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	07/25/2024

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** 37074 Based on observations, record review, hospital staff, staff and family interview the facility failed to follow physician's orders for 1 of 3 (Resident #1) residents reviewed. The facility also failed to appropriately enter a physician's order in to the Electronic Health Record (EHR) for 1 of 3 (Resident #2) residents reviewed. The facility reported a census of 76 residents. Findings include: 1. According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of 4/19/24, Resident #1's cognitive skills for daily decision-making skills was not assessed. Resident #1 utilized a wheelchair and was frequently incontinent of urine and bowel. The MDS listed the following diagnoses: dementia, urinary tract infection (UTI), depression, autoimmune hepatitis, lymphedema, and pulmonary hypertension. The Care Plan focus area with an initiation date of 11/14/22 documented Resident #1 has a UTI related to incontinence of urine and stool. The care plan instructed staff to administer her antibiotics as ordered. The Care Plan focus area with an initiation date of 12/18/23 documented she has a history of being able to participate more with her activities of daily living (ADL) with family prompting. She does not like to listen to staff and will refuse. Resident #1 required assistance of one staff for personal hygiene and assistance of two staff for toileting. The care plan directed staff to use warm soapy wash cloths for peri care. Staff are to not use peri wash sprays or foam per family. A Progress Note dated 6/7/24 at 6:14 PM documented Resident #1's daughter requesting for resident to only be washed with Ivory soap and washcloths during routine peri/incontinent cares every two hours. Requests to have no wipes used on resident since it has caused previous irritation. The nursing assistants have been instructed on request, note left in communication binder, a note taped in resident's room and requested order from her provider via nurse's note. A facsimile was sent to the facility on [DATE] at 11:59 AM from the resident's provider's office with the order for Ivory soap and warm washcloths to be used for incontinence care, no wipes. The ordered was signed by Staff A Licensed Practical Nurse (LPN) on 6/17/24. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the June 2024 Treatment Administration Record (TAR) revealed an order for staff to clean peri area with Ivory soap and water every morning and at bedtime. The order had a start date of 6/25/24 at 7:00 AM. Review of resident's orders revealed an order for Cefdinir (antibiotic), give 300 milligrams (mg) by mouth two times a day for UTI with an order date of 6/5/24 at 11:42 AM. Review of Resident #1's June 2024 Medication Administration Record (MAR) revealed an order for Cefdinir 300mg, two times a day for UTI for 7 days. The medication was ordered to be administered at the morning and bedtime medication pass. The order had a start date of 6/5/24 at 8:00 PM. The order was not signed out as being given on 6/5/24 during the bedtime medication pass. A Progress Note dated 6/7/24 at 1:48 PM documented the antibiotic was not started on time. The antibiotic was started as soon as the error was caught, primary care provider was notified. On 7/25/24 at 2:22 PM Staff D Assistant Director of Nursing (ADON) stated when an order is received it techniqually should be started then, when the doctor orders it to start. 2. According to a quarterly MDS assessment tool with a reference date of 5/1/24, documented Resident #2 had a BIMS score of 13, suggesting no cognitive impairment. The MDS documented she did not utilize oxygen therapy while a resident during the review period. The MDS listed the following diagnoses for Resident #2: stroke, anemia, peripheral vascular disease, renal failure, dementia, hemiplegia/hemiparesis, and depression. A Care Plan focus area with an initiation date of 2/22/24 documented Resident #2 required oxygen therapy related to history of respiratory illness. The care plan documented she was to receive 2 liters (L) of oxygen via nasal cannula at bedtime. Review of Resident #2's Orders revealed an order for 2L of oxygen via nasal cannula at night and as needed (PRN) due to her diagnoses of Chronic Obstructive Pulmonary Disease (COPD). The order had as start date of 11/23/23. Review of Resident #2's November 2023, June 2024, and July 2024 MAR and TAR revealed the administration records did not contain an order for oxygen at night and PRN. Review of the Vital Signs tab revealed the oxygen saturations documented the saturations with room air. Four entries were made in December 2023 where the resident wore oxygen via nasal cannula when the saturation was obtained. On 7/23/24 at 12:14 PM observed no supplemental oxygen supplies in Resident #2's room. On 7/24/24 at 6:49 AM resident was lying in bed with supplemental oxygen on via nasal cannula that was attached to an oxygen concentrator. A Progress Note dated 7/17/24 at 9:35 PM documented Resident #2 was found lying sideways on her bed. Staff tried to assist her with sitting up in her bed but she could not help. Resident could not squeeze with both of her hands, she would look at the nurse but could not respond. Her oxygen saturation was noted to be 88% on room air, running from 84% to 90%. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/23/24 at 1:06 PM the hospital staff member stated she was there when Resident #2 came to the emergency roiagnom on [DATE]. She stated when she came in with EMS she was on 6L of oxygen. She was to have oxygen on at night too whether she had it on she was not sure, but it was not on when EMS arrived to the facility. On 7/23/24 at 6:39 PM Staff B Registered Nurse (RN) stated the night Resident #2 went to the ER, she would not respond when she was trying to help her. She did her vital signs and her oxygen saturations was 84-88% but was staying between 88-90%. When asked if Resident #2 had her oxygen on at that time, she stated no and that she would not usually wear it. Staff B stated the oxygen order was PRN at that time. On 7/24/24 at 11:29 AM Resident #2's family member stated someone visits Resident #2 almost daily. When asked if the resident wore her oxygen, she stated it has been awhile since she had noticed oxygen in the resident's room. She added their used to be an oxygen concentrator in her room but it has not been in her room. She didn't realize this until this recent hospitalization . On 7/25/24 at 1:15 PM the Regional Nurse Consultant stated when the oxygen order was put in to their Electronic Health Record (EHR) it did not allow staff to document or see the order on the TAR. They were able to identify this while looking in to the oxygen order. Since then, staff have placed a concentrator in her room before she returned to the facility on [DATE]. On 7/25/24 at 2:07 PM Staff C ADON stated she was not working at the facility when the oxygen order was put in place. She was informed about it recently and was to make sure all oxygen orders are on the resident's TAR. She indicated before the resident returned from the hospital on 7/23/24, a concentrator was placed in Resident #2's room.

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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 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** 37074 Based on observations, record review, resident, staff and hospital staff interview and policy review the facility failed to ensure 1 of 3 residents (Resident #2) reviewed were assisted with cleaning their dentures and that her peri-area was adequately cleansed appropriately prevent moist associated skin damage (MASD). The facility reported a census of 76 residents. Findings include: According to a quarterly MDS assessment tool with a reference date of 5/1/24, documented Resident #2 had a BIMS score of 13, suggesting no cognitive impairment. The MDS listed the following diagnoses for Resident #2: stroke, anemia, peripheral vascular disease, renal failure, dementia, hemiplegia/hemiparesis, and depression. The Care Plan focus area with an initiation date of 11/16/23 documented she required the assistance of one staff for toileting and personal hygiene. The Care Plan focus area with an initiation date of 12/4/23 instructed staff to assist Resident #2 with oral care to reduce irritation from food. Review of the Fire Rescue Patient Care Report dated 7/17/24 documented when the Emergency Medical Services (EMS) arrived to the facility, as they assisted Resident #2 to the stretcher they noted a very strong smell of urine coming from her, much like a urinary tract infection (UTI) smell. Review of Resident #2's skin assessments revealed an assessment was completed upon her admission, with an evaluation date of 7/24/24. The skin issue was labeled as MASD-Incontinence Associated Dermatitis (IAD) that was present on admission. Dimensions documented as: surface area 17.9 centimeter (cm), 7. 04cm x 3.41cm to the genital region. On 7/24/24 at 7:40 AM resident was sitting on the toilet with staff present in the room. Resident stood up and wiped herself, then pulled her adult brief and pants up. Resident was given a container that had her dentures in it. Staff encouraged her to brush her dentures then was given mouthwash to rinse her mouth out. On 7/23/24 at 1:06 PM a hospital staff member stated she was the primary nurse when Resident #2 came to the emergency roiagnom on [DATE]. When they took Resident #2 to get an MRI, they took her dentures out. There were dark green specks on her upper plate that sat between her gums. The family thought it was mold. The family was very angry and took pictures of them. Their nurse's aide worked on them for about 20 minutes to get them clean but they were not able to get them completely clean. Dentures do not get that yucky easily, they must not have been removed for a week. When she went to insert a foley catheter for Resident #2, she had horrible excoriated diaper rash to her peri-area. It was so horrible, she felt bad cleaning her with iodine. It looked like she had not been cared for and the family was upset about this as well. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/23/24 at 6:39 PM Staff B Registered Nurse (RN) stated she thought Resident #2 had orders for powder to her groin area and would take herself to the bathroom. When asked if she required assistance with cleaning her dentures she indicated she was not 100% sure on that. She thought she got help from the aides but guessed she could do it herself. On 7/24/24 at 11:29 AM Resident #2' Power of Attorney (POA) stated when her mom went to the emergency room they took her dentures out to complete some testing. When they removed them they were disgusting, it took the hospital staff 30 minutes to get them cleaned; it was so gross. She was under the impression that the facility staff were to help Resident #2 clean her dentures, maybe an assistance of one staff. She was not sure if she was to be reminded to clean her dentures or if staff were to oversee her cleaning them. She thought staff assisted her mom or cleaned the dentures for her. When asked if she had any skin issues that she was aware of, Resident #2's POA stated her peri-area was so raw when she got to the hospital. Her peri-area was red and raw, her skin was almost purple in color. She thought her mom was an assistance of one when going to the bathroom, but she was not really sure. She believed she was going to the bathroom by herself but she was concerned why they did not see this during her baths. When the hospital completed their complete body intake, it was like someone punched her in the stomach when she saw these things with Resident #2. She does have photos but wished not to share them with the surveyor. The POA did indicate she shared the photos with the facility staff members. On 7/25/24 at 2:07 PM Staff C Assistant Director of Nursing (ADON) stated Resident #2 was usually pretty independent with oral cares but would need some cueing. She would assume at night, someone would check everyone's dentures, even the independent residents. Staff should have been checking her dentures when getting ready for bed. When asked if Resident #2 had any skin issues she stated she has personally gone down to her room to do skin checks. She would ask the resident if she had any redness, she would tell her no and that she was ok down there. When asked if any what was found in the ER would have been noticed during the resident's bath, she stated the aides are usually pretty good about noticing skin issues on bath days. She added she was surprised the hospital staff said that about her peri-area as she is usually pretty good about cleaning herself up. Resident #2 is also usually pretty good about letting staff know if she is hurting or if anything was wrong in her peri-area. The facility provided a document titled Bath, Shower/Tub with a revision date of February 2018. The purpose of this procedure is to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Under the documentation section staff are directed to document all the assessment data (any reddened areas, sores, etc. on the resident's skin) obtained during the shower/tub bath. Under the reporting section staff are directed to notify the physician of any skin areas that may need to be treated. The facility provided a document titled Dentures, Cleaning and Storing with a revision date of March 2018. The purposes of this procedure are to cleanse and freshen the resident's mouth, to clean the resident's dentures, to prevent infections of the mouth, to protect the resident's dentures from breakage when dentures are out of the resident's mouth, and to store dentures at bedtime. General Guidelines 1. Provide denture care before breakfast and at bedtime. Encourage and assist the resident as needed to rinse his or her mouth after each meal. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Handle dentures carefully to prevent loss or breakage. Store dentures whenever they are not in the resident's mouth. 3. Loose or poor fitting dentures can cause gum sores and prevent the resident from chewing his or her food properly. If a resident is not chewing his or her food thoroughly, report it to your supervisor. 4. Encourage the resident to keep dentures in his or her mouth as much as possible. When dentures are left out of the mouth for several days, the bone structure to the mouth changes and the gums will shrink causing the dentures to fit improperly. 5. As you provide denture care examine the resident's mouth and gums for any paleness of the gums, mouth sores, bleeding, or areas of discoloration. 6. Encourage the resident to perform as much of the procedure as possible. Steps in the Procedure 5. Ask the resident to remove his or her dentures. If the resident cannot remove his or her dentures: a. Put on gloves. b. Instruct the resident to rinse his or her mouth with water. c. Place a tissue/gauze pad over the fingers of the hand you are using to remove the dentures. d. Remove the upper dentures. Gently move the dentures from side to side and pull down. Place dentures in the emesis basin. e. Remove the lower dentures. Use an upward motion. Move the dentures to the inside of the mouth then remove them. Place dentures in the emesis basin. 6. Take the emesis basin to the sink. 7. Clean the dentures by brushing them with a denture cleaner or toothpaste. 8. Hold the dentures in the palm of your hand and over the sink while brushing to prevent them from dropping on the floor. Rinse dentures thoroughly. 9. Fill the denture cup one-half (1/2) full with fresh water and one-half (1/2) full of mouthwash. Place dentures into the denture cup. 10. Take the denture cup and emesis basin to the bedside table. Leave dentures in the cup until the resident is ready to replace them in his or her mouth. 11. Instruct the resident to rinse out his or her mouth thoroughly with fresh water or with a mouthwash solution. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12. Instruct the resident to spit the rinse solution into the emesis basin. Provide mouth care as necessary. 13. Dry the resident's face and chin area. 14. If the resident wishes to replace the dentures into his or her mouth, moisten the dentures so that they will fit easily. Use adhesive paste as requested. When handling the dentures hold with a tissue or gauze pad. 15. To assist the resident in replacing the dentures: a. Ask the resident to rinse his or her mouth with water. Assist as necessary. b. Apply denture adhesive or paste as requested by the resident. c. Pick dentures up with a tissue or gauze pad. d. Replace the upper/lower dentures. Ask resident to assist you in properly fitting the dentures. e. Dry the resident's face and chin area as necessary. Documentation 6. If the resident refused the treatment, the reason(s) why and the intervention taken. Reporting 1. Notify the supervisor if the resident refuses the denture care. 2. Report other information in accordance with facility policy and professional standards of practice.