STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165174	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa DE Paz Health Care Center	2121 West 19th Street Sioux City, IA 51103

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical document review, observation, staff interview, and policy review the facility failed to assist residents with activities of daily living by not assisting with fingernail trimming for 1 of 1 residents (Resident #8) reviewed. The facility reported a census of 71 residents. Findings include:Review of Resident #8's Minimum Data Set (MDS) dated [DATE] indicated Resident #8 required maximal assistance with personal hygiene. The MDS further indicated that Resident #8 had diagnoses of non-Alzheimer's dementia, and anxiety disorder.Review of Resident #8's Care Plan with a revision date of 2/19/26 indicated staff were to keep Resident #8's fingernails short. Observation on 4/6/26 at 2:32 PM revealed Resident #8's fingernails to be long at this time with debris under the nails. Interview on 4/7/26 at 12:10 PM with Staff C, Certified Nursing Assistant (CNA) revealed that the bath aid usually cuts residents fingernails, unless the resident is diabetic then the nurse is to trim the nails. Staff C then confirmed Resident #8's fingernails were long and had build up under them with old food at this time. Interview on 4/7/26 at 12:22 PM with Staff D, Registered Nurse (RN) confirmed that nurses trim fingernails of residents with diabetes, and the bath aid then trims the other residents fingernails. Staff D then confirmed Resident #8 is not a diabetic, and the bath aid would be responsible for nail trims. Interview on 4/7/26 at 12:51 PM with the Director of Nursing (DON) revealed that she would expect finger nails to be trimmed as this is a care issue. Review of a facility provided policy titled, Nail Care with a copyright date of 2025 indicated staff will complete routine nail care, to include trimming and filing, that will be provided on a regular schedule.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff interview, and policy review the facility failed to provide proper transfer techniques while transferring a resident to prevent accidents for 1 of 3 residents (Resident #8) reviewed. The facility reported a census of 71 residents. Findings include:Review of Resident #8's Minimum Data Set (MDS) dated [DATE] indicated Resident #8 required moderate assistance with chair/bed-to-chair transfers, toileting transfers, and walking. The MDS further indicated Resident #8 utilized a walker for a mobility device. Review of Resident #8's Care Plan with a revision date of 2/19/26 indicated Resident #8 had a self-care deficit as evidenced by requiring assistance with activities of daily living, impaired balance during transitions and requiring assistance with walking. The Care Plan further listed an intervention of Resident #8 being transferred with assistance from one staff member. Observation on 4/7/26 at 12:05 PM Staff E Certified Nursing Assistant (CNA) was observed walking Resident #8 from the dining room table to the edge of the dining room without a gait belt. Staff E then left Resident #8 standing at the doors of the dining area, and went back to the dining area. Staff C CNA was then observed walking to Resident #8, and placing a gait belt onto Resident #8. Staff C then assisted Resident #8 to his bedroom. Interview on 4/7/26 at 12:10 PM with Staff C revealed that she walks Resident #8 with a gait belt every time Resident #8 needs assistance with transferring. Interview on 4/7/26 at 12:16 PM with Staff E revealed that she was unaware if Resident #8 was an assist with one staff and a gait belt for transfers. Staff E then revealed Resident #8 has walked by himself as long as she has worked here. Staff E then confirmed Resident #8 puts his walker out in front of him, and leans really far forward. Interview on 4/7/26 at 12:22 PM with Staff D Registered Nurse (RN) revealed that she did observe Staff E assist Resident #8 from the dining room table with his walker and no gait belt. Staff D then confirmed that Resident #8 is an assist with one staff member, and should have a gait belt when assisting with transfers. Interview on 4/7/26 at 12:51 PM with the Director of Nursing (DON) revealed she would have liked to have seen staff place a gait belt on Resident #8 as he is an assist with one staff member when transferring. Review of facility provided policy titled, Use of Gait Belt with a copyright date of 2025 indicated facility staff are to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety.

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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. Based on observation, staff interview, and policy review the facility failed to store food in accordance with professional standards by not labeling foods that were open with open dates. The facility reported a census of 71 residents.Findings include:During continuous observation on 4/6/26 from 10:20 AM to 10:40AM during the initial kitchen tour revealed:a. Four large plastic cereal containers with no open dates noted. b. A five gallon bucket of flour with no open date noted. c. Half eaten bowl of soup with spoon in bowl in the freezer of the fridge/freezer. Interview on 4/6/25 at 10:25 AM with Staff B dietary aide revealed that the half eaten bowl of soup with a spoon should not have been in the freezer. Interview on 4/7/26 at 10:20 AM with the Certified Dietary Manager (CDM) revealed that her expectations would be for items to be labeled and dated when they are opened. The CDM further revealed that half eaten bowls of soup should never be in the freezer. Interview on 4/7/26 at 10:37 AM with the Administrator revealed that she would like to see items in the kitchen labeled and dated when they are opened. Review of a facility provided policy titled, Food Safety Requirements with a copyright date of 2025 indicated staff will label, date, and monitor refrigerated food, including, but not limited to leftovers, so it is used by its use-by date.