STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER Holy Spirit Retirement Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 West 25th 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, Electronic Health Records (EHR) review, resident interview, staff interviews and policy review the facility failed to provide dignity and respect to a resident who wanted a brief change and staff refused to change the brief for 1 of 3 residents reviewed (Resident #3). The facility reported a census of 56 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] revealed Resident #3 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment.On 4/28/26 at 1:08 PM Resident #3 self propelled down the hallway as she stated she was upset because Staff N, Certified Nurse Assistant (CNA) ripped her brief when she changed the brief and refused to change it.On 4/28/26 at 1:10 PM Staff M, Housekeeping stated Resident #3 said Staff N refused to change her brief after there was a huge rip in the brief. Staff M explained Resident #3 was upset because there was a huge rip in her brief. Staff M asked Resident #3 if she wanted her to get another staff member to change her brief. Staff M asked Staff O, Licensed Practical Nurse (LPN) to help change the ripped brief. Observation on 4/28/26 at 1:15 PM of Staff O assisted Resident #3 with a brief change revealed Staff O completed hand hygiene, applied gloves, removed pants, removed brief, changed Resident #3's brief, Staff O asked Resident #3 if she wanted peri care completed, Resident #3 said yes, Staff O completed personal cares, Staff O removed gloves, completed hand hygiene, applied gloves replace the brief, pulled pants up and assisted Resident #3 to sit down.On 4/28/26 at 1:16 PM an observation of brief change for Resident #3 revealed a large rip to the left side of the brief going around past Resident #3's middle of back. On 4/28/26 at 1:18 PM Resident #3 explained the brief she was wearing with the hole was uncomfortable and that was why she wanted it changed. Resident #3 stated she felt the staff did not provide her with dignity and respect when she asked to have a new brief and Staff N did not change the brief. On 4/28/26 at 1:21 PM Staff O stated she thought Resident #3 reported the staff that did not change her brief was Staff N because she identified the CNA wearing a bandana. Staff O explained Staff M stopped her and talked to her about Resident #3. Staff O stated Staff M stated her brief was ripped and Staff N refused to change the brief. Staff O acknowledged there was a very large hole in the brief when she assisted Resident #3 and changed her brief. Staff O stated Resident #3 was very upset about the incident. Staff O acknowledged Resident #3 stated she did not feel the staff had provided her with dignity or respect when she did not change the brief. Staff O stated Resident #3 did say the brief was uncomfortable and the whole back was ripped. On 4/28/26 at 1:38 PM Staff N, CNA acknowledged she was caring for Resident #3 today. Staff N stated Resident #3 was doing okay but did not get up this morning until 8:00 AM and had been upset ever since. Staff N stated Resident #3 had behaviors at times. Staff N stated if Resident #3 sleeps in then she will probably have a behavior that day. Staff N stated she got Resident #3 dressed that morning and had toileted her after every meal. Staff N stated she had just toileted her. Staff N stated Resident #3 did not voice any concerns to her at that time. Staff N stated Resident #3 said she wanted her brief changed because there was a rip and told her the brief would still work just fine. Staff N stated she explained to Resident #3 that urine would not get everywhere. Staff N said Resident #3 said she could not wear it because there was a tear. Staff N (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she explained to Resident #3 the tear was not an issue because it was just a little tear. Staff N stated if she asked her to change the brief she would have changed it but she did not ask her to change it. Staff N said Resident #3 just said she could not wear it because it was ripped. Staff N stated she had been upset all day and did not seem anymore upset from the incident. On 4/29/26 at 12:42 PM the Director of Nursing (DON) stated Staff N ripped the brief and Resident #3 stated she wanted a brief change. The DON explained that Staff N said she would not change the brief. The DON stated Staff N should have changed the brief. The DON acknowledge a lack of dignity did occur when Staff N refused to change Resident #3's brief.Review of a policy provided by the facility dated 2/20 titled, Quality of Life - Dignity documented residents are treated with dignity and respect at all times. The facility's culture is one that supports and encourages humanization and individuation of residents, and honors resident choice, preferences, values, and beliefs. This begins with the initial admission and continues throughout the resident's stay. Some examples of ways in which respect for choices and values are exercised included personal grooming - residents are groomed as they wish to be groomed. Residents are encouraged and assisted to dress in their own clothes.

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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 observations, record review and interviews the facility failed to properly use both mechanical stand brakes in a manner that prevented accidents and hazards for 1 of 2 residents reviewed (Resident #21). The facility reported a census of 56 residents. Findings include:The Minimum Data Set (MDS) assessment dated [DATE] for Resident #21 documented a Brief Interview for Mental Status (BIMS) score of 7, which indicated severe cognitive impairment. The MDS showed Resident #21 required substantial assistance for transfers. The MDS diagnosis included hip fracture, dementia, and muscle wasting. The Care Plan on 12/3/25 for Resident #21 showed the facility initiated use of a mechanical stand for transfers. Observation on 04/27/2026 at 2:01 PM showed Staff P, Certified Nursing Assistant, applied a sling to Resident #21 then locked the right wheel of the mechanical stand. Using the controls, the CNA lifted the resident from the chair, unlocked the right wheel, then positioned the resident over the toilet. The CNA then lowered the resident onto the toilet and locked the right wheel. When the resident finished, the CNA lifted the resident from the toilet, unlocked the right wheel, positioned the resident over the chair, locked the right wheel, then lowered the resident. The CNA failed to keep the mechanical stand brakes unlocked during transfer. The Operator's Instructions for the mechanical stand instructed staff to only lock the brakes when raising and lowering the resident during ambulation.In an interview on 4/29/26 at 2:31 PM, the Director of Nursing (DON) reported staff should follow the operator's instructions and keep the wheels unlocked during transfers.