

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165174	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2026
NAME OF PROVIDER OR SUPPLIER Casa DE Paz Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. Based on clinical record review, resident and staff interviews, and facility policy review, the facility failed to ensure 1 of 6 resident's (Resident #11) care plan was updated to reflect their transfer status. The facility reported a census of 70 residents. Findings include: The quarterly Minimum Data Set (MDS) assessment with a reference date of 7/1/2026 documented Resident #11 had a Brief Interview of Mental Status (BIMS) score of 14. A BIMS score of 14 suggested no cognitive impairment. The MDS documented Resident #11 had impairments to her bilateral lower extremities and utilized a wheelchair. Resident #11 required substantial/maximal assistance to go from a sitting to lying position and lying to sitting position. She was also dependent on staff to go from a sitting standing position, chair/bed transfer to chair transfer and a toilet transfer. The following diagnoses were listed for Resident #11: right tibia fracture, anemia, multiple sclerosis (MS), lack of coordination, repeated falls, weakness, reduced mobility, need for assistance with personal care and chronic pain syndrome. The Care Plan Focus Area with an initiated and revision date of 6/10/2026 documented Resident #11 had self-care deficit as evidenced by requiring assistance with Activities of Daily Living (ADLs), impaired balance transitions requiring assistance and/or walking, incontinence. The Care Plan documented Resident #11 did not ambulate, utilized a motorized wheelchair that she can self-propel. The Care Plan also documented during transfers Resident #11 required one person to assist with a stand-pivot transfer (SPT). On 7/9/2026 at 9:25 AM Staff B Certified Nursing Assistant (CNA) stated when transferring Resident #11, they use two staff and a mechanical lift. On 7/9/2026 at 9:31 AM Staff C CNA stated when Resident #11 would like to get out of bed, they will use a mechanical lift with two staff present. On 7/9/2026 at 9:36 AM Staff D CNA stated Resident #11 can roll side to side in bed but if she wanted out of bed, they would use the assistance of two staff and a mechanical lift. On 7/9/2026 at 3:04 PM Staff E CNA stated when they assist Resident #11 out of bed they always use two staff and a mechanical lift. On 7/9/2026 at 3:14 PM Staff F CNA stated they assisted Resident #11 with transfers with the assistance of two staff and a mechanical lift. It has been that way since Resident #11 was admitted to the facility in April. On 7/9/2026 at 3:28 PM Staff A CNA stated Resident #11 required the assistance of two staff and a mechanical lift for transfers. On 7/14/2026 at 10:25 AM the Assistant Director of Nursing (ADON) stated Resident #11's assistance level is with the assistance of two staff and a mechanical lift. When she was informed the Care Plan stated Resident #11 was an assist of 1 staff for a stand pivot transfer. She indicated she would get the care planned changed. The ADON stated the Corporate MDS Coordinator initiates the main Care Plan then the updates are done by herself or the Director of Nursing (DON). The facility provided a document titled Care Plan Revisions Upon Status Change. The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. Policy Explanation and Compliance Guidelines: The comprehensive care plan will be (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed, and revised as necessary, when a resident experiences a status change. Procedure for reviewing and revising the care plan when a resident experiences a status change: d. The care plan will be updated with the new or modified interventions. f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews and facility policy review the facility failed to provide the appropriate interventions when 1 of 3 residents (Resident #10) experienced a hypoglycemic (low blood sugar) episode. The facility reported a census of 70 residents. Findings include: On 7/10/2026 at 9:10 AM observed [NAME] Hall and Memory Hall medication carts had two glucagon IM pens, each in a red plastic container; as house stock, not specific for certain residents. On 7/10/2026 at 9:12 AM observed one glucagon IM pen, in a red plastic container; as house stock, not specific for certain residents. The quarterly Minimum Data Set (MDS) assessment tool with a reference date of 6/8/2026 documented Resident #10 had a Brief Interview of Mental Status (BIMS) score of 9. A BIMS score of 9 suggested mild cognitive impairment. Resident #10 had the following diagnoses listed: diabetes mellitus, heart failure, renal failure, neurogenic bladder, Alzheimer's disease, stroke dementia and anxiety. The Care Plan Focus Area with an initiation and revision date of 6/16/2026 documented Resident #10 had diabetes mellitus. The Care Plan directed staff to administer diabetic medications as ordered. It also directed staff to follow protocol per facility for low blood sugars. Record review of the Census tab, revealed Resident #10 resided on Memory Hall. Review of the June 2026 Medication Administration Record (MAR) for Resident #10 revealed the following orders: Glucagon emergency kit, 1 milligram (mg). Inject 1mg intramuscularly as needed for low blood sugar. The order had a start date of 5/20/2026, Glucose oral packet (dextrose (diabetic use)). Give one packet by mouth as needed for low blood sugar. The order had a start date of 11/17/2023. Review of Resident #10's clinical record revealed the following Progress Note: On 6/6/2026 at 6:14 PM: at approximately 4:00 PM this nurse was notified by a Certified Nursing Assistant (CNA) that resident needed to be checked on. Upon seeing resident lethargic and sweating, a blood sugar was obtained and was 37. Glucagon gel was attempted to be given. At 4:06 PM the paramedics were called and arrived within 10 minutes, an IV was started and Dextrose was given. Resident was responsive upon leaving facility. The responding Emergency Medical Service (EMS) department provided a document titled Patient Care Record dated 6/6/2026. The record documented the following information: Primary Impression: diabetic hypoglycemia, Patient's Level of Distress: severe, Level of Consciousness: unresponsive with a blood sugar of 36 mg/dL, Mental Status: resident unconscious, unable to answer questions. Head, Eyes, Ears, Nose, and Throat: head supported upright by facility staff while seated in a wheelchair. Pink gel-like substance noted within oral cavity and partially protruding from her mouth. Oral glucose administration reported by staff despite resident being unconscious. Chest: snoring respirations noted, respiratory effort present, no obvious respiratory distress beyond decreased level of consciousness. Airway partially compromised by decreased level of consciousness and presence of oral glucose gel within oral cavity, lung sounds are diminished bilaterally. Narrative: upon arrival at the facility, the nursing staff directed them to the resident's room. Inside they found the resident to be unconscious in her wheelchair and exhibiting snoring respirations. The staff was supporting her head and reported that her blood glucose level was 37 mg/dL. EMS personnel noticed glucose paste dripping from her mouth, which the staff had attempted to give her despite her unresponsiveness. The resident was assessed and established IV access to administer dextrose. EMS suctioned her mouth to clear out the remaining glucose paste. Facility staff was advised to never place anything in the mouth of an unconscious resident. The resident became alert and transported to the hospital. On 7/7/2026 at 2:30 PM a Paramedic stated he responded to the facility for a diabetic problem. The EMS crew was told the resident had a low blood (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sugar and was unconscious. When they arrived to the facility Resident #10 was sitting in a wheelchair, with her head supported upright by a Certified Nursing Assistant (CNA) and the resident was unconscious. He immediately noted a clear pink like gel coming out of the resident's mouth, while she was unconscious. When he asked what it was the CNA told him it was her oral glucose, the nurse was not present. Someone from the EMS team informed staff to never put something in an unconscious person's mouth again. Once they started an IV and administered Dextrose the resident started to wake up and was coughing forcefully. After they transported Resident #10 to the hospital, he went to the dispatch center to find out more information about the 911 call. The 911 caller, a nurse from the facility, had told dispatch she put glucagon gel in Resident #10's mouth. This was a dangerous intervention on that nurse's behalf. On 7/8/2026 at 9:41 AM Staff G Registered Nurse (RN) was asked what she would do if she found a resident with a blood sugar in the 30's and unconscious. She stated she would give a glucagon IM injection that is located in the medication cart then call 911. When asked if she would give the same resident glucose gel, she stated she would not because they would not be able to swallow it. Staff G added they can put the gel on the resident's cheeks and rub it in with their gloved fingers. During a follow-up interview at 11:16 AM Staff G stated she gave Resident #10 her insulin with lunch. After lunch staff came to her and said she was not responding and sweating. Staff G obtained her blood sugar and it was 37. She could not find the glucagon injection, which should have been in the medication cart but it was not in there. She called 911, got the glucose gel and put it around Resident #10's mouth but it was not successful; she did not perk up. Resident #10 sat in her wheelchair, leaning to one side. She was sweating, not able to answer any questions. Staff G stated she attempted to do sternal rubs but received no response from Resident #10. On 7/14/2026 at 10:25 AM the Assistant Director of Nursing (ADON) stated it would not be appropriate to attempt to administer oral glucose gel if the resident was unconscious. If the resident was unconscious, she would expect staff to obtain the glucagon IM from the red box within the medication cart. She added there are certain residents that have order for the glucagon IM if they experience low blood sugars. The ADON acknowledged she was not aware of the nurse giving Resident #10 glucose gel until after the fact. They did educate Staff G on making sure the resident is able to swallow prior to administering oral glucose gel. The resident needs to be able to sit upright and swallow. The facility provided a document titled Hypoglycemic Management. It is the policy of this facility to ensure effective management of a resident who experiences a hypoglycemic episode. Compliance Guidelines:3. Residents that have a diagnosis of diabetes or on medications that could lower the blood sugar should have orders for glucose monitoring and treatment of hypoglycemia, unless otherwise ordered by the practitioner.5. If the blood glucose reading is 70 milligram per deciliter (mg/dL) or below, the nurse will utilize the hypoglycemic protocol as per the practitioner's orders, with follow up blood glucoses as indicated, and notify the practitioner of the results as ordered.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review, staff interviews and facility policy review, the facility filed to ensure proper documentation was completed after 1 of 3 residents (Resident #11) sustained a fall. The facility reported a census of 70 residents. Findings include: The quarterly Minimum Data Set (MDS) assessment with a reference date of 7/1/2026 documented Resident #11 had a Brief Interview of Mental Status (BIMS) score of 14. A BIMS score of 14 suggested no cognitive impairment. The MDS documented Resident #11 had impairments to her bilateral lower extremities and utilized a wheelchair. Resident #11 required substantial/maximal assistance to go from a sitting to lying position and lying to sitting position. She was also dependent on staff to go from a sitting standing position, chair/bed transfer to chair transfer and a toilet transfer. The following diagnoses were listed for Resident #11: right tibia fracture, anemia, multiple sclerosis (MS), lack of coordination, repeated falls, weakness, reduced mobility, need for assistance with personal care and chronic pain syndrome. The Care Plan Focus Area with an initiated dated of 4/6/2026 documented Resident #11 was at risk for falls related to impaired balance, poor safety awareness, neuromuscular/functional impairment and/or the use of medications that may increase falls risks related to diagnoses of right fibula and tibia fractures, pain, and MS. The Care Plan encouraged staff to following the facility's fall protocol related to falls i.e.: initiation of neurological assessments, fall report/investigation, immediate interventions and long term interventions. Record review on 7/7/2026 revealed the following Progress Notes: 6/15/2026 at 6:31 AM an as needed (PRN) pain medication was administered, 6/15/2026 at 8:41 AM the PRN pain medication was effective, 6/15/2026 at 3:18 PM a PRN pain medication was administered, 6/15/2026 at 3:20 PM daily skilled charting: skilled services provided with treatment by a licensed therapist at last 5 days/week. There are no complaints of pain/signs of non-verbal pain. Musculoskeletal Status: fractured right ankle, cast present, weight bearing as tolerated. Remains on skilled level of care for right ankle fracture, 6/15/2026 at 4:38 PM a PRN pain medication was effective, 6/15/2026 at 11:20 PM a PRN pain medication as administered, 6/16/2026 at 3:06 AM resident complains of pain on her left leg, that felt stabbing and radiating from toe proximal to dorsal. Resident complained that pain is from impact of earlier incident in her room with Physical Therapist, that led to her leg getting bent over. Resident #10 had a PRN pain medication at 11:00 PM and by 1:00 AM she indicated the pain was unbearable, on call provider was called and explained the situation. Provider suggested the resident to sent to the emergency room (ER), 6/16/2026 at 4:28 AM PRN pain medication was effective, 6/16/2026 at 7:16 AM PRN pain medication was administered, 6/16/2026 at 8:35 AM PRN pain medication was effective, 6/16/2026 at 10:01 AM resident is skilled for fracture to right ankle, 6/16/2026 at 10:30 AM resident left the facility to go to urgent care, 6/16/2026 at 2:23 PM resident left the facility for a MRI, 6/16/2026 at 7:00 PM Late Entry: Occupational Therapist (OT) came and got nurse. Resident lowered to ground after standing with therapy and getting tired. Could not slide over to the bed, resident was transferred to bed with a mechanical lift. There lacked a Progress Note when the fall took place on 6/15/2026 from the nurse on duty. Record review of the Assessment tab revealed the only fall follow-up assessment was completed on 6/17/2026. The tab lacked an initial assessment charted from a fall that took place on 6/15/2026. On 7/9/2026 at 3:51 PM Staff H Registered Nurse (RN) stated on the day Resident #10 fell she was working with the OT when she had to lower her to the floor because she could not complete the transfer. Once he assessed Resident #10, it took three staff and a mechanical lift to get her off the floor and to her bed. While he completed his assessment on the resident, she did not complain of pain until early morning hours. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked why this fall or assessment was not charted, he stated he called the Director of Nursing (DON) to notify her but she told him it was not a fall. He asked what he needed to document and the DON told him he did not need to because it was not a fall. Staff H stated usually they would fill out a fall form but since she was assisted to the floor he did not do one. On 7/14/2026 at 10:25 AM the Assistant Director of Nursing (ADON) stated if a resident is lowered to the floor, it is still considered a fall. When asked what kind of assessment should be done if a resident is lowered to the floor, she stated a risk assessment. This explains what happened, any injuries at that time, fall risk assessment and who was notified. When the ADON was told there was no progress note documented by Staff H in reference to the incident, she stated they were not told until later that she was lowered to the floor. She acknowledged Staff H should have completed a note. The facility provided a document titled Fall Prevention Program. The policy indicated each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The policy defined a fall as an unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat) or the result of an overwhelming external force (e.g., a resident pushes another resident). An intercepted fall occurs when the resident would have fallen if they had not caught themselves or had not been intercepted by another person - this is still considered a fall. If there is a loss of balance during supervised therapeutic interventions and the resident comes to rest on the ground, floor, or next lower surface despite the clinician's effort to intercept the loss of balance, it is considered a fall. Policy Explanation and Compliance Guidelines: 9. When any resident experiences a fall, the facility will: a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments and actions. g. Obtain witness statements in the case of injury.		