STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165271	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Specialty Care	4201 Fieldcrest Drive Sioux City, IA 51104

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** 41785 Based on observation, interviews, record and policy review, the facility failed to provide professional standards of care by following physician ordered wound treatment for 1 of 4 residents reviewed (Resident #24). The facility reported a census of 70 residents. Findings include: According to the MDS dated [DATE], Resident #24 had a BIMS score of 14 (intact cognitive ability). She was totally dependent on staff for toileting, lower body dressing and bathing. Her skin conditions included Moisture Associated Skin Damage (MASD) and she was on diuretic therapy related to edema. Diagnoses included heart failure, chronic kidney disease, metabolic encephalopathy. The Care Plan updated on 1/17/24 indicated that staff were to monitor her legs for skin changes and report to the nurse. She required 2 staff for bed mobility and used a bedpan for bowel movements. She was at risk for potential infection related to an indwelling catheter. Staff were directed to use enhanced barrier precautions when performing high-contact care activities. Staff were to follow physicians' orders to prevent further impairment of skin integrity. An addition was made to the Care Plan on 4/26/24 showing that she had a ruptured blister on the top of her left leg. In an observation on 4/30/24 at 3:25 PM, Staff A and Staff B, Certified Nurse Aides (CNA) provided incontinence cares for Resident #24 while the resident remained in bed. The resident had some edema to her lower extremities and her skin was dry and frail. After completing the care, Staff A went to pull the sheet over the resident's feet and it was discovered that she had an open wound on the front of her ankle. When asked about the spot, the aides were not sure if nursing was aware. Staff A then pulled up the resident's stocking over the wound and covered her with a blanket. According to the Skin and Wound Evaluation dated 4/24/24 at 10:54 PM, staff discovered that the resident had a blister on left lateral malleolus. There was light bleeding and a dry dressing was applied at that time. A fax communication was sent to the provider on 4/26/24 regarding the skin issue, indicating that the area would be covered for protection. A facility policy titled Acute Condition Changes dated 2018 showed that physician would identify and authorize appropriate treatments. Staff would monitor and document the resident progress and response to treatment and the physician would adjust treatment accordingly.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interviews, and record review the facility failed to reposition residents according to their needs for 2 of 3 residents reviewed (Resident #2 & Resident #15). The facility reported a census of 70 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #2 was unable to participate in a Brief Interview for Mental Status (BIMS) assessment, indicating that she was rarely/never understood. The resident had a pressure ulcer/injury over a bony prominence. His diagnoses included: Peripheral Vascular Disease, renal insufficiency, arthritis, osteoporosis, and Alzheimer's Disease. The Care Plan revised on 2/15/23 showed that Resident #2 had a history of a stroke and was nonverbal. She did not ambulate and required 2 staff assistance for bed mobility. She was at risk for pressure ulcers, staff were to monitor the sacrum after cares and ensure that the dressing was in place. A review of the Orders tab in the electronic medical record showed an order dated 3/25/24 at 6:10 PM, that the resident was to be positioned on her side, not on her back. In an observation on 4/23/24 at 2:35 PM, Resident #2 in bed the call light on her chest. She did not respond to questions. In an ongoing observation on 4/24/24, the resident was found to be in bed on her back at; 1:48, 2:43, 3:06, 3:55, 4:42 and 5:20 PM. At 5:25 PM an unidentified Certified Nurse Aide (CNA) said that she would get the resident up for supper at 5:30. On 4/25/24 10:27 AM, when asked if she would be concerned to learn that Resident #2 had been on her back in bed for over 3 hours, the agency Registered Nurse (RN) said that she would expect the resident to have position changes every two hours. 2) According to the MDS dated [DATE], Resident #15 was severely impaired in cognitive skills for daily decision making, and was not able to complete a BIMS assessment. She was totally dependent on staff for toileting, transfers, dressing, and hygiene. The resident was frequently incontinent of urine and always incontinent of bowel. The resident's diagnoses included; Non-Alzheimer's Dementia, malnutrition, abnormal posture, and a history of falling. The Care Plan revised on 4/25/24, showed that Resident #15 was dependent on a wheelchair for mobility. Staff were directed to lay the resident down after meals if she was sleeping. The resident had difficulty making herself understood and staff were to check on her every 2 hours and assist with toileting and to help the resident to weight shift while sitting up in the chair. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/24 at 7:20 AM, Resident #15 was in the dining room area with a baby doll in her lap. Her head was hanging down, resting on her chest and she appeared to be sleeping. At 8:19 AM, along with 3 other residents, she had been relocated into a small room for residents needing eating assistance. At 10:05 AM, she was still in the room, sleeping in the wheel chair. At 10:50 AM she was still in the wheel chair sleeping with her head down on her chest. On 4/30/24 at 6:45 AM, Resident #15 was in her wheel chair by the table in the dining room. Her head was on her chest and she appeared to be sleeping. At 8:04 AM, resident was in the small dining room for assistance but hadn't been served any food. At 8:20 AM, she was eating and at 9:03 AM she was still at the table, head hanging. At 9:20 AM the resident was in her room, still in the wheel chair. A facility policy titled: Repositioning, dated 2013, showed that staff were to review the resident's care plan to evaluate for any special needs of the residents. Develop an individualized care plan for repositioning to promote comfort for all bed or chair-bound residents to prevent skin breakdown.

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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 observations, interview, and record review the facility failed to use adequate infection control measures to mitigate the spread of pathogens for 2 of 4 residents reviewed (Resident #5 and Resident #24). The facility reported a census of 70 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15 (intact cognitive ability). The resident had functional limitations in range of motion and used a wheel chair. Resident #5 was totally dependent on staff for sit to stand, transfers, toilet transfer, and she had an indwelling catheter. The Care Plan updated on 4/23/24, indicated that Resident #5 had skin and soft tissue cellulitis infection on her leg. Staff were directed to administer medications and treatments as ordered. The resident was at risk for potential infection related to indwelling catheter and chronic wounds, staff were to use enhanced barrier precautions when performing high-contact care activities. The resident's diagnoses included: neurogenic bladder, diabetes mellitus, anemia, malnutrition, transient cerebral ischemic attack, and acquired absence of the left lower limb. In an observation on 4/30/24 at 4:29 PM, Resident #5 was sitting in her wheel chair in her room and the urinary catheter bag contained over 1000 cubic centimeters (cc) of urine. Staff C, Certified Nurse Aide (CNA) went to the back of the wheel chair and put a container on the floor. Without gloves or gown, she unhooked the catheter bag from the bottom of the wheel chair, lifted it above the container and opened the spigot for the urine to empty. The container overflowed onto the floor so she went to the bathroom and emptied the container. Staff C then used a paper towel to wipe the urine off the floor and hooked the bag back up onto the wheel chair without gloves. 2) According to the MDS dated [DATE], Resident #24 had a BIMS score of 14 (intact cognitive ability). She was totally dependent on staff for toileting, lower body dressing, and bathing. Her skin conditions included Moisture Associated Skin Damage (MASD) and she was on diuretic therapy related to edema. Diagnoses included heart failure, chronic kidney disease, and metabolic encephalopathy. The Care Plan updated on 1/17/24 indicated that staff were to monitor her legs for skin changes and report to the nurse. She required 2 staff for bed mobility and used a bedpan for bowel movements. She was at risk for potential infection related to indwelling catheter. Staff were directed to use enhanced barrier precautions when performing high-contact care activities. Staff were to follow physicians' orders to prevent further impairment of skin integrity. An addition was made to the Care Plan on 4/26/24 showing that she had a ruptured blister on the top of her left leg. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 4/30/24 at 3:25 PM, Staff B, CNA and Staff A, CNA stood on each side of the bed and provided incontinence cares for Resident #24 while the resident remained in bed. Staff A used disposable wipes to clean the resident's legs, abdomen, and in the abdominal fold. The CNA's turned the resident on her side and Staff B helped stabilize the resident while Staff A cleaned feces from her bottom. As Staff A bent over to wipe the buttocks, her long hair fell in front of her and onto the protective padding on the resident's bed where she had just been laying. Staff A flung her head to the side several times to get her hair over her back but as she leaned over to wipe, the hair fell back onto the bed. When Staff A had completed the cares, she removed her gown, over her head, the long hair flowed over the front of the gown. Without washing her hands, Staff B left the resident's room with the trash in her hand and said that she would wash her hands when she got to the soiled linen room. She grabbed the door handle on the resident's door and to the soiled linen room with a gloved hand. On 5/2/24 at 2:38 PM the Administrator indicated that staff were to arrange their hair so that it would not interfere with direct resident cares. According to the facility policy titled: Policies and Practices - Infection Control the goal of the facility was to maintain a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.