STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Spirit Retirement Home	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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interview and record review the facility failed to update the Care Plan for 1 of 17 residents reviewed. Resident #36 was admitted to Hospice on 4/16/25 and staff failed to include a focus area for the special service. The facility reported a census of 61 residents. Findings include: According to the Minimum Data Set assessment dated [DATE], Resident #36 did not have a Brief Interview for Mental Status (BIMS) assessment completed due to severe cognitive deficits. She was total dependent for dressing, hygiene, transfers and toileting. Her diagnoses included; diabetes mellitus, Alzheimer's disease, cerebrovascular accident (CVA) hemiplegia or hemiparesis, and oral dysphagia, The Care Plan updated on 4/8/25 showed that Resident #36 was on oxygen therapy, she was not able to ambulate or propel a wheel chair. The resident required 2 staff with mechanical lift for transfers and required assistance with all decision making. The Care Plan lacked a focus area for Hospice. On 5/12/25 at 11:11 AM, Resident #36 was in a high-backed wheel chair and her husband sat in a chair next to her. He said that the resident had experienced several CVA episodes and that Hospice services had recently started. The resident's chart included a Physician Fax, dated 4/17/25 that Hospice had accepted Resident #36 as of 4/16/25. On 5/15/25 at 9:12 AM, The Director of Nursing (DON) said that she would expect an addition of Hospice would be on the Care Plan as soon as a resident was admitted to Hospice. A facility policy titled: Care Plans, Comprehensive Person-Centered indicated that a comprehensive, person centered care plan would include measurable objective and timetable to meet the resident physical, psychosocial and functional needs. The care plan would describe services that were to be furnished to attain and maintain the residents highest practicable physical mental and psychosocial well-being.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Spirit Retirement Home	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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on direct observation, resident interviews, staff interviews, and document review the facility failed to provide and document restorative cares for 4 of 4 residents reviewed (Residents #4, #37, #41 and #42). The facility reported a census of 61 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #4 documented diagnoses of repeated falls, muscle wasting, unsteadiness on feet and need for assistance with personal care. The MDS showed the Brief Interview for Mental Status (BIMS) score of 13, which indicated no cognitive impairment. In an interview on 5/14/25 at 2:08 PM, Resident #4 reported he rides the therapy bike about once a week. When asked if he received other restorative care the resident said, no I ride the bike once a week. The resident denied he received restorative care for transfers. The Care Plan for Resident #4 showed ADL self-care performance deficit related weakness, balance deficit, and activity intolerance following hospitalization . A restorative program and well groups to maintain strength and balance initiated on 11/24/24. The May 2025 Restorative Care Flow Record for Resident #4 showed the goal to maintain ADLs transfer gait abilities. The record showed restorative care occurred two times in 15 days. The May 2025 Restorative Nursing Program Weekly Review for Resident #4 showed no restorative care occurred in week 1. 2. The MDS assessment dated [DATE] for Resident #37 documented diagnoses of muscle wasting, muscle weakness, and stroke. The MDS showed the BIMS score of 14, which indicated no cognitive impairment. In an interview on 5/14/25 at 10:01 AM, Resident #37 stated, They don't have time to do all the restorative therapy. I get therapy once a week, sometimes twice a week. Resident #37 did not believe she lost function but is afraid that she might if restorative therapy is not performed regularly. The Care Plan for Resident #37 showed an ADL self-care performance deficit and limited physical mobility related to weakness, balance deficit, and activity intolerance following hospitalization . The resident participates with restorative program initiated on 1/27/22. The May 2025 Restorative Care Flow Record for Resident #37 showed the goal to maintain current ADLs transfer gait abilities. The record showed restorative care occurred two times in 15 days. The May 2025 Restorative Nursing Program Weekly Review for Resident #37 showed no restorative care occurred in week 1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Spirit Retirement Home	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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.The MDS assessment dated [DATE] for Resident #41 documented diagnoses of muscle wasting, muscle weakness, and unsteadiness on feet. The MDS showed the BIMS score of 15, which indicated no cognitive impairment. In an interview on 5/14/25 at 10:08 AM, when asked if Resident #41 received restorative care, help with range of motion and with walking the resident stated, no. When asked how often she received help with restorative care the resident replied, I don't. When asked if she understood what restorative care meant the resident stated, exercises, I don't get help with exercises. The Care Plan for Resident #41 showed required occasional ADL and Mobility assist related Sequela effects from stroke. Resident #41 will be encouraged to continue to be as independent as possible with ADLs and as she is able to tolerate and remain safe, she will be encouraged to participate in wellness groups and restorative programs initiated on 7/8/24. The May 2025 Restorative Care Flow Record for Resident #41 showed the goal to maintain current transfers. The record showed restorative care occurred two times in 15 days. The May 2025 Restorative Nursing Program Weekly Review for Resident #41 showed no restorative care occurred in week 1. 4. The MDS assessment dated [DATE] for Resident #42 documented diagnoses of Chronic Obstructive Pulmonary Disease (COPD), general weakness, repeated falls and need for assistance with personal cares. The MDS showed the BIMS score of 14, which indicated no cognitive impairment. In an interview on 5/12/25 at 1:06 PM, Resident #42 reported he received restorative care a couple of times since last month. Resident #42's Family Member stated, he doesn't get help. They need to make sure he doesn't lose anymore. The program here doesn't exist. We came here because it was five stars but they're not doing what they're supposed to. The Care Plan for Resident #42 showed a risk for falls related to balance deficit, weakness, and history of falls. A restorative program and well groups to maintain strength and balance initiated on 11/3/24. The May 2025 Restorative Care Flow Record for Resident #42 showed the goal to maintain current ambulation functional transfers and with Activities of Daily Living (ADL). The record showed no restorative occurred in May. The May 2025 Restorative Nursing Program Weekly Review for Resident #42 showed no review occurred. The Restorative Nursing Services policy last dated July 2017 identified: Policy Statement : Residents will receive restorative nursing care as needed to help promote optimal safety and independence. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Spirit Retirement Home	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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Interpretation and Implementation: Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services (e.g, physical, occupational or speech therapies). Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care. Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care. The resident or representative will be included in determining goals and the plan of care. Restorative goals may include, but are not limited to supporting and assisting the resident in: Adjusting or adapting to changing abilities;Developing, maintaining or strengthening his/her physiological and psychological resources; Maintaining his/her dignity, independence and self-esteem; and Participating in the development and implementation of his/her plan of care. In an interview on 5/14/25 at 10:05 AM the Restorative Aide reported she often gets reassigned to resident care. The Restorative Aide stated, I can't do restorative care, I don't have time. I have to take care of the residents. In an interview on 5/15/25 at 9:27 AM, the Director of Nursing (DON) stated unfortunately restorative care doesn't always get done. We had staff quit and we had to pull the restorative aide to fill in on the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Spirit Retirement Home	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 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** 41785 Based on observation, interview and record review the facility failed to provide adequate assistance with Activities of Daily Living (ADL) for 2 of 3 residents reviewed (Resident #3 and #19.) Resident #3 required regular toileting and repositioning, she was found to be sitting in a urine saturated brief, and in her wheel chair with her legs dangling without support. Resident #19's urinary catheter was hanging on the bedrail above the bladder. The facility reported a census of 61 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #3 was not able to participate with a Brief Interview for Mental Status (BIMS) due to severe cognitive deficits. She was total dependent on staff for dressing, toileting and transfers. The Care Plan last updated on 5/9/25, showed that Resident #3 had self-care performance deficit with limited physical mobility. The resident had cognitive deficits, weakness and activity intolerance. She was not able to ambulate and dependent on 2-staff assistance with a mechanical lift for transfers. Staff were directed to use a padded foot rest under her lower legs while in the wheel chair. She was at risk for falls and staff were to anticipate and meet her needs. Resident #3 had frequent incontinence, she was to be offered toileting before and after meals and with rounds at night. Her diagnoses include post-polio syndrome, intracerebral hemorrhage, type 2 diabetes, and chronic kidney disease. On 5/12/25 at 1:40 PM Staff E, Certified Nurse Aide (CNA) and Staff H, CNA transferred Resident #3 from the wheel chair to the bed, with the use of the full-body mechanical lift. The sling for the lift was already under the resident. They hooked her up to the lift and as they raised her into the air, urine spilled through her clothing and pooled in the seat of the wheel chair. As she was transferred to the bed, urine dribbled across the floor. When asked the last time that the resident had been toileted, Staff H said she was changed before lunch. On 5/13/25 at 6:24 AM, Resident #3 was in her wheel chair near the nurse's station in front of the television with her head hanging, and sleeping. Her feet did not reach the foot pedals and dangled. There was no padded foot rest under her legs or feet. On 5/14/25 at 6:15 AM, Resident #3 was in the wheel chair near the nurse's station sleeping. She was slouched down in the seat, her feet dangled, and did not reach the pedals. At 7:30 AM, the resident was in the same position. On 5/14/25 at 11:39 AM, Staff M said that the overnight CNA's were directed to get Resident #3 up and dressed at 5:30 every morning. She said that at times, they need to wake her up, but she did not know why they had to get the resident up so early. On 5/14/25 at 12:51 PM, Staff J CNA, said that he worked the overnight shift and sometimes the aides would wake up Resident #3 before 6:00 AM and transfer her to the wheelchair. Once in the wheel chair, she would often fall asleep. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Spirit Retirement Home	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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/25 at 1:12 PM, Staff N, Licensed Practical Nurse (LPN) said she worked overnights that Resident #3 was up by 6:00 AM because she was on the get up list. Staff N said that the resident would sometimes holler out early in the morning. 2) According to the MDS dated [DATE], Resident #19 had a BIMS score of 12 (moderate cognitive deficit.) He was totally dependent on staff for toileting hygiene and dressing, and required substantial assistance with transfers. The resident was occasionally incontinent of bowel, and had an indwelling urinary catheter. His diagnoses included; benign prostatic hyperplasia, renal insufficiency, pneumonia and septicemia. The Care Plan updated on 5/6/24, showed that Resident #19 had an indwelling Foley Catheter, staff were to provide catheter care every shift and as needed, and to monitor for signs and symptoms of urinary tract infections. The following was included in the Nursing Progress Notes: a. On 4/5/25 at 10:39 AM, the Foley catheter was plugged, unable to flush, drains cloudy straw yellow urine with sediment. b. On 4/6/25 at 4:16 PM, doctors order for a urinary analysis with culture due to cloudy purulent urine with foul odor. c. On 4/7/25 at 9:08 PM, Resident #19 was started on an antibiotic for urinary tract infection. On 5/14/25 at 6:15 AM, Resident #19 was laying on his left side in bed and the catheter bag was hanging on the bed rail, near his head, and above the bladder. At 7:20 AM, Staff K, LPN, acknowledged that the catheter bag should be hung at level below the bladder. On 5/15/25 at 9:12 AM, the Director of Nursing (DON) said that staff were directed to check and change Resident #3 before and after meals. She said that with the amount of urine described that spilled out of the brief, it wouldn't seem that she had gone that much longer between changes on that day. The DON said that Resident #3 was on a get up list because the resident had been hollering out at 5:30 AM, so staff were getting her up at that time. The DON agreed that if the resident's feet were dangling without support, that was not good positioning, and she should have the support under her legs. The DON said that a catheter bag should not be hanging on the bedrail and should be below the bladder. An undated facility policy titled: Incontinence Care and Toileting showed that residents that are incontinent should be checked and changed every 2 hours, and as needed for incontinence management. An article titled: Indwelling Urinary Catheter Insertion and Maintenance; Retrieved on 5/15/25 at 8:19 AM from https://www.cdc.gov/infection-control/media/pdfs/Strive-CAUTI104- 508.pdf showed that in order to maintain unobstructed urine flow, keep the bag below the level of bladder when a drainage bag was raised above the level of bladder, contaminated urine from the drainage bag or tubing may reflux into the bladder or organisms may be introduced when there are breaks in the closed drainage system.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Spirit Retirement Home	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 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** 41785 Based on observation, interview and record review the facility failed to adequately supervise vulnerable residents to prevent injury for 1 of 3 residents reviewed (Resident #3). Resident #3 was observed to have a bruise on her right cheek that spread up under her eye. Staff hypothesized about the cause, but were unable to fully explain the injury. The facility reported a census of 61 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #3 was not able to participate with a Brief Interview for Mental Status (BIMS) due to severe cognitive deficits. She was total dependant on staff for dressing, toileting and transfers. The Care Plan last updated on 5/9/25, showed that Resident #3 had self-care performance deficit with limited physical mobility. The resident had cognitive deficits, weakness and activity intolerance. She was not able to ambulate and dependent on 2-staff assistance with a mechanical lift for transfers. Staff were directed to use a padded foot rest under her lower legs while in the wheel chair. She was at risk for falls and staff were to anticipate and meet her needs. Resident #3 had frequent incontinence, she was to be offered toileting before and after meals and with rounds at night. Her diagnoses include post-polio syndrome, intracerebral hemorrhage, type 2 diabetes, and chronic kidney disease. In an observation on 5/12/25 at 1:40 PM, Staff E CNA and Staff H CMA transferred Resident #3 from the wheel chair to bed with the use of a mechanical lift. The resident did not hold her head up very well and made repetitive tongue movements and in-auditable, sounds that increased in volume and number as the staff moved her to the bed with the lift. Resident #3 had a large bruise under her right eye, with yellow area around the outside and purple in middle. An incident report titled: Injury of Unknown Cause, dated 5/10/25 at 6:00 AM, showed that Resident #3 was sitting in her wheel chair in the dining room area when Staff C, Licensed Practical Nurse, (LPN) noticed the bruise on her right cheek. The immediate action taken, was to educate staff on the proper use of the Hoyer (mechanical lift.) According to the Pressure Ulcer/Non-Pressure Ulcer Healing Record Dated 5/10/25, the right cheek bruise measured 3 centimeters (cm) x 2 cm. It was light blue with a red center. On 5/13/25 at 1:47 PM, Staff C, said that on the morning of 5/10/25 she worked at 6:00 AM and Resident #3 was in her wheel chair out in the dining room area. She noticed bruising under her eye seemed faint with red in center. She talked to the overnight nurse and CNA who had not yet left and asked them what happened, they both said that they didn't have any knowledge of any accidents and this was the first that they saw it. Staff C said that the resident had a pair of glasses, but she didn't wear them very often. The glasses were bent and didn't fit on her face very well. Resident #3 was not able to tell them how she got the bruise. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Spirit Retirement Home	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/25 at 11:50 AM a family member said that she got a call about the bruise was told that they didn't know how it happened. They thought the Hoyer arm swung back and hit her face. The family member said that Resident #3 spoke very few words but she would be able to say if anyone hit her or intentionally hurt her. On 5/14/25 at 10:20 AM, the Director of Nurse (DON) said that she had just started an investigation on the bruising on the resident. She said that the most likely explanation was that the Hoyer arm hit her and said that the resident bruised so easy that it could have tapped her on the face and staff would maybe not even notice. On 5/15/25 at 9:12 AM, the DON said that after further investigation she and the staff believe that Resident #3 may have fallen asleep with her glasses on and that pressed into her check, could have caused bruise. According to an undated facility policy titled: Abuse, Neglect and/or Misappropriation of Resident Funds or Property Exploitation Prohibition, injuries of unknow source, would be evaluated and staff would make necessary changes in resident care plan to protect against the occurrence of similar injuries.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Spirit Retirement Home	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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on observations, record review, staff and resident interviews, and policy reviews, the facility failed to provide staff with current continuous positive airway pressure (CPAP) machine settings, and failed to monitor and maintain CPAP mask and tubing needs for 2 of 2 residents reviewed (Resident #8 and #42). The facility reported a census of 61. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #8 documented diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD) and renal insufficiency. The MDS indicated Resident #8 used a non-invasive mechanical ventilator. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Observation on 5/12/25 at 1:48 PM revealed a CPAP on Resident #8's bedside table. Resident #8 reported she used the CPAP during sleep. Resident #8 reported she used the same CPAP mask and tubing since admission in June 2024. Resident #8 stated, you can tell the tubing and mask are worn. Observation showed the tubing to be misshaped and the mask to be darkened around the nose pillow and headgear. Resident #8 reported no knowledge of the CPAP settings. The Clinical Physician Orders for Resident #8 showed 7/23/24 a CPAP ordered to be used during hours of sleep. No CPAP settings present. The Care Plan for Resident #8 showed admission occurred on 6/20/24 and showed a diagnosis of sleep apnea. The Care Plan indicated Resident #8 used a CPAP during hours of sleep, settings per provider and to assist in cleaning and maintaining the CPAP. No CPAP settings present. Review of Resident #8's chart on 5/13/25 at 10:43 AM failed to show CPAP settings or documentation of the CPAP mask and tubing change. In an interview on 5/14/24 at 12:04 PM, the Intake Coordinator at the CPAP home equipment supplier reported no supplies ordered since 2019. 2. The MDS assessment dated [DATE] for Resident #42 documented diagnoses of Chronic Obstructive Pulmonary Disease (COPD), insomnia and renal insufficiency.The MDS indicated Resident #42 used a non-invasive mechanical ventilator. The MDS showed the Brief Interview for Mental Status (BIMS) score of 14, which indicated no cognitive impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Spirit Retirement Home	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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 5/12/25 at 1:12 PM revealed a CPAP on Resident #42's bedside table. Resident #8 reported he used the CPAP during sleep. Resident #42 and a present Family Member reported Resident #42 used the same CPAP mask and tubing since over a year ago. The Family Member reported staff set a pillow on the CPAP and they weren't certain if settings were inadvertently changed. The Family Member reported she took the CPAP to the home supplier to make certain the settings were correct. The Family Member stated, I don't think it should be my job to take the machine downtown to make sure it's set right. Someone here should be able to know the settings and check just in case something goes wrong. Observation showed the tubing to be misshaped and the mask to be darkened around the nose pillow and headgear. The Progress Note dated 5/8/2025 at 3:21 PM for Resident #42 indicated the following documentation: CPAP machine and respiratory therapy, reminded the family that we do not have a respiratory therapist on staff as she feels we should. I asked her to inquire with the company she purchased the machine from if she has questions regarding proper functioning. I will reach out to pulmonology to clarify settings for CPAP. The Clinical Physician Orders for Resident #42 showed 10/24/24 a CPAP ordered to be used at bed time for sleep apnea. No CPAP settings present. The Care Plan for Resident #42 showed this admission occurred on 10/24/24. The Care Plan indicated Resident #42 used a CPAP during hours of sleep, settings per provider and to assist in cleaning and maintaining the CPAP. No CPAP settings present. Review of Resident #42's chart on 5/13/25 at 10:43 AM failed to show CPAP settings or documentation of the CPAP mask and tubing change. In an interview on 5/14/24 at 11:41 AM, the Branch Coordinator at the CPAP home equipment for Resident #42's supplier reported no supplies ordered since 9/7/23. The Branch Coordinator reported the supplier had a replacement schedule for CPAP machines. In an interview on 5/15/25 at 9:27 AM, the Director of Nursing (DON) reported the facility is responsible for maintaining the CPAP machines. The DON reported the CPAP settings should be available for staff if needed. The DON reported she has never thought about CPAP supplies. The DON stated, Now that I think about it, we are responsible for the CPAPs, so it makes sense we look into the supplies. I'm not 100% sure how insurance works on that. I have some research to do. The CPAP Supplier Replacement Schedule showed the following: Frame used with CPAP device (if gotten separately from kit), maximum replacement allowance for insurance, 1 per 3 months. Headgear, used with CPAP device (if gotten separately from kit), maximum replacement allowance for insurance, 1 per 6 months. Mask Kit (which would include the Headgear and frame), maximum replacement allowance for insurance, 1 per 6 months. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Spirit Retirement Home	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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Replacement cushion for full face mask, maximum replacement allowance, for insurance 1 per 1 month. Replacement nasal cushion for nasal mask, maximum replacement allowance, for insurance 2 per 1 month. Replacement pillows for nasal pillow mask, maximum replacement allowance for insurance, 2 per 1 month. Chin strap, used with CPAP device, maximum replacement allowance for insurance, 1 per 6 months. Tubing, used with CPAP device, maximum replacement allowance for insurance, 1 per 3 months. Filter, disposable, used with CPAP device (white filters), maximum replacement allowance for insurance, 2 per 1 month. Water Chamber for humidifier used with CPAP device, maximum replacement allowance for insurance, 1 per 6 months. Tubing with integrated Heating Element for use with CPAP device, maximum replacement allowance for insurance, 1 per 3 months. *Replacement schedules are subject to change based upon physician orders, your medical condition, and the discretion of your insurance company* The Continuous Positive Airway policy last updated July 2019 indicated: DESCRIPTION: 1. CPAP (Continuous Positive Airway Pressure) - Provides continuous positive airway pressure (CPAP) to airways to spontaneously breathing Residents. Delivered via circuit to mask nasal prongs or trach. 2. BIP AP (Bi Level Positive Airway Pressure) - Provides CPAP but allows for different pressures on inhalation and expiration. Also allows for a back up respiratory rate to be set. PURPOSE: 1. To augment Resident breathing 2. To treat Resident with sleep disorders. 3. To correct arterial hypoxema. 4. To avoid tracheostomy and/or mechanical ventilation. 5. To decrease atelectasis. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Spirit Retirement Home	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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. To increase compliance. EQUIPMENT NEEDED: 1. CAP/BIPAP unit 2. CPAP mask kit, nasal prong kit or trach adapter 3. Whisper Swivel 4. CPAP/BIPAP circuit or 6 corrugated tubing (CPAP/BIPAP) and pressure adapter, oxygen tubing 5. Head strap (for mask and nasal prongs only) 6. Bacteria Filter 7. Pressure manometer or NIF meter (with tubing/pressure adapter) 8. Optional a. [NAME] Strap b. Humidifier and 18 corrugated tubing c. Oxygen adapter and tubing d. Apnea monitor and supplier e. Pulse oximeter nose wheel f. External Pressure Alarm, tubing and adapter POLICY: 1. CAP/BIPAP MUST NOT be used for life support. It is not a ventilator. 2. Must be ordered by the physician. 3. All orders must include the following: a. Type of unit (CPAP/BiPAP) b. Pressure setting(s) c. Oxygen order (if applicable) d. Delivery device and size (mask, nasal prongs, trach) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Spirit Retirement Home	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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Frequency of therapy (continuous, at HS, etc.) f. Need for humidifier 4. BIPAP users must be monitored at least every 4 hours for breathing patterns, color and respiratory status. 5. Circuits are to be cleaned/changed weekly. 6. Change filters every thirty (30) days and PRN. Clean non-disposable filters weekly. PROCEDURE: The respiratory therapist/nurse shall follow the steps outlined below when setting up a CAP/BiPAP unit: 1. Gather equipment. 2. If needed, fill the humidifier to full line with sterile water and attach to the unit. Connect one end of 18 corrugated tubing to the outlet port of the unit and the other end to the inlet port of the humidifier. 3. Connect bacterial filter to outlet port of unit. 4. Assemble circuit (if not using pre-made circuit): a. Connect whisper swivel to mask, nasal prong holder or trach adapter. b. Connect the pressure adapter to the other end of the whisper swivel. Connect oxygen tubing to the adapter. c. Connect 6 corrugated tubing to the other end of the whisper swivel or pressure adapter. 5. If oxygen is ordered: a. Place the oxygen adapter on the end of the bacteria filter, connect one end of the oxygen tubing to the adapter, and the other end to the oxygen source. b. Turn oxygen on to prescribed LPM. If a specific FiO2 was ordered, place the oxygen analyzer inline and adjust LPM until FiO2 is met. 6. Connect the end of the circuit to the outlet port of the unit or humidifier. 7. Connect pressure manometer. 8. Set pressure(s), ramp time and mode (spontaneous, resp. rate) per physicians' orders. 9. Plug unit in and turn on. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Spirit Retirement Home	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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10. Make a tight seal on mask: prongs or trach adapter. Assure there are no leaks in the circuit. Measure Resident's nose with rose wheel. 11. Check pressure manometer to verify pressure settings. Cycle BiPAP unit by alternately occluding then opening circuit outlet 12. Adjust pressures as needed. 13. Assure that all panel doors on wit are closed and locked. 14. Connect delivery device to Resident. Make sure there is a tight seal. 15. Assure that pressure level(s) are maintained. 16. When using BiPAP place Pulse Ox on Resident and apnea monitor if applicable. 17. If using BIPAP on a trached Resident, place external alarm in-line following. 18. Assure the Resident can tolerate use of equipment and is having no difficulty in breathing CLINICAL CONSIDERATION: 1. Indications: a. Residents who exhibit unacceptable or worsening hypo-ventilation as reflected by elevation or rising PaCO2. b. Residents with chronic ventilatory muscle dysfunction. c. Residents with unacceptable hypotemia despite administration of higher FiO2's (P50%). d. Residents with sleep disorders. 2. Contradictions: a. Unastable facial fracture b. Extensive facial lacerations. c. Pre-existing pneumothorax or pneumomediastinum. d. Pre-existing bullous disease. e. Allergies or hypersensitivity to mask f. Frequent emesis. g. Laryngeal trauma. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Spirit Retirement Home	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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. Recent gastric surgery 3. Side effects (typically only found with higher pressures): a. Gastric Distention. b. Decreased cardiac and urinary output. c. Carbon Dioxide retention. d. Skin abrasions or breakdown. e. Resident discomfort facial and ear discomfort f. Acute sinusitis or middle ear infection. g. Hypotension due to positive pressure breathing. h. Inability to breathe during disconnect or loss of flow. 4. Precautions: a. Advise Resident to immediately report any chest discomfort, shortness of breath or headache. b. When using a mask, advise Resident not to eat 2-3 hours prior to using the unit. c. Whisper swivel must not be occluded at any time. This is the only exhalation port. d. IPAP and EPAP settings should be re-evaluated when there is a change in Resident physiological condition. 5. Documentation: a. Residents on a CPAP or BiPAP should be checked for breathing patterns, color and respiratory status every 4 hours and this assessment should be documented in the nursing notes every shift while on Medicare part A.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Spirit Retirement Home	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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 44474 Based on review of the planned menu, observations, staff interviews and facility policy review the facility staff failed to follow the planned menu for residents. The facility identified a census of 61 residents. Findings include: Review of the menu for Week 5 Day 3 identified the following items as part of the planned menu for the lunch meal on 5/13/25: Turkey Tetrazzini Buttered Peas Bread and margarine Fruited Gelatin Milk Observation on 5/13/25 at 10:47 a.m., of the puree process no bread and margarine was pureed for the lunch meal. Observation on 5/13/25 at 12:48 p.m., of lunch meal service revealed the lunch meal served consisted of: Turkey Tetrazzini Buttered Peas Fruited Gelatin Observation of lunch service was completed with the main dining room. No bread and margarine was served with the lunch meal, noted resident menus to have circled bread and margarine as meal choice. Review of the facility provided policy titled Accuracy and Quality of Tray Line Service dated 2021 revealed the following: a. tray line and or meal service positions for breakfast, lunch and dinner will be planned and determined according to the menu. b. The meal will be checked against the therapeutic diet spread sheet to assure that foods are served as listed on the menu. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Spirit Retirement Home	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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 5/13/25 at 12:51 p.m., with the Dietary Manager and the Dietician revealed if the menu had bread and margarine and the resident picked the item it should have been served. The Dietician further revealed residents on a pureed diet should have been served the bread and margarine as well.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Spirit Retirement Home	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 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide specialized rehabilitative services by qualified personnel, when ordered for a resident by a doctor. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on observation, clinical record review, staff and resident interviews, the facility failed to train staff to maintain properly maintain CPAP settings for resident usage for 1 of 2 residents reviewed (Resident #42). The facility reported a census of 61 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #42 documented diagnoses of Chronic Obstructive Pulmonary Disease (COPD), insomnia and renal insufficiency.The MDS indicated Resident #42 used a non-invasive mechanical ventilator. The MDS showed the Brief Interview for Mental Status (BIMS) score of 14, which indicated no cognitive impairment. Observation on 5/12/25 at 1:12 PM revealed a CPAP on Resident #42's bedside table. Resident #8 reported he used the CPAP during sleep. The Family Member reported staff set a pillow on the CPAP and they weren't certain if settings were inadvertently changed. The Family Member reported she took the CPAP to the home supplier to make certain the settings were correct. The Family Member stated, I don't think it should be my job to take the machine downtown to make sure it's set right. Someone here should be able to know the settings and check just in case something goes wrong. The Family Member stated, No one helps him with the CPAP. The Receptionist comes to help with the CPAP machine because no one knows how to operate it. The Family Member stated, the Receptionist had to come in the room to help them two different times because no one knew how to run the CPAP. No nurse knew how to run it, there's no respiratory therapist, no nothing. In an interview on 5/14/25 at 9:47 AM, the Receptionist reported she assisted Resident #42 with the CPAP two different times. The Receptionist stated, I did it because no one else knew how. No one knew how to operate it. I was the only one. I have a CPAP, so I knew what to do then the DON found out and told me that I couldn't do that anymore. In interview on 5/15/25 at 9:27 AM, the Director of Nursing (DON) reported she knew the Receptionist assisted Resident #42 because the facility lacked staff trained in CPAPs. The DON reported only a respiratory therapist should be monitoring the CPAP settings as needed. When asked if the facility had a respiratory therapist the staff could reach if needed, the DON replied no it's something we need to work on.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Spirit Retirement Home	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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 44474 Based on record review, interview, and facility policy the facility failed to have the Medical Director at quarterly meetings for their quarterly Quality Assessment and Assurance (QAA) meetings. The facility reported a census of 61. Findings include: Review of the facility document titled Quality Assurance Performance and Improvement Meeting Minutes: a. Document dated 11/13/24 lacked the signature of the Medical Director Review of the facility provided policy titled Quality Assurance and Performance Improvement (QAPI) Program-Governance and Leadership dated March 2020 revealed the following individuals serve on the committee, Medical Director. The committee meets at least quarterly or more often as necessary. Interview on 5/15/25 at 09:40 a.m., with the Director of Nursing revealed the Medical Director should be at the quarterly meetings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Spirit Retirement Home	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 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** 41785 Based on observation, interviews and record review the facility failed to ensure that staff used appropriate hand hygiene during resident cares for 1 of 3 residents reviewed, (Resident #3). The facility reported a census of 61 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #3 was not able to participate with a Brief Interview for Mental Status (BIMS) due to severe cognitive deficits. She was total dependent on staff for dressing, toileting and transfers. The Care Plan last updated on 5/9/25, showed that Resident #3 had self-care performance deficit with limited physical mobility. The resident had cognitive deficits, weakness and activity intolerance. Resident #3 had frequent incontinence, she was to be offered toileting before and after meals and with rounds at night. Her diagnoses include post-polio syndrome, intracerebral hemorrhage, type 2 diabetes, and chronic kidney disease. On 5/12/25 at 1:40 PM Staff E, Certified Nurse Aide (CNA) and Staff H, CNA transferred Resident #3 from the wheel chair to the bed, with the use of the full-body mechanical lift. The sling for the lift was already under the resident. They hooked her up to the lift and as they raised her into the air, urine spilled through her clothing and pooled in the seat of the wheel chair. As she was transferred to the bed, urine dribbled across the floor. Staff E and Staff H removed the soiled clothing with gloved hands, then braced the resident and rolled her onto her side with the same gloves. After completing incontinence cares, Staff F left the resident's room without washing her hands. On 5/13/25 at 1:24, Staff G, CNA and Staff F, CNA provided incontinence cares for Resident #3. Staff G changed her gloves several times but failed to use hand sanitizer between changes. Both of the staff members left the room without washing their hands. On 5/15/25 at 9:12 AM, the Director of Nursing (DON) said that they provide education and random audits to monitor appropriate hand hygiene. Staff were taught to change gloves after touching soiled areas and to wash their hands before leaving the residents rooms. A facility policy undated titled; Personal Protective Equipment-Gloves shoed that all employees must wear gloves when touching blood, body fluids, secretions, excretions, mucous membranes and or non-intact skin. Gloves should be used only once and discarded. An undated facility policy titled: Handwashing/Hand Hygiene, showed that all personnel would follow handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel residents and visitors.