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	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Spirit Retirement Home	1701 West 25th Street Sioux City, IA 51103

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview and policy review the facility failed to provide food at an appetizing temperature when mashed potatoes had a temperature of 125 degrees on the steam table before the lunch meal and had a temperature of 121 degrees for a room tray with 2 of 8 residents reviewed (Resident #24 and #40) that had complained about food temperatures. The facility reported a census of 56 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] revealed Resident #40 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. On 4/27/26 at 1:31 PM Resident #40 stated the food is served cool when it should be warm a couple times a week. Resident #40 stated she does not ask them to heat it up but would like the warm food to be served warm. Resident #40 stated the food should be served warm. 2. Review of Resident #24's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognitive functioning. Interview 4/27/26 at 3:33 PM with Resident #24 revealed that food is sometimes not hot, and this happens on days that she orders room trays. 3. On 4/29/26 at 12:02 PM an observation of pre-temperatures of the 2nd floor kitchenette steam table included: mashed potatoes at 125 degrees Fahrenheit during lunch service. On 4/29/26 at 12:28 PM an observation revealed Staff C, Dietary Aide using a temperature probe to puncture through the tin foil dated with permanent marker that covered the residents food items on a room tray to obtain the temperature of those items. Temperatures included: Mash Potatoes at 121 degrees Fahrenheit and salisbury steak at 130 degrees Fahrenheit. On 4/29/26 at 2:35 PM Staff E, Certified Dietary Manager (CDM) revealed concerns with the room tray temperatures and steam table pre-serving temperatures. Staff E stated the food temperatures were to be above 135 degrees Fahrenheit. On review of a policy provided by the facility dated 3/29/21 titled, Food Temps P&P documented all hot food items must be cooked to appropriate internal temperatures, held, and served at a temperature of at least 135 degrees Fahrenheit.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 observations, staff interviews, and policy review, the facility failed to store, prepare, and serve food in accordance with professional standards. The facility did not label and date open food items, follow best-by dates, discard expired food items, perform hand hygiene prior to or during food services, complete hand hygiene when assisting residents with meals, or wear appropriate hair nets during food preparation. The facility reported a census of 56 residents. Findings Include:On 4/27/26 at 11:00 AM, a continuous observation in the kitchen revealed several improperly dated items. The first stand-up refrigerator contained apple juice with an open date of 4/23/26, grape juice with an open date of 4/23/26, and prune juice with an open date of 2/26/26. The second stand-up refrigerator contained red french dressing with an open date of 2/18/26 and salsa with an open date of 2/13/26. The walk-in refrigerator contained an open bag of lettuce without an open or date of delivery. The south pod refrigerator contained a lemonade pitcher with an open date of 4/9/26, grape juice with an open date of 4/9/26, tomato juice with an open date of 4/4/26, and medication pass with an open date of 4/13/26. The dry storage contained items without an open or in date, including a bag of spiral noodles and a bag of elbow noodles.On 4/28/26 at 11:53 AM, an observation revealed Staff B, Dietary Aide, did not complete hand hygiene prior to lunch service. Staff B licked her fingers three times while reviewing meal tickets. After each instance, she continued to grab plates, add food items, and hand plates to staff serving residents without completion of hand hygiene.On 4/29/26 at 12:00 PM, an observation of the drink cart revealed expired food items. The drink cart contained one gallon of chocolate milk with an open date of 4-24-26 and a best-by date of 4-27-26. It also contained grape juice with an open date of 4/23/26 and a best-by date of 1/26/26, and prune juice with an open date of 2/26 and a best-by date of 1/25/26. On 4/29/26 at 12:03 PM, while Staff C, Dietary Aide, served lunch on the second floor unit. The observation revealed multiple staff members entered the kitchenette during the meal service without wearing hair nets. On 4/29/26 at 12:18 PM, an observation revealed Staff D, Certified Nurse Assistant (CNA), assisted two residents with oral intake of the lunch meal without performing hand hygiene beforehand or throughout the meal. Staff D went between the two residents multiple times during the meal without completing hand hygiene. On 4/29/26 at 12:28 PM, an observation revealed Staff C used a temperature probe to puncture through the tin foil with permanent marker with resident room number covering the residents' food items on a room tray to obtain the temperature of those items. Temperatures included Mash Potatoes at 121 degrees Fahrenheit and Steak at 130 degrees Fahrenheit.On 4/27/26 at 11:40 AM, Staff E, Certified Dietary Manager (CDM), stated staff must throw away refrigerator items after three days, and freezer items are acceptable for up to one year after the open date.On 4/28/26 at 12:45 PM, Staff E stated she expects staff to perform proper hand hygiene after the dietary aide licked her fingers and would not want her staff to lick their fingers during food service at any time. She stated refrigerator items are good for three days after the open date and she believed freezer items were acceptable for one year after the open date. Staff E stated she was unsure of the length of time the condiments in the big containers were good for after the open date, but she believed it was a long time.On 4/29/26 at 12:13 PM, Staff C stated that this kitchenette does not have any hair nets and staff must go down to the main kitchen to get a hair net before coming up to the second-floor kitchenette. On 4/29/26 at 2:35 PM, Staff E revealed her concerns about the room tray temperatures, staff entering the kitchenette without proper hairnets, and staff assisting two residents with eating without performing proper hand hygiene. Staff E stated her expectations include staff performing hand hygiene in between assisting multiple residents with feeding each time and wearing hair nets at all times during food service and anytime in the kitchen or kitchenette.On review of an undated policy provided by the facility titled, Storage and Use of Condiments (Open Products), revealed that all opened condiment containers must be properly labeled, stored, and used within defined timeframes. While many (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	condiments are not classified as Time/Temperature Control for Safety (TCS) foods, extended storage after opening may compromise quality, consistency, and resident acceptability. The policy requires staff to document the date opened and keep manufacturer dates visible. The policy mandates staff follow manufacturer guidance for shelf life; if guidance is unavailable, staff must use the item within a 30-60 day timeframe. The rationale documents that extended storage reduces quality and resident satisfaction; timelines support safety and dining experience. On review of an undated policy provided by the facility titled, Hair Restraints in Food Service Areas documented hair restraints are required for all staff involved in food preparation, plating, or direct service of exposed food.On review of an undated policy provided by the facility titled, Hand Hygiene documented the following list of some of the situations that require hand hygiene included: before and after direct contact with a resident, before and after handling food, before and after assisting a resident with meals and after contact with mucous membranes, body fluids or other excretions. On review of a policy provided by the facility dated 2021 titled, Food Storage documented food should be dated as it is placed on the shelf with date marking visible to indicate the date by which it is ready to eat, TCS food should be consumed, sold or discarded. All containers or storage bags must be legible and accurately labeled and dated. All foods should be covered, labeled and dated and routinely monitored to assure that foods will be consumed by their safe use by dates, or frozen or discarded. On review of an undated policy provided by the facility titled, Food Dating and Rotation documented all food items with be labeled with clear date markings and rotated using first in, first out principles. All items removed from original packaging must be dated including month/day/year and also applies to frozen items where original manufacturer date is no longer visible. Monitoring documentation included routine checks for dating and rotation and discard expired or improperly labeled items.

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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 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 observations, staff interviews, Electronic Health Record (EHR) review, resident interviews, family interviews, and policy review the facility failed to utilize Enhanced Barrier Precautions (EBP) during wound care for 2 of 4 residents (Residents #50, and #4). The facility further failed to use universal infection control measures (hand hygiene) during catheter care for 2 of 4 residents (Resident #1, and #2). The facility reported a census of 56 residents.Findings Include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #1 had a Brief interview for Mental Status (BIMS) of 15 that indicated cognitive mental status. Review of Resident #1's EHR page titled, Order Summary Report revealed an order for a Foley catheter size 16 French with a 10 milliliter balloon to be changed monthly and flush catheter with 60-120 cc of normal saline as needed for urine retention. On 4/29/26 at 1:55 PM an observation revealed Staff F, a Certified Nurse Assistant (CNA) employed for approximately one year with the facility, entered Resident #1's room and explained the procedure to the resident. Staff F applied a gown and gloves without performing hand hygiene. Staff F then retrieved five washcloths, placed them in the sink, and ran water over them, ringing out excess water before placing them on the sink edge. Staff F then took a plastic cylinder and alcohol swabs from a box on the paper towel dispenser and walked to Resident #1's bedside where Resident #1 laid in bed. Staff F pulled down Resident #1's boxers, and initiated peri-care while wearing the original gloves. Staff F then proceeded to wipe the right side of the groin twice with one washcloth. Staff F walked to a trash can, removed a trash bag, and placed the soiled washcloth inside, continuing to wear the same gloves. Staff F performed peri care to the left side of the groin using one washrag and discarded it into the trash bag. Staff F held the catheter at the penis and wiped the catheter tubing twice with the same washcloth, then pulled the resident's boxers back up. Staff F completed the cares using the same gloves to remove an alcohol swab, swabbed the end of the catheter bag, and opened the valve to empty the bag into the cylinder. Staff F used a second alcohol swab to cleanse the end of the catheter bag before closing the valve. Staff F performed no hand hygiene when entering the room, throughout peri-care, or while emptying the catheter leg bag. Staff F helped the resident pull up his jeans and assisted him to stand at the bedside while continuing to wear the same set of gloves. STaff F then retrieved Resident #1's walker, helped pull up Resident #1's jeans and suspenders and proceeded to help Resident #1 into his recliner. STaff F then removed the other washcloths and alcohol swab packaging from the bed and discarded the trash into the trash can. Staff F walked into the restroom with the cylinder, emptied the urine contents into the toilet, and rinsed the cylinder. Staff F at this time then doffed her gloves, removed her gown, and performed hand hygiene. On 4/27/26 at 12:53 PM, Resident #1 revealed that the staff often fail to clean his penis correctly. Resident #1 explained he has a bladder infection, takes antibiotics for a frequent Urinary Tract Infection (UTI). Resident #1 further revealed staff do not wear white gowns when they provide peri care or empty his catheter bag. On 4/29/2026 at 2:05 PM, Staff G Registered Nurse (RN) revealed she has worked at the facility for approximately three years and frequently works with Resident #1. Staff G reported Resident #1 is currently taking an antibiotic (ATB) for a Urinary Tract Infection (UTI) that began on 4/22/26. Staff G explained she monitors the resident for a red and inflamed penis. Staff G stated Resident #1 has never complained to her about needing better penile peri-care before. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/29/2026 at 2:19 PM, Staff H, Director of Nursing (DON), expressed concerns regarding the catheter care performed during peri-care on Resident #1. Staff H confirmed she did not perform the procedure correctly, and did not perform hand hygiene as Staff H would expect. Staff H stated she provided education to all CNA staff one week ago, and will provide education again. Staff H acknowledged risk for infection with improper catheter care and peri care during observation. 2. Observation on 04/27/2026 at 12:05 PM of catheter care for Resident #2 showed Staff Q, Certified Nursing Assistant (CNA), gathered supplies, failed to complete hand hygiene, then applied gloves without applying full EBP. The CNA then emptied the leg bag per policy, removed soiled gloves, failed to perform hygiene, then applied new gloves. The CNA discarded urine in the toilet, flushed the toilet, and discarded the urine container into the trash. Next, the CNA changed the garbage bag, removed gloves, failed to complete hand hygiene, shut the bathroom door, exited the resident's room, then closed the door. In an interview on 4/29/26 at 2:31 PM, the Director of Nursing (DON) stated that staff must use EBP for catheter care and perform hand hygiene immediately before and after changing gloves. In an interview on 4/29/26 at 2:31 PM, the Infection Preventionist (IP) reported she provided staff EBP and hand hygiene education but felt overwhelmed by her duties, which prevented her from performing necessary follow-up. 3. The Minimum Data Set (MDS) dated [DATE] for Resident #50 documented a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. MDS also indicated Resident #50 had surgical wounds. On 4/27/26 at 3:37 PM Resident #50 stated she had a small broken bone in her right foot. Resident #50 explained she had a surgical dressing that was changed every 3 days. Resident #50 stated the staff did not wear gowns while they changed the dressing. Observation on 4/27/26 at 3:38 PM revealed no Enhanced Barrier Precaution (EBP) equipment in the room and no EBP sign outside of Resident #50's room. Review of Resident #50's document dated 4/11/26 titled, Discharge Summary documented Resident #50 had 3 surgical wounds to the right ankle. Review of Resident #50's electronic health records documented a physician's order to change band aids to incision 3 times a week. Observation on 4/29/26 at 9:12 AM revealed Staff A, Infection Preventionist / Licensed Practical Nurse (LPN) completed hand hygiene, applied gloves, removed previous dressing on both side of right ankle, 8 sutures on the outer right side top and 1 suture on right side outer right side of right leg with serous drainage on dressing, appeared to have 7 sutures on the inner right ankle, purple bruising to arch of foot and ball of foot, gloves removed, hand hygiene completed, dressing applied to outer right ankle, dressing applied to the inside right ankle, ace wrap applied to the area, 2nd ace wrap applied up to the knee, boot applied to right leg, gloves removed and hand hygiene completed. On 4/29/26 at 12:46 PM the Director of Nursing (DON) stated Resident #50 should have EBP in place. The DON acknowledged Resident #50 had a surgical wound and Resident #50 had some drainage on the bandage and that would require EBP as well. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident #4 MDS dated [DATE] revealed an admission date of 7/23/25 from a short-term general hospital stay. The MDS further indicated that Resident #4 had surgical wounds. Interview 4/27/26 at 1:02 PM with Resident #4's family member revealed that Resident #4 has an area on her right foot that the facility has been treating for a long time. Review of Resident #4's EHR page titled, Clinical Physician Orders revealed an order for a silver med dressing to be changed daily to Resident #4's right big toe dated 4/1/26. Review of Resident #4's Care Plan with a revision dated of 4/14/26 revealed Resident #4 is on Enhanced Barrier Precautions and for staff to wear a gown and gloves when performing high contact care activities. Observation 4/29/26 at 11:28 AM Staff A Licensed Practical Nurse (LPN) completed hand hygiene and donned gloves. Staff A then was observed to remove Resident #4's sock and shoe. Staff A then removed Resident #4's old bandage from the area on the right foot with the open area to the inside of the right toe. Staff A then doffed her gloves and completed hand hygiene. Staff A then donned new gloves and completed the dressing change per the physician orders. Staff A was observed not wearing a gown while completing the dressing change. Interview 4/29/26 at 11:37 AM with Staff A revealed that she should have been wearing a gown as Resident #4 is on EBP precautions. Interview 4/29/26 at 12:41 PM with the DON revealed she would expect staff to wear gowns for Enhanced Barrier Precautions when doing dressing changes. Review of a facility provided undated policy titled, Enhanced Barrier Precautions indicated staff should be wearing gowns and gloves to prevent contamination of healthcare personnel's hands and clothing during the activities that demonstrate the highest risk of transfer of Multidrug-Resistant Organisms. Review of another facility provided policy titled, Catheter Care dated 4/1/26 indicated staff are to use supplies including a wash basin, towels, gloves, wash clothes, soap and plastic bags. The policy further indicated procedure steps for staff to place a towel on the bedside table as a barrier, hand hygiene, donning gloves with staff to use a clean area/side of the washcloth with every swipe, hold/anchor catheter and cleanse tubing with one swipe aware from meatus to the connection site, do not clean tubing back and forth and to clean away from the body, rinse with warm water in the same order, pat dry, remove towel and complete peri-care if needed, dispose of soiled linens in plastic bag at the foot of the bed, remove gloves and wash hands. Review of a facility provided undated policy titled, Hand Hygiene documented the following list of some of the situations that require hand hygiene included: before and after direct contact with a resident, before and after contact with mucous membranes, body fluids or other excretions, before and after entering isolation precaution settings, before and after assisting a resident with personal care, before and after handling a catheter or other invasive devices, before and after changing a dressing, before and after applying gloves, before and after coming in contact with a resident's skin , after handling soiled or used linens, dressings, bedpans, catheters, and urinals, after handling soiled equipment, surfaces or utensils, after removing personal protective equipment, after having contact with body fluids, wounds or broken skin and after moving contaminated body site to clean body site during resident care delivery.

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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 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 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to refer 1 resident with a negative Level I result for the Preadmission Screening and Resident Review (PASRR), who was later identified with newly evident or possible serious mental disorder, intellectual disability, or other related condition, to the appropriate state-designated authority for Level II PASRR evaluation and determination for 1 out of 2 residents (Resident #3) reviewed for PASRR requirements. The facility reported a census of 56 residents.Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 documented diagnoses of psychotic disorder, depression, and schizophrenia. The MDS for Resident #3 included a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. The PASRR Notice of Nursing Facility Approval dated 1/29/14 for Resident #3 indicated the facility failed to resubmit the PASRR with changes that occurred since 2014. The PASRR Notice also failed to indicate what medications were prescribed at the time of approval. The current Clinical Physician Orders for Resident #3 revealed the following medications:On 8/16/22 Venlafaxine extended release 77.5 mg started for treatment of major depressive disorderOn 8/27/25 Quetiapine 300 milligrams (mg) started for treatment of schizoaffective disorder and bipolarThe admission Criteria policy revised March 2019 failed to provide instructions for when a new Level 1 screening must be initiated. In an interview on 4/29/26 at 2:31 PM, the Director of Nursing (DON) reported staff should resubmit a Level I for screening when there are changes in medications. In an interview on 4/29/26 at 2:31 PM, the Infection Preventionist (IP) reported she felt overwhelmed by her duties, which prevented her from catching changes that would require a resubmission of a Level I. The IP acknowledged medications changes have occurred since 2014. The IP stated, I don't know that there have been any behavioral changes. When asked why new medications were ordered, the IP stated, I see what you're saying. I started the resubmission yesterday morning.

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	04/30/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, Electronic Health Records (EHR) review, and policy review, the facility failed to maintain a professional standard of quality when staff did not apply the prescribed Thrombo-Embolic Deterrent (TED) hose for Resident #7. The facility reported a census of 56 residents.Findings include: On review of the Minimum Data Set (MDS) dated [DATE] documented Resident #7 had a Brief Interview for Mental Status (BIMS) of 10 that indicated moderate cognitive impairment.On review of EHR titled, Order Summary dated 4/28/26 documented a Physician's Order for Resident #7 knee high TED hose to be applied in the morning and removed in the evening. On review of Resident #7's Treatment Administration Record (TAR) for the month of April documented TED hose to be applied in the morning and removed in the evening. Further review of TAR documented nurse signatures everyday of application and removal.On 4/27/26 at 1:52 PM an observation revealed Resident #7 sitting in the common area watching a movie with white ankle socks present without TED hose noted to be on at this time.On 4/28/26 at 9:18 AM an observation revealed Resident #7 sitting in a recliner without the TED hose present. Resident #7 was wearing white ankle socks. On 4/29/26 at 11:17 AM an observation revealed Resident #7 sleeping in her wheelchair in her room without the TED hose in place. Resident #7 had white ankle socks on at this time.On 4/27/26 at 3:57 PM Resident #7's daughter, stated during a phone interview that her mother should wear TED hose daily and confirmed her belief that Resident #7 needs to wear them every day. Resident #7's daughter confirmed she has never seen her mother wearing them during her visits. On 4/29/26 at 11:23 AM, Staff I, Certified Nurse Assistant (CNA) stated she was assigned to Resident #7's hall today. She reported Resident #7 wore the TED hose occasionally, but the TED hose are sent to the laundry and they do not always return. Staff I stated the pharmacy sends the TED hose, and Resident #7 has been through quite a few pairs this month. She specified Resident #7 has brown and tan TED hose, and staff only applies them if they are in Resident #7's room. Staff I admitted she did not apply the TED hose this morning because none were available in the room, and she did not report the omission to anyone.On 4/29/26 at 11:26 AM, Staff J, CNA reported she frequently worked with Resident #7. Staff J explained the staff sent the TED hose to the laundry, and they did not return. Staff J stated if staff do not find the TED hose present in Resident #7's room staff do not apply them and instead the staff placed regular socks on the resident. On 4/29/26 at 11:28 AM, Staff K, Certified Nurse Assistant (CNA) / bath aide, reported she frequently worked with Resident #7 and provided showers/baths. She stated Resident #7 must wear the TED hose daily, with AM CNAs applying them and PM CNAs removing them. Staff K reported she applied regular socks after Resident #7's shower because she usually does not have the TED hose. She believed the TED hose are not present because staff sends them to the laundry, and they do not return. Staff K estimated she applied the TED hose only two to three times a week.On 4/29/26 12:45 PM an interview with Staff L, Licensed Practical Nurse (LPN) revealed she worked with Resident #7 frequently. Staff L stated the physician order documented the TED hose were to be applied every morning and removed every evening. Staff L stated anyone can apply the TED hose though the nurse is supposed to check and make sure they were applied and / or removed. Staff L stated she checks to make sure before charting if TED hose are present. Staff L explained she does not know if they are frequently missing.On 4/29/26 at 2:20 PM the Director of Nursing (DON) stated nurses must ask CNAs about the TED hose application or removal, and then personally verify the hose's placement. Staff H required nurses to check the TED hose placement before charting and to document the reason for omission if they do not apply the hose. On review of a policy provided by the facility dated 4/01/26 titled, Physician Visits and Medical Orders (task Delegating), documented the members of the interdisciplinary team will provide care, services and treatment according to the most recent medical orders and according to laws, regulations and standards of practice.

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	04/30/2026

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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.