| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165271 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westwood Specialty Care | 4201 Fieldcrest Drive<br>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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on observations, facility policy review and staff interview the facility failed to cover exposed catheter bags for 3 of 3 residents reviewed (Resident #1, #5 and #6). The facility reported a census of 77 residents Findings include: 1. Observation on 12/16/25 at 2:24 p.m., revealed Resident #1 laying in bed with a catheter bag hanging on the side of the bed with no privacy cover, urine visible in the bag from the hallway. 2. Observation on 12/16/25 at 9:59 a.m., revealed Resident #1 laying in bed with a catheter bag hanging on the side of the bed with no privacy cover, urine visible from the door in the hallway. 3. Observation on 12/16/25 at 2:25 p.m., revealed Resident #6 in bed with a catheter bag hanging on the side of the bed with no privacy cover and urine visible from the door in the hallway. 4. Observation on 12/16/25 at 10:04 p.m., revealed Resident #5 laying in bed with catheter bag hanging on the side of the bed with no privacy cover, urine visible from the door in the hallway Review of the facility provided policy titled Dignity with a revised date of February 2021 revealed Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents, for example, helping the resident to keep urinary catheter bags covered. Interview on 12/22/25 at 3:43 p.m., with Regional Nurse Consultant, revealed all catheter bags should have a cover as that is a dignity concern. |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interview, staff interview and facility policy review the facility failed to provide bathing assistance as scheduled for 3 of 3 residents reviewed for bathing (Resident #2, #3 and #6). The facility reported a census of 77 residents. Findings include:1. The MDS assessment dated [DATE] for Resident #2 documented diagnoses of muscle wasting, repeated falls and disorientation. The MDS showed the Brief Interview for Mental Status (BIMS) score of 14, which indicated no cognitive impairment. The care plan with an initiated date of 6/20/25 for Resident #2 showed the resident required assistance from one person for bathing.In an interview on 12/30/25 at 2:26 PM, Resident #2 stated he did not want to get anyone in trouble and reported that he is not routinely offered a bath twice per week. When asked about refusals, the resident stated that he sometimes refused bathing. He further stated that despite occasional refusals, he is not consistently offered bathing services twice weekly. The resident stated that at times he is bothered by missing a bath and at other times he is not.The Documentation Survey Report dated November 2025 indicated that Resident #2 scheduled to receive baths on Tuesdays and Fridays. Documentation showed the resident received only two baths during November, on 11/21/25 and 11/25/25.The Documentation Survey Report dated December 2025 indicated that Resident #2 scheduled to receive baths on Tuesdays and Friday. Documentation showed that the resident did not receive baths during the first 20 days of December. 2. The MDS assessment dated [DATE] for Resident #3 documented diagnoses of dementia, Parkinson's Disease and failure to thrive. The MDS showed the Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. The MDS also revealed Resident #6 required partial to moderate assistance for bathing.The care plan with an initiated date of 2/20/25 for Resident #3 showed the resident dependent for bathing and required assistance from one person for bathing. In an interview on 12/30/25 at 2:47 PM, Resident #3 reported that baths are scheduled twice weekly. The resident stated the facility failed to offer baths twice per week in November and does not recall refusing a bath. Resident #3 reported that the bath schedule changed for some residents but reported that it did not appear to improve the situation.The Documentation Survey Report dated November 2025 indicated that Resident #3 scheduled to receive baths on Tuesdays and Fridays. Documentation showed that the resident failed to receive a bath on or around the following dates:a. 11/15/25b. 11/18/25c. 11/21/25The Documentation Survey Report dated December 2025 indicated that Resident #3 scheduled to receive baths on Tuesdays and Fridays. Documentation showed that the resident failed to receive a bath on or around the following dates:a. 12/2/25b. 12/5/25c. 12/12/25d. 12/23/25e. 12/26/253. The MDS assessment dated [DATE] for Resident #6 documented diagnoses of unsteadiness on feet, need for assistance with personal cares and repeated falls. The MDS showed the Brief Interview for Mental Status (BIMS) score of 13, which indicated no cognitive impairment. The MDS also revealed Resident #6 required partial to moderate assistance for bathing.The care plan with an initiated date of 8/25/25 for Resident #6 showed the resident required substantial assistance from one person for bathing.In an interview on 12/30/25 at 3:02 PM, Resident #6 reported feeling very upset by the lack of bathing provided by the facility. Resident #6 stated, I haven't had a bath for a week then it was okay but before that I didn't get a bath for two weeks. When asked if she ever refused a bath, Resident #6 stated, it's not often.The Documentation Survey Report dated November 2025 indicated that Resident #6 scheduled to receive baths on Monday and Thursdays. Documentation showed the resident received only two baths during November, on 11/21/25 and 11/25/25.Documentation showed Resident #6 failed to receive a bath on the following dates:a. 11/3/25b. 11/6/25c. 11/10/25d. 11/13/25e. 11/17/25f. 11/20/25The Documentation Survey Report dated December 2025 indicated that Resident #6 scheduled to receive baths on Mondays and Thursdays. Documentation showed that the resident failed to receive a bath on or around the following dates:a. 12/8/25b. 12/11/25c. 12/15/25d. 12/22/25e. 12/25/25f. 12/29/25In an interview on 12/29/25 at 12:55 PM, Staff E, Certified Nursing Assistant (CNA) reported several CNAs have recently resigned after being held accountable for not completing assigned duties. Staff E revealed the facility previously used bath aides, and residents were not consistently receiving scheduled baths. As a result, a new plan was implemented in which some resident baths are assigned to day shift and others to night shift. Staff E reported that none of the residents in her hall who are scheduled for night-shift baths have received them. Staff E is now expected to complete those missed baths during the day in addition to her regularly scheduled assignments and baths often don't get done. The Bath, Shower/Tub policy last revised |

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| | 165271 | A. Building<br>B. Wing | 12/31/2025 |

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| Westwood Specialty Care | 4201 Fieldcrest Drive<br>Sioux City, IA 51104 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews and facility policy review the facility failed to provide physician ordered daily weights 1 of 1 residents reviewed (Resident #2). The facility reported a census of 77 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 documented heart failure, hypertension and coronary artery disease. The MDS showed the Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment. Review of the physician order dated 7/17/25 at 3:21 p.m., revealed an order for daily weights if weight gain of greater than 3 pounds in one day or greater than 5 pounds in one week fax weights weekly. Review of daily weight records lacked daily weights on the following days:October 11, 17 and 31November 8, 9, 20, 21, 22, 28 and 30December 5 and 12 Review of the clinical record lacked any documentation the physician had been notified daily weights were not being completed and monitored as ordered. Review of the facility provided policy titled Physician Services with a revised date of February 2021 revealed supervising the medical care of residents includes monitoring changes in resident's medical status, providing consultation or treatment when called by the facility and overseeing a relevant plan of care for the resident. Interview on 12/30/25 at 2:01 p.m., with Regional Nurse Consultant revealed the facility should be doing daily weights if they are ordered and they should notify the physician if they are not being completed or per the order with weight gains. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and facility policy review, the facility failed to provide safe transfers of residents with transfers 2 of 3 residents reviewed (Resident #4 and #13). The facility reported a total census of 77 residents. Findings include:<br><br>1. Observation on 12/29/25 at 1:41 p.m., of Staff D, Certified Nursing Assistant (CNA) assisting Resident #4 into the bathroom. Staff D assisted Resident #4 to the grab bar. Resident proceeded to grab the bar and Staff D grabbed under resident's right armpit with her forearm and pulled her up to a standing position. When the resident was completed in the bathroom Staff D assisted the resident to a standing position by using her forearm pulling under her left armpit to a standing position.<br><br>Review of the care plan with a revision date of 10/31/25 revealed Resident #4 required 1 assist with toileting and personal hygiene.<br><br>Review of the MDS dated [DATE] revealed Resident #4 is dependent on staff assistance for toileting, requires partial to moderate assistance with personal hygiene and requires partial to moderate assistance with toilet transfers.<br><br>Review of the facility provided policy titled Safe Lifting and Movement of Residents revealed in order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. Staff responsible for direct resident care will be trained in the use of manual ([NAME]/transfers belts) and mechanical lifts. Safe lifting and movement of residents is part of an overall facility employee health and safety program.<br><br>Interview on 12/29/25 at 2:26 p.m., with Regional Nurse Consultant revealed when staff are assisting a resident with a 1 assist transfer she expects staff to use a gait belt and not to pull on their arms.<br><br>2. The MDS assessment dated [DATE] for Resident #13 documented diagnoses of seizure disorder, anxiety disorder and chronic obstructive pulmonary disorder. The MDS showed the Brief Interview for Mental Status (BIMS) score of 04, which indicated severe cognitive impairment.<br><br>The care plan with an initiation dated of 8/22/18 identified Resident #13 required assistance to the bathroom and required the mechanical stand lift with assistance of one for transfers.<br><br>Observation on 12/16/25 at 12:35 PM revealed Staff E, a Certified Nursing Assistant (CNA), transferred Resident #13 from the bed to the toilet using a mechanical stand lift. While raising the resident from the toilet, Staff E failed to lock the lift brakes, paused when the resident was mostly standing, then locked the brakes and continued raising the resident to a fully standing position. Staff E then pushed the resident out of the bathroom and positioned the mechanical stand lift at the wheelchair. Staff E again failed to lock the brakes before lowering the resident into the wheelchair.<br><br>The mechanical stand operators manual instructed staff to lock the stand brakes prior to lifting the resident or lowering the resident into a seated position.<br><br>(continued on next page) |

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| Westwood Specialty Care | 4201 Fieldcrest Drive<br>Sioux City, IA 51104 |

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|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 12/29/25 at 12:55 PM, the Administrator reported staff should follow the operators manual when using the mechanical stand lift. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>Based on observations and staff interview, the facility failed to provide complete and appropriate incontinence care in a manner to prevent urinary tract infections for 2 of 3 residents observed (Resident #1 and #4). The facility reported a census of 77 residents. Findings include: 1. Observation on 12/23/25 at 12:14 p.m., of Staff C, Certified Nursing Assistant (CNA) empty Resident #1's catheter bag. Staff C cleaned the catheter end prior to emptying the urine from the bag. Staff C emptied the urine into the graduate, after the bag was empty she closed the end and without cleaning the end placed back into the bag and cleaned up her supplies for the resident. When completed, she removed gown and gloves and performed hand hygiene. 2. Observation on 12/29/25 at 1:41 p.m., of Staff D, CNA assisting Resident #4 to the bathroom. When resident #4 was completed in the bathroom, Staff D assisted her to a standing position and then took a disposable wipe and wiped from front to back with the first wipe, used the same side and wiped the rectum 3 times and disposed of it into the trash. Took another wipe and wiped from front to the back and with the same side of the wipe on the rectum 2 times and disposed of it into the trash. Took another clean wipe and wiped from the front to the back and with the soiled side wiped the residents rectum 3 times and disposed of it into the trash. Staff with soiled gloves on pulled up the residents brief, and with the soiled gloves on pulled up the residents pants and adjusted her sweater and pulled the wheelchair closer to the resident. After the resident was in the chair, removed gloves and performed hand hygiene. Interview on 12/29/25 at 2:26 p.m., with Regional Nurse Consultant revealed she expected staff to perform peri care properly and to use a clean part of the wipe when doing care. She further revealed staff should be using an alcohol swab after emptying the catheter tubing. |

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|---|---|
| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to provide and maintain accurate resident records to reflect an incident occurring in the facility for 1 of 3 residents (Residents #4). The facility reported a census of 77 residents.Findings include: The MDS assessment dated [DATE] for Resident #4 documented diagnoses of muscle wasting, dependence on a wheelchair and nerve damage. The MDS showed moderate cognitive impairment for daily decision making. The Clinical Physician Orders for Resident #4 dated 7/18/23 showed tramadol 50 milligram (MG) three times a day ordered for pain. The Controlled Drug Count Record dated 9/16/25 for Resident #4 showed Staff F, Certified Medication Assistant (CMA) failed to sign the count record at 6 AM. The Individual Narcotic Record for Resident #4 showed that on 9/16/25 PM shift the tramadol tablet count to be 30 tablets. The 9/17/25 AM tramadol showed the count to be 28 tablets. The September Medication Reconciliation for 2025 showed Staff F, CMA administered Tramadol 50 mg at bedtime to Resident #4. In an interview on 12/30/25 at 12:00 PM, Staff G, a Licensed Practical Nurse (LPN), reported that on 9/16/25, after bedtime medications were administered, Staff G assumed responsibility for Staff F's assigned medication cart and residents. Staff G reported that at the end of their shift, during the AM narcotic count with Staff F, they discovered two tramadol tablets missing. Staff G could not specifically recall the number of tablets. When asked what happened next, Staff G reported that Staff F refused to sign the Drug Count Record and immediately left the building. When asked whether they had previously encountered issues with incorrect narcotic counts involving Staff F, Staff G reported that she and Staff F were new and that Staff F no longer worked at the facility after the tramadol went missing. When asked if she reported the missing medication, Staff G stated that she immediately contacted the Regional Nurse Consultant. The Storage of Medications policy last revised April 2020 identified Schedule II-V controlled medications are stored in separately locked, permanently affixed compartments. Access to controlled medication is separate from access to non-controlled medications. Controlled medications that are part of a single unit dose distribution system may be stored with non-controlled medications when the supply is minimal and shortages are readily detectable. The policy failed to address directions specific to narcotic counting, destruction of narcotics or action to be taken in the case of missing medication. In an interview on 12/29/25 at 12:55 PM, the Regional Nurse Consultant reported she received notification of missing tramadol the morning of 9/17/25 and arrived at the building shortly after. The Regional Nurse Consultant confirmed two tramadol 50 mg tablets went missing. She reported the facility is unable to determine the cause of the missing tramadol. The Regional Nurse Consultant reported the investigation concluded when Staff F did not come back to the facility or answer their calls. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to assure residents were free from significant medication errors for 1 of 3 resident reviewed (Resident #1). The facility reported a census of 77 residents.Findings Include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented a diagnosis of heart failure, renal insufficiency and stroke. The MDS showed a Brief Interview for Mental Status (BIMS) score of 13, which indicated no cognitive impairment. The Medical Diagnosis report for Resident #2 showed no diagnosis of Diabetes [NAME]. The Clinical Physician Orders for Resident #2 showed no orders of jardiance or gabapentin. The Progress Note dated 11/3/25 at 7:30 AM for Resident #1 documented the following:Resident received wrong AM medications this AM. Spit out most of all medications. Received jardiance and gabapentin, but medications not ordered. Resident verbalizes understanding of receiving wrong medications. Denying pain and no signs of pain observed.Vitals within normal limits. No abnormal new assessment findings. Nurse from a supporting agency called. Nurse Practitioner explains to proceed with scheduled AM medications. Family updated. Administrator updated. The Progress Note dated 11/3/25 at 5:30 PM for Resident #1 indicated a nurse from a supporting agency present in the facility when the resident's family reported concerns regarding increased drowsiness. Upon assessment, the nurse observed new stroke-like symptoms not noted during prior evaluations. The nurse instructed facility staff to initiate emergency response. Emergency medical services contacted. In an Interview on 12/17/25 at 1:04 PM, Staff H, Licensed Practical Nurse (LPN) reported on the morning of 11/3/25 Resident #1 received another resident's medications. Staff H reported because of swallowing issues Resident #1 spat out most of the other resident's medications. Staff H indicated after identifying the individual medications spat out the resident ingested two or three medications. Staff H failed to recall the specific names of the medications swallowed, however identified one of the pills as diabetic medication. When asked whether she reported the specific names of the medications swallowed to the provider during notification, the Staff H reported that she did. When asked what orders were given, Staff H stated that the provider instructed her to monitor the resident and administer her scheduled medications. When asked whether she received specific monitoring parameters, Staff H stated that she did not. When asked if she received orders to check blood glucose levels, Staff H stated no. Staff H added, Looking back, I know I should have checked them, but I didn't. I checked on her several times. I thought the half life of jardiance was long acting. When asked whether she assessed vital signs, Staff H stated that she completed vital signs and cognitive checks. When asked if she documented the assessments, Staff H stated that she did not recall and acknowledged that she did not document all assessments. Staff H reported emergency medical services (EMS) transferred the resident to the emergency room. The Fire Rescue report dated 11/3/25 indicated upon arrival Resident #1 opened eyes in response to pain, not alert or orientated. EMS found Resident #1 very diaphoretic and hot. The report noted Resident #1 received the wrong medication of gabapentin and jardiance at 6:45 AM along with regularly scheduled tramadol. The report also noted a blood glucose level of 64 milligram per deciliter. Resident #1 transferred to the emergency room via ambulance. The Administering Medication policy last April 2019 identified:9. The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include:a. Checking identification band;b. Checking photograph attached to medical record; andc. If necessary, verifying resident identification with other facility personnel.10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. In an interview on 12/29/25 at 12:55 PM, the Regional Nurse Consultant reported staff should follow policy when administering medications. When asked if she would have expected staff to respond differently when Resident #1 received the jardiance and gabapentin, the Regional Nurse Consultant reported the staff notified the provider and followed physician orders. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>(continued on next page) |

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| | 165271 | A. Building<br>B. Wing | 12/31/2025 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to provide and maintain accurate resident records to reflect an incident occurring in the facility for 2 of 2 residents (Residents #2 and #4). The facility reported a census of 77 residents.Findings include: 1. The MDS assessment dated [DATE] for Resident #2 documented diagnoses of muscle wasting, repeated falls and disorientation. The MDS showed the Brief Interview for Mental Status (BIMS) score of 14, which indicated no cognitive impairment. Review of the untitled facility investigation dated 10/8/25 at 6:02 p.m. revealed an incident investigated by the Administrator involving the disappearance of $105 in cash from the pouch attached to Resident #2's walker. In an Interview on 12/30/25 at 2:01 PM, the Administrator stated that Resident #2 returned from the hospital and requested to speak with him. The Administrator went to the resident's room, where the resident reported that $105 was missing, consisting of one $100 bill and five $1 bills. The resident informed the Administrator that he kept the money in a pouch attached to his walker and that he had approximately $1,400.00 when he was admitted . The resident indicated that the money was present when he left for the hospital but was missing upon his return. Review of Resident #2's records on 12/30/25 at 2:30 p.m. revealed the facility failed to document information regarding the missing money. 2. The MDS assessment dated [DATE] for Resident #4 documented diagnoses of muscle wasting, dependence on a wheelchair and nerve damage. The MDS showed moderate cognitive impairment for daily decision making. Review of the facility investigation dated 9/16/25 revealed on 09/16/2025, during the narcotic count, staff discovered two tablets of tramadol 50 milligrams missing from Resident #4's medication bubble pack. Review of Resident #4's records on 12/30/25 at 1:07 PM revealed the facility failed to document information regarding the missing tramadol. The Charting and Documentation policy last revised July 2017 identified all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation 1. Documentation in the medical record may be electronic, manual or a combination. 2. The following information is to be documented in the resident medical record: a. Objective observations; b. Medications administered; c. Treatments or services performed; d. Changes in the resident's condition; e. Events, incidents or accidents involving the resident; and f. Progress toward or changes in the care plan goals and objectives. 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 4. Entries may only be recorded in the resident's clinical record by licensed personnel (e.g., RN, LPN/LVN, physicians, therapists, etc.) in accordance with state law and facility policy. Certified Nursing Assistants may only make entries in the resident's medical chart as permitted by facility policy. 5. Information documented in the resident's clinical record is confidential and may only be released in accordance with state law, the Health Insurance Portability and Accountability Act (HIPAA) and facility policy. Refer all requests for information to the Director of Nursing Services, Nurse Supervisor/Charge Nurse or to the business office. 6. To ensure consistency in charting and documentation of the resident's clinical record, only facility approved abbreviations and symbols may be used when recording entries in the resident's clinical records. 7. Documentation of procedures and treatments will include care-specific details, including: a. The date and time the procedure/treatment was provided; b. The name and title of the individual(s) who provided the care; c. The assessment data and/or any unusual findings obtained during the procedure/treatment; d. How the resident tolerated the procedure/treatment; e. Whether the resident refused the procedure/treatment; f. Notification of family, physician or other staff, if indicated; and g. The signature and title of the individual documenting. In an interview on 12/29/25 at 12:55 PM, when asked whether the missing money and mediation should have been documented in the resident's records, the Regional Nurse Consultant stated something should have been documented. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165271 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westwood Specialty Care | 4201 Fieldcrest Drive<br>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) |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>Based on observation, infection control policy and staff interview, the facility failed perform proper hand hygiene and adhere to infection control guidelines during medication pass for 4 of 4 residents observed (Resident #1, #4, #7 and #8) The facility reported a total census of 77 residents. Findings include: 1. Observation on 12/23/24 at 9:01 a.m., revealed Staff A, Licensed Practical Nurse (LPN) did not perform hand hygiene prior to applying gloves. Once the gloves were applied the nurse cleaned off the top of the insulin bottle with an alcohol swab and drew up the insulin into the syringe, with gloves still on, placed the bottle back into the box and placed into the medication drawer. Staff took the gloved hand and locked the computer screen, with the soiled gloves on, entered the residents room with the insulin syringe and with another alcohol swab cleaned the area and administered the insulin to the resident. When completed, removed gloves and performed hand hygiene. 2. Observation on 12/23/24 at 9:11 a.m., revealed Staff A, LPN preparing medications for Resident #4. The nurse pushed pantoprazole (medication to decrease stomach acid) out of the pill card and the medication dropped onto the top of the medication cart. Staff A without performing hand hygiene applied a glove, picked up the medication and placed it into the medication cup with the other medication. Staff A removed the glove and performed hand hygiene and administered the medications to Resident #4. 3. Observation on 12/23/25 at 9:27 a.m., of Staff B, Registered Nurse (RN) preparing Resident #1's medication. Staff B took out a pill cutter out of the medication cart to cut the Guaifenesin tablet (medication to relieve chest congestion) tablet. The pill cutter was observed to have a white power substance on the top and bottom of the pill cutter. Staff B did not clean the pill cutter and poured the tablet out of the bottle onto the pill cutter and without doing hand hygiene applied gloves. Staff B with a gloved hand placed the tablet in the correct spot to cut the tablet. Staff B cut the tablet and placed half into the medication cup and the other half into the sharps container, removed her glove and did not perform hand hygiene. Staff B placed the pill cutter back into the medication cart and finished preparing the medications. Staff B administered Resident #1's medications and returned to the medication cart and proceeded to the next resident. 4. Observation on 12/23/25 at 9:40 a.m., with Staff B, RN with Resident #7's medication pass. Staff B brought in residents Fluticasone-Salmeterol (an inhaler to reduce lung inflammation) inhaler into his room and laid it directly on the bedside table with no barrier. Staff administered medications and inhaler and when completed exited the room with the inhaler and without wiping down the inhaler placed the inhaler back into the box and placed into the medication cart. Review of facility provided policy titled Administering Medications with a revised date of April 2019 revealed staff follows established facility infection control procedures for the administration of medications as applicable. Review of the facility provided policy titled Handwashing and Hand Hygiene revised August 2019 revealed the use of an alcohol-based hand rub or soap and water for the following before and after handling medications and before applying gloves and after removing gloves. Interview on 12/23/25 at 10:10 a.m., with the Regional Nurse Consultant revealed staff should be following infection control measures at all times. |