 AM on 1/5/26, DM-J confirmed foods delivered, opened, and used to serve residents should include the delivery date or use-by date that the vendor stamps on products. DM-J verified the items observed in the reach-in cooler and freezer did not contain delivery dates and/or use-by dates.On 1/5/26 at 2:36 PM, Surveyor interviewed DM-J who verified food in the unit refrigerators is delivered to the unit from the kitchen, is subject to the same dating system used by the kitchen, and should include the delivery date or use-by date the vendor stamps on products.Hand Hygiene:The 2022 Wisconsin Food Code documents at 3-301.11 Preventing Contamination From Hands: (A) food employees shall wash their hands as specified under S 2-301.12. (B) Except when washing fruits and vegetables as specified under S 3-302.15 or as specified in (D) of this section, food employees may not contact exposed, ready-to-eat foods with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment.The 2022 Wisconsin Food Code documents at 3-304.15 Gloves, Use Limitation: (A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat foods or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.During a continuous observation of lunch service that began at 12:01 PM on 1/5/26, Surveyor observed CK-K apply gloves and begin lunch service at a unit steam table. CK-K obtained temperatures of the food, touched a thermometer, recorded the temperatures with a pen, and began meal service with the same gloved hands. CK-K picked up a bowl and used a ladle to put food in the bowl. CK-K then picked up a plate, crackers, and a small cup to scoop cheese from a bin. CK-K touched the inside of the bin with gloved hands. CK-K then picked up a piece of cornbread and put it on the plate. CK-K put plates on trays, touched counter tops and service areas, and picked up scoops and ladles with the same gloved hands. CK-K served eleven residents before CK-K ran out of small cups to scoop cheese and left the steam table. CK-K opened a package of cups on a supply cart and removed cups to take back to the steam table. CK-K then resumed lunch service with the same gloved hands. CK-K served six more residents and again used a ladle to put food in a bowls, picked up plates, crackers, and small cups to scoop cheese from a bin and again touched the inside of the bin with gloved hands. CK-K used the same gloved hands to put cornbread on plates. CK-K then put the plates on trays and again touched counter tops, service areas, scoops, and ladles with the same gloved hands.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to prevent the development and transmission of communicable disease and infection. This practice had the potential to affect more than 4 of the 48 residents residing in the facility.The facility did not have an accurate flow diagram of the facility's water system that identified areas where Legionella could grow. In addition, the facility did not maintain drinking fountains on two units or post signs that residents and visitors should not use the fountains.Staff did not appropriately remove personal protective equipment (PPE) and cleanse hands during the provision of care for R4.Findings include:The facility's Legionella/Water Management policy, revised 4/15/25, indicates: Grancare Nursing Center, care partners, and neighbors will benefit from this policy by being prevented from an outbreak. Grancare will provide a sanitary environment to avoid sources and transmission of infection and communicable disease .Legionella can be found everywhere in natural, [NAME] environments, but generally in those environments, the bacteria are present in insufficient numbers to cause disease. In human-made water systems like the plumbing of large buildings, cooling towers, decorative fountains, and hot tubs, Legionella can amplify and be transmitted to susceptible hosts through aerosolization. Certain conditions allow for amplification of Legionella. Water systems that are not properly cleaned, maintained, or disinfected are at risk for Legionella amplification .Legionella can grow in parts of the building's water systems that are continually wet, and certain devices can spread contaminated water droplets via air. Examples of these system components and devices include: Hot and cold water storage tanks .Electronic and manual faucets .Showerheads .Ice machines .Decorative fountains.Internal factors in buildings that can lead to Legionella growth: Biofilm; Scale and sediment; Water temperature fluctuations; Water pressure changes; pH; Inadequate disinfectant; Water stagnation .The facility's Implementation of Enhanced Barrier Precautions to Prevent Spread of Multidrug-Resistant Organisms (MDROs) policy, revised 6/6/25, indicates: Grancare will decrease the spread of MDROs to all neighbors by using enhanced barrier precautions (EBP) .Neighbors are at risk of becoming colonized and developing infection with an MDRO. Grancare will implement EBP as directed by the Centers for Disease Prevention and Control (CDC) to balance the use of personal protective equipment (PPE) and room restriction to prevent MDRO transmission with neighbors' quality of life .EBP expands the use of PPE and refers to the use of gowns and gloves during high-contact care activities that provide opportunities for the transfer of MDROs to care partners' hands and clothing. MDROs may be indirectly transferred from neighbor to neighbor during high-contact care activities. Neighbors with wound and indwelling medical devices are at especially high risk of acquisition and colonization with MDROs. The use of gowns and gloves for high-contact care activities is indicated when contact precautions do not otherwise apply, for neighbors with wounds and/or indwelling medical devices regardless of MDRO colonization, as well as for neighbors with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for EBP include: Dressing; Bathing/ showering; Transferring; Providing hygiene; Changing dirty linens; Changing briefs or assisting with toileting; Device care or use: central line/intravenous (IV), urinary catheter, feeding tube, bodily drain; Wound care: any skin opening with drainage requiring a dressing .Gowns and gloves are required prior to high-contact care activities and during cares.1. On 1/6/26, Surveyor reviewed the facility's Water Safety and Management Plan. The plan indicated the facility did not have a water fountain which Surveyor observed on a wall in the facility. The plan also included diagrams of water flow that did not include the water fountain, rehabilitation ice machine, rehabilitation tub room, and 2 drinking fountains.On 1/6/26 and 1/7/26, Surveyor noted the water shut off valve was turned off on the Caring Hall drinking fountain. Surveyor attempted to push the button on the water fountain. Water came to the surface of the spout but did not come out. Surveyor also noted the Caring Hall and Grand (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hall drinking fountains were unplugged from their outlets. On 1/7/26 at 10:22 AM, Surveyor interviewed Maintenance Director (MD)-G who reviewed the facility's water diagram with Surveyor. MD-G pointed out where the 2 drinking fountains, the rehabilitation ice machine, and the rehabilitation tub room should be indicated on the diagram. MD-G stated MD-G cleans and completes maintenance on the water fountain and facility's two ice machines quarterly but does not have documentation of maintenance or cleaning. (Nursing Home Administrator (NHA-A) provided documentation of monthly maintenance and cleaning on 1/14/26.) MD-G stated MD-G flushes the rehabilitation tub room weekly, however, it was not indicated on MD-G's weekly flush log. MD-G verified the water shut off valve on the Caring Hall drinking fountain was turned off and turned it back on. MD-G was not aware the valve was shut off. MD-G verified the 2 drinking fountains were not plugged into the outlets and stated the drinking fountain compressors were not functioning. MD-G stated the water in the drinking fountains was at room temperature because the compressors did not work to cool the water. MD-G indicated the drinking fountains were used daily by housekeeping to fill cat water dishes. MD-G verified there was not a sign instructing residents or visitors not to use the drinking fountains and verified there was nothing in place to prevent residents or visitors from using drinking fountains. 2. From 1/6/26 to 1/7/26, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including history of urinary tract infections, multiple sclerosis, paraplegia, resistance to multiple antibiotics, and candidiasis. R4's Minimum Data Set (MDS) assessment, dated 11/14/25, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R4 had intact cognition. R4's medical record indicated R4 was on EBP and had a Foley catheter.On 1/7/26, Surveyor observed an EBP sign on R4's door and a PPE cart outside R4's room. On 1/7/26 at 12:58 PM, Surveyor observed Certified Nursing Assistant (CNA)-H and CNA-I apply PPE and complete peri care for R4. CNA-H then removed gloves, repositioned R4, positioned a Hoyer sling in R4's bed, and removed CNA-H's mask. CNA-H attached the sling to the lift, hooked R4's catheter bag on the lift, and transferred R4 to a wheelchair. CNA-H then hooked R4's catheter bag to the wheelchair, covered R4 with a blanket, picked up a soiled wash cloth off the floor and put it in a soiled linen bag. CNA-H then washed hands, removed CNA-H's gown, and placed the gown in a bin outside R4's room. CNA-H did not complete hand hygiene after removing PPE and exiting R4's room. CNA-I removed gloves while transferring R4 to the wheelchair and held the left side of R4's face to protect R4 from the lift bar. CNA-I repositioned R4, removed the sling from the lift, and removed the lift from R4's room. CNA-I then removed CNA-I's gown and brought the lift to the shower room. Surveyor did not observe CNA-I complete hand hygiene. On 1/7/26 at 1:10 PM, Surveyor interviewed CNA-H who indicated CNA-H removed gloves after completing peri care because the gloves were soiled. CNA-H acknowledged R4 was on EBP and CNA-H should have worn gloves during contact with R4. CNA-H confirmed hand hygiene should be completed upon exit of a resident's room and after PPE is removed. On 1/7/26 at 1:15 PM, Surveyor interviewed CNA-I who verified R4 was on EBP and confirmed gloves should be worn during the provision of personal care. CNA-I also verified hand hygiene should be completed upon exiting a resident's room.On 1/7/26 at 2:03 PM, Surveyor interviewed Director of Nursing (DON)-B regarding EBP and hand hygiene. DON-B verified CNA-H and CNA-I removed gloves prematurely while providing care for R4. DON-B stated staff should wear gloves and a gown for the entirety of direct patient care and confirmed CNA-H and CNA-I should have completed hand hygiene upon exiting R4's room.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure a call light was within reach for 1 resident (R) (R22) of 14 sampled residents.R22 did not have a call light within reach during observations on 1/5/26 and 1/6/26.Findings include:The facility's Room Service Lights/Call Lights policy, dated 10/19/15, indicates: Facility neighbors will have the ability to call for and receive assistance .each neighbor when in their room or in bed, must have the room service light placed within reach at all times, regardless of the care partner's assessment of neighbor's ability to use it.From 1/5/26 to 1/7/26, Surveyor reviewed R22's medical record. R22 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, legal blindness, spinal stenosis, and segmental and somatic dysfunction of the sacral region. R22 had an activated Power of Attorney for HealthCare (POAHC) who assisted with medical decisions. R22's Minimum Data Set (MDS) assessment, dated 11/14/25, had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R22 had severely impaired cognition.A care plan, dated 8/13/25, indicated R22 was unaware of safety risks due to poor vision and occasional confusion. R22 had a history of falls and had interventions to remind R22 to ask for help and to keep important items within reach. On 1/5/26 at 10:01 AM, Surveyor observed R22 in a wheelchair in R22's room. R22's call light was on the bed and not within reach.On 1/5/26 at 10:03 AM and 1/7/26 at 9:02 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-E who indicated R22 did not usually use the call light, however, the call light should be within reach. CNA-E stated CNA-E always clipped the call light to R22's wheelchair. CNA-E then entered R22's room and clipped the call light to R22's wheelchair. CNA-E stated staff complete a visual check any time they walk past R22's room and/or every 2 hours if not more. CNA-E stated R22 can respond to questions and staff offer R22 the recliner, the bathroom, or a drink. CNA-E stated staff need to know when R22 is in the room so they can check on R22. (Of note: R22's care plan did not address frequent checks except to assist with repositioning every 1-2 hours while in bed.)On 1/6/26 at 3:50 PM, Surveyor observed R22 in a wheelchair in R22's room. R22's call light was on the bed and not within reach.On 1/6/26 at 3:51 PM, Surveyor interviewed CNA-F who indicated R22 does not use the call light, however, CNA-F usually leaves the call light next to R22. CNA-F indicated the call light should be clipped to R22's wheelchair before staff leave the room. CNA-F then entered R22's room and clipped the call light to R22's wheelchair.R22's medical record indicated R22 had a fall on 11/29/25. The assessment indicated R22 used the remote control for an electric recliner to put the recliner in a position that caused R22 to slide down to the base of the recliner. The fall investigation indicated R22 did not call for assistance. The assessment did not indicate if R22's call light was within reach or if R22 was capable of using the call light.On 1/7/26 at 9:07 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated R22's call light should have been within reach. DON-B stated R22 can not use the call light but the call light should still be within reach. DON-B indicated staff know R22 well and anticipate and provide for R22's needs.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 1 resident (R) (R8) of 5 sampled residents suspected of having a mental illness was screened through the Pre-admission Screen and Resident Review (PASRR) Level II process to determine if nursing home placement was appropriate and if specialized services were required.R8's PASRR Level I Screen did not indicate R8 was admitted to the facility with a mental illness and took antidepressant medication. Therefore, a PASRR Level II Screen was not completed to determine if nursing home placement was appropriate and if R8 required specialized services.Findings include:The facility's Preadmission Screening and Annual Resident Review policy, dated 12/28/21, indicates neighbors with mental illness will be evaluated to ensure proper care and treatment is provided in the most appropriate setting.From 1/5/26 to 1/7/26, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including major depressive disorder, migraine with aura, and atrial fibrillation. R8 was responsible for R8's own medical decisions. R8's Minimum Data Set (MDS) assessment, dated 12/12/25, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R8 had intact cognition.R8's medical record contained a PASRR Level I Screen, dated 3/24/23, that did not indicate R8 had a diagnosis of major depressive disorder and did not identify that R8 was prescribed nortriptyline (an antidepressant medication). The PASRR Level I Screen listed mirtazapine (Remeron) as an other drug but not an antidepressant. Due to inaccurate documentation, R8 did not receive a PASRR Level II Screen to determine if nursing home placement was appropriate and if specialized services were required.A hospital record from an overnight stay, dated 8/10/23, indicated R8 had a diagnosis of major depressive disorder and orders for nortriptyline (for headaches) and Remeron (for depression).On 1/7/26 at 1:21 PM, Surveyor interviewed Neighbor Advocate (NA)-D who was not aware that R8 had a diagnosis of major depressive disorder and was prescribed antidepressant medication. NA-D verified a PASRR Level II Screen was not completed for R8. NA-D confirmed R8's PASRR Level I Screen should have indicated R8 had a serious mental illness and took antidepressant medication. NA-D stated NA-D would complete a correct PASRR Level I Screen for R8 on 1/7/26.On 1/7/26 at 1:57 PM, Surveyor interviewed Minimum Data Set Coordinator (MDSC)-C who coded R8's MDS assessment to indicate PASRR Level II conditions were met due to R8's diagnosis of a serious mental illness and orders for antidepressant medication. MDSC-C indicated R8 was admitted to the facility with major depressive disorder and was prescribed 2 antidepressant medications, nortriptyline and Remeron.On 1/7/26 at 2:04 PM, Surveyor interviewed NA-D who indicated NA-D filled out R8's admission PASRR Level I Screen incorrectly on 3/24/23. NA-D indicated the PASRR Level I Screen should have contained R8's diagnosis of major depressive disorder and that R8 was prescribed both antidepressant medications upon admission which would have required a PASRR Level II Screen.