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	06/06/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 44474 Based on observations, staff interviews, and policy review the facility failed to ensure all residents had their call light within reach in their rooms for 1 of 1 resident reviewed, (Resident #31). The facility reported a census of 68 residents. Findings include: 1. Observation on 6/3/24 at 11:51 a.m., Resident #31 ' s call light over the end of the bed Resident #31 is unable to reach the call light. 2. Observation on 6/5/24 at 10:08 a.m., Resident #31 ' s call light laying across the end of the bed. Resident #31 is unable to reach the call light. 3. Observation on 6/6/24 at 9:46 a.m., Resident #31 ' s call light laying at the end of the bed. Resident #31 is unable to access the call light. Review of the facility provided policy titled Answering the Call Light with a revision date of March 2021 revealed when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. Interview on 6/6/24 at 10:11 a.m., with Regional Nurse Consultant revealed she would expect the staff to have the call light within reach for Resident #31 even though she cannot use it.

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: 165271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review, resident interview and facility policy, the facility failed to ensure bed hold notice was sent to resident and or the resident's responsible person after giving a verbal consent when residents transferred out of the facility for 1 of 3 residents reviewed, (Residents #18). The facility reported a census of 68 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #18 documented diagnoses of heart failure, diabetes mellitus and asthma. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. Interview on 6/3/24 at 2:32 p.m., with Resident #18 revealed he went to the hospital and got a bill that he was unaware of. Resident #18 revealed the facility called his sister and she gave a verbal to hold the bed but was unaware of what the cost was for each day the bed was held. Resident #18 further revealed he nor his sister ever seen a bed hold form from his hospitalization . Review of Resident #18 ' s Progress Notes revealed the following information: a. On 7/29/24 at 4:20 a.m., resident admitted to hospital with fluid overload. b. On 8/1/23 at 1:52 p.m., re-admit. Review of the residents #18 ' s Census tab revealed the following information: a. 7/29/23 hospital unpaid leave b. 8/1/23 active Review of the clinical record revealed a Bed Hold dated 7/28/23 lacked information regarding bed hold notice that was sent to resident and or the resident's responsible person after giving a verbal consent. Review of facility provided policy titled Bed Hold-Returns revised March 2017 revealed prior to transfer and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. Interview on 6/6/24 at 9:46 a.m., with the Business Office Manager revealed the facility did not send the resident or residents responsible person after receiving a verbal bed hold notice.

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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** 44474 Based on record review, staff interviews, and policy review the facility failed to resubmit Preadmission Screening and Resident Review (PASRR) after a 180 day short stay approval expired on [DATE] for 1 of 1 residents reviewed for PASRR requirements, (Resident #45). The facility reported a census of 68 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #45 documented diagnoses of depression, anxiety disorder, post traumatic stress disorder (PTSD), bipolar disorder and homelessness. The MDS showed a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. Review of the clinical record revealed a Notice of PASRR Level II Outcome dated [DATE] revealed the PASRR determination was a short term approval with specialized services- limited time with an expiration date of [DATE]. Review of the clinical record revealed a Notice of PASRR Level I Outcome dated [DATE] was the next PASRR competed with determination PASRR Level I Determination of Level I Positive, No Status Change. Review of the PASRR Level I Determination dated [DATE] lacked the following information: a. Active diagnosis of anxiety b. Lacked documentation of current ongoing behavioral health services c. Lacked documentation of homelessness Review of the clinical record lacked an active PASRR from [DATE]-[DATE]. The facility does not have a policy on PASRR. Interview on [DATE] at 2:47 PM with the Regional Nurse Consultant revealed there was not a PASRR completed when the short term approval expired until [DATE]. There should have been one completed prior to the [DATE] PASRR and all the appropriate documentation should have been on the [DATE] PASRR.

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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** 44420 Based on record review, resident interview, and staff interviews the facility failed to provide professional standards of care by not following physician orders and by not entering orders into the electronic health record for 1 of 21 residents reviewed, (Resident #36). The facility reported a census of 68 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #36 documented the Brief Interview for Mental Status (BIMS) score of 15 which indicated no cognitive impairment. The MDS diagnosis included unsteadiness on feet, need for assistance with personal care and muscle atrophy. Observation on 6/3/24 at 3:17 PM showed Resident #36 wearing a right foot cam boot while ambulating the hall. In an interview on 6/3/24 at 3:33 PM, Resident #36 explained that she fractured her ankle as a result of fall. Resident #36 reported that she wore another ankle brace inside the boot. When asked how long she had to wear the boot and brace, Resident #36 stated that she didn' t know. When asked if she had to wear the brace all the time, Resident #36 replied, I think so. When asked about wearing the cam boot, the resident thought she should be wearing the boot when ambulating. In an interview on 6/4/24 at 3:40 PM, Staff C, Certified Nursing Assistant (CNA) reported that she didn't know when Resident #36 should be wearing the cam boot or for how long. Staff C stated, I think when she gets up. Staff C also reported that she wasn't sure when Resident #36 should be wearing the ankle brace or for how long. The Care Plan for Resident #36 identified the resident as suffering from a recent ankle fracture that occurred at a relative's home due to a fall. The Care Plan revealed the resident will wear a cam boot per doctor's orders until healed. Review of Physician Orders on 6/5/24 at 12:17 PM showed a lack of orders related to the cam boot and ankle brace, and failed to give staff specific instructions as to when and how long the devices needed to be worn. The Orthopedic Consult Notes with a service date of 5/20/24 showed Resident #36 diagnosed as having a right ankle sprain leading to an avulsion fracture on the lateral malleolus. The plan instructed the resident to use a lace up ankle brace and could wean off from the walking boot. In an interview on 6/6/24 at 8:41 AM, the Director of Nursing (DON) reported the facility lacked physician orders related to Resident #36's boot and ankle brace. When asked what she expected in this scenario, the DON replied, there should be orders.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on record review, policy review, and staff interview, the facility failed to notify the primary care provider (PCP) for worsening of a deep tissue injury (Resident #16) as well a delay in initiating wound care treatment on a newly identified deep tissue injury (#4) for 2 of 4 resident identified with a pressure injury. The facility reported a census of 68. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] documented Resident #16 had a Brief Interview for Mental Status (BIMS) of 12 indicating a moderate cognitive impairment. The MDS further indicated Resident #16 is at risk for developing pressure injuries but did not have any unhealed pressure injuries. The Care Plan dated 4/17/24 included a new skin injury to the left second toe. Clinical record review showed staff notified the PCP of a new skin impairment on 4/2/24, which was classified as a deep tissue injury (DTI). Orders received from the PCP were to Monitor left 2nd toe. Notify PCP if worsens. Staff completed weekly assessments to the area with picture documentation. No wound decline identified until the skin assessment of May 23rd, which showed the area to have almost doubled in size. Progress Note review showed the PCP was not notified of this change. In an interview on 6/5/25 at 9:30 am with the Director of Nursing (DON) and the Regional Nurse Consultant, both acknowledged that there were changes to the DTI on the left second toe and the PCP should have been notified. The undated policy Change in a Resident's Condition or Status outlined that nursing will notify the resident's attending physician or physician on-call when there has been a(an): 1. Significant change in the resident's physical/emotional/mental condition. 2. Need to alter the resident's medical treatment significantly. 3. Specific instruction to notify the physician of changes in the resident's condition. 2. The MDS dated [DATE] documented Resident #4 had a BIMS of 15 indicating an intact cognition. The MDS further indicated Resident #4 was at risk for developing pressure injuries but did not have any unhealed pressure injuries. Medical diagnoses included anemia, deep vein thrombosis/pulmonary embolus/pulmonary thrombo-embolism, and diabetes. Resident #4 had an above the knee amputation of left leg. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clinical record review showed the facility discussed Resident #4's skin assessment during a Standards of Care meeting on 4/26/24 after the resident was readmitted from the hospital. A new DTI to Resident #4's heel was discussed noting that treatment and monitoring in place. Heel lift boot is utilized. Picture documentation of the DTI noted on 4/25/24. The only ordered wound care treatment, dated 4/26/24, included the addition of zinc, vitamin C, and vitamin A and for Hibi cleanse with shower days to the RLE as tolerated. An updated treatment to the right lower extremity ordered on 4/30/24 noted the use of betadine for a blister on the right heel. April and May's Treatment Administration Record (TAR) confirmed no orders specifically for the DTI on the right lateral heel from 4/26/24 thru 5/3/24. On 5/4/24, treatment was initiated to the right heel. In an interview on 6/5/25 at 9:30 am, the Regional Nurse Consultant confirmed that Resident #4 returned to the facility with a newly identified DTI on 4/25/24. During the interview, the consultant or the DON could not initially identify in the clinical record that treatment to the right heel had been initiated prior to 5/4/24. During follow-up interview at 12:30 pm on the same day, the DON acknowledged that no treatment orders were in place from 4/26/24-5/4/24.

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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 44420

Based on observations, record review and interviews the facility failed to properly use a mechanical lift, low bed positions and ensure proper footwear and gait belt used to avoid hazards and prevent accidents for 3 of 21 residents reviewed, (Resident #6, #63 and #74). The facility reported a census of 68 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #6 documented the Brief Interview for Mental Status (BIMS) score of 5 which indicated severe cognitive impairment. The MDS showed Resident #6 dependent on staff for transfers from bed to chair. The MDS diagnoses included hemiplegia, cerebral vascular disease, and muscle weakness.

Review of the Care Plan last revised on 5/16/24 for Resident #6 identified the facility failed to update the care plan to reflect the use of a mechanical lift for transfers.

Observation on 6/4/24 at 3:10 PM revealed Staff A, Certified Nurse's Aide (CNA), and Staff C, CNA used a mechanical lift to transfer Resident #6 from the bed to the wheelchair. Staff failed to lock the wheelchair brakes before lowering the resident down into the wheelchair from the mechanical lift.

The Operator 's Instruction last revised 6/14/23 for the mechanical left directed staff to position the wheelchair under the patient and lock the wheels of the wheelchair before lowering the resident from the mechanical lift into the wheelchair.

The Lift Machine, Using a Mechanical policy last revised July 2017 failed to instruct staff to lock wheelchair brakes before lowering the resident using a mechanical lift as per the Operator 's Instructions.

In an interview on 6/5/24 at 1:32 PM, the Director of Nursing (DON) reported in this case she would have followed the lift operator ' s guide and applied the wheelchair brakes before lowering the resident into the wheelchair.

2. The MDS assessment dated [DATE] for Resident #74 documented the BIMS score of 6 which indicated severe cognitive impairment. The MDS showed Resident #74 used a walker and wheelchair for mobility and required partial or moderate assistance for bed to chair transfers. The MDS diagnoses included dementia, heart failure and renal insufficiency.

The Fall Risk Screening dated 5/23/24 for Resident #74 showed a fall score of 12 which indicated a high risk for falls. The screening instructed staff to develop a care plan, should have been developed for the following:

Goal: I will not experience any injuries related to falls.

Intervention: Encourage me to use my call light for assistance.

(continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Intervention: Encourage me to wear proper footwear. Intervention: I need a safe environment without clutter. Intervention: Monitor me for unsteady gait. Intervention: Physical Therapy (PT)/Occupational (OT) evaluation and treat as ordered. Observation on 6/4/24 at 3:05 PM showed Staff A, Certified Nursing Assistant (CNA) assisted Resident #74 from a sitting position at the edge of the bed, to a standing position without the use of a gait belt. Staff A then ambulated Resident#74 to the recliner by holding the back of the resident's pants. While ambulating with the resident Staff A stated, this is where I would have put either gripper socks or shoes on him. Observation of Resident #74's feet showed the presence of socks without non-slip grippers and the absence of shoes. In an interview on 6/5/24 at 1:32 PM, the Director of Nursing (DON) reported the standard practice dictated that staff applied a gait belt, and either gripper socks, or shoes to residents that are at high fall risk before ambulation. In an interview on 6/6/24 at 8:25 AM, the Regional Nurse Consultant reported the facility lacked a specific policy related to the usage of gait belts. 26527 3. According to the MDS assessment dated [DATE] Resident #63 scored 6 on the BIMS indicating severe cognitive impairment. The resident depended on staff for transfers, and did not walk. The resident had diagnoses including cognitive communication deficit and hearing loss. The Care Plan revised 3/26/24 identified the resident at risk for falls. The interventions included the resident needed a safe environment without clutter. The intervention of applying bolsters initiated 5/28/24 as a result of the incident. An Incident Report dated 5/26/24 at 11:20 p.m. documented the resident experienced an unwitnessed fall. The nurse did rounds and upon entering the resident's room found she was not on her bed. Going around the foot of her bed the resident laid on the floor between the bed and the wall with her legs under the bed and her head at the foot of the bed. The resident had been incontinent at the time. The nurse put a pillow under the resident's head, and assessed the resident carefully before pulling the bed away. The resident complained of pain to her shoulder, but couldn't say if she hit her head. The resident went to the hospital for proper evaluation. The report checked there were no predisposing environmental factors. A Reporting Event dated 5/28/24 documented upon review of documentation, the resident had a fall leading to an emergency room (ER) visit. The fall was from the resident's bed at a height of approximately 3 feet high. On 6/4/24 at 9:00 a.m. the bed controls of the residents bed were located on outside of her left rail. Using a tape measure, the bed lying surface measured 2 feet off the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/24 at 3:16 p.m. Staff D Registered Nurse (RN) Stated he worked the night Resident #63 fell . Staff D said he gave resident #63 medications at 10:15 p.m. and then at 11:20 p.m. he went into her room to check on her and did not see her on the bed. She was on the other side of the bed between the bed and the wall although the bed was not up against the wall her legs were towards the head of the bed and under the bed, and her head was towards the foot of the bed. She had the covers off of the bed with her on the floor. Staff D said the bed was in a high position. He did not know if that's how she wanted the bed or if she put the bed in that position herself. He did not know if she normally had the bed that high, because he was not familiar with the resident, he worked for an agency. On 6/5/24 at 8:30 a.m. Staff E RN stated when she went in the resident's room after the resident fell , and the bed was probably hip level, but she didn't know if Staff D raised it after he found her on the floor. She didn't know if the resident used the bed control herself. On 6/5/24 at 10:00 a.m. Staff F Certified Nursing Assistant (CNA) stated she didn't know how far the bed mattress was off the ground, she didn't notice. She didn't know if the resident could use the control herself. On 6/5/24 at 10:48 a.m. Staff G CNA stated he did not know if the resident could use the bed control herself. The clinical record lacked documentation the facility investigated the height of the bed, or put interventions in place to prevent it from reoccurring, to prevent more significant injury if the resident fell from the bed again. On 6/6/24 at 9:30 a.m. the Regional Nurse Consultant stated she would expect staff to put the bed in low position. The facility Falls - Clinical Protocol revised March 2018, based on assessment the staff and physician would identify pertinent interventions to try to prevent subsequent falls, and address the risks of clinically significant consequences of falling.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on record review and staff interview, the facility failed to update and liberalize a diet order, as discussed during a Standards of Care meeting (SOC) to improve nutritional intake, for 1 of 1 residents reviewed (Resident #66). The facility reported a census of 68. Findings include: The Minimum Data Set (MDS) dated [DATE] documented Resident #66 had a Brief Interview for Mental Status (BIMS) of 5 indicating a severe cognitive impairment. The MDS noted Resident #66 as having a one stage 2 pressure injury. Resident #66's Care Plan noted the pressure injury as well chronic pain and a dementia diagnosis. For diabetes management, Resident #66 was care planned for a control carb small portion diet. Clinical record review indicated the physician ordered a regular diet with small portions upon facility admission on 3/26/24 due to a diabetes diagnosis. A nutritional supplement was initiated due to pressure ulcers and trending sub-optimal appetite. The Registered Dietitian (RD) documented a significant weight loss at 30 days on 5/3/24 with recommendations to discontinue the small portions diet to meet nutritional needs to prevent continued weight loss. Resident #66 was discussed in the facility's SOC meeting, also on 5/3/24, where weight loss was discussed and that the small portions diet is discontinued. Record review did not indicate that the diet was changed, as per the RD's recommendation and SOC documentation that the diet discontinued. Resident #66 continued on a regular small portion diet. The Director of Nursing (DON) and the Regional Nurse Consultant were interviewed on 6/5/24 at 9:30 am. Updates discussed during the SOC meetings would be completed by nursing, which may include reaching out to the physician for new orders or address items themselves. Both the DON and nurse consultant acknowledged that the diet order was not updated as discussed in the SOC meeting.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on observation, record review, policy review, and staff interview, the facility failed to follow the prescribed oxygen order for 1 of 2 residents reviewed, (Resident #16). The facility reported a census of 68. Findings include: The Minimum Data Set (MDS) dated [DATE] documented Resident #16 had a Brief Interview for Mental Status (BIMS) of 12 indicating a moderate cognitive impairment. The MDS classified Resident #16 as having medically complex conditions, which include chronic kidney disease, heart failure, and respiratory failure. The use of respiratory/oxygen therapy identified but zero days listed as the number of days the therapy was administered for at least 15 minutes within the seven-day reporting period. Resident #16's Care Plan was updated on 5/2/24 and included a new focus for chronic respiratory failure. Interventions included administering oxygen as ordered, monitor for signs/symptoms of respiratory distress, report to the physician as needed, and the use of oxygen at 1-5 liters per nasal canula as needed to keep oxygen saturation above 90%. Resident observations on 6/3/24 at 1:30 pm showed oxygen setting at 4L and at 3.5L on 6/4/24 at 10:15 am. Clinical record review showed oxygen use initiated on 11/1/23 with an order of 1-5L oxygen as needed to keep sats above 90% every shift. On 4/12/24, a Progress Note confirms a new order for continuous oxygen at 2L. The previous oxygen order of 1-5L as needed was discontinued. The order for continuous oxygen was not listed as an intervention on Resident #16's Care Plan. Furthermore, no staff documentation found, beside oxygen saturation levels on the Treatment Administration Record (TAR), which indicated a need for oxygen settings above 2L. In an interview on 6/5/25 at 9:30 am, both the Director of Nursing and the Regional Nurse Consultant reviewed current and discontinued orders. The consultant acknowledged that the order for oxygen at 1-5L as needed should have been removed altogether from the continuous oxygen order. Since the as needed order was not removed, both oxygen orders are listed on the TAR. During a follow-up interview, the consultant confirmed that staff have been directed to obtain specific oxygen amounts and not to include a buffer as this is inappropriate. The undated policy Oxygen Administration outlined that staff verify that there is a physician order for this procedure and to review the resident's care plan to assess for any special needs of the resident. The policy further outlined staff to assess for the following: 1. Signs/symptoms of cyanosis 2. Signs/symptoms of hypoxia (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Signs/symptoms for oxygen toxicity 4. Vitals 5. Lungs sound 6. Arterial blood gases and oxygen saturation, if applicable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50500 Based on staff documentation, staff interview, policy review, and observations, the facility failed to ensure the blade on the manual can opener in the kitchen was clean and free of residue to reduce the risk of bacteria growth and cross contamination. The facility reported a census of 68 residents. Findings include: The blade on the manual can opener was assessed on 6/3/24 during the initial kitchen tour. It was a blackish color with a small to moderate amount of residue. The blade was assessed again on 6/5/24 and found to be in the same condition. The Certified Dietary Manager was alerted and the entire arm of the can opener, which included the blade, was put through the dish machine to be cleaned. The blade was visible cleaner afterwards with no signs of residue. The Certified Dietary Manager (CDM) and the Registered Dietitian (RD) were interviewed on 6/5/24 at 12:30 pm. Documented daily cleaning schedule logs for May '24 and Jun '24 show the can open was checked off as cleaned. The CDM and RD both explained the employee wiped down the top and sides of the can opener arm but did not wipe off the blade. The undated Sanitation policy states the following: 1. All equipment, food contact surfaces, and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. 2. For fixed equipment or utensils that do not fit in the dishwashing machine, washing shall consist of the following steps: a. Equipment will be disassembled as necessary to allow access of the detergent/solution to all parts; b. Removable components will be scraped to remove food particle accumulation and washed according too manual or dishwashing procedures

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

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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** 44420 Based on observations, record review, staff interviews and policy reviews, the facility failed to provide proper hand hygiene after catheter care and medication administration for 2 of 21 residents reviewed, (Resident #21 and #74). The facility reported a census of 68 residents. 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #74 documented the Brief Interview for Mental Status (BIMS) score of 6 which indicated severe cognitive impairment. The MDS showed Resident #74 used a walker and wheelchair for mobility and required partial or moderate assistance for bed to chair transfers. The MDS diagnoses included dementia, heart failure and renal insufficiency. Observation on 6/4/24 at 3:05 PM of Resident #74 showed Staff A, Certified Nursing Assistant (CNA) applied personal protective equipment including goggles, gown, mask and gloves. Staff A cleansed Resident #74 ' s groin folds, penis, and catheter tubing. Staff A then removed soiled gloves, discarded gloves, and failed to perform hand hygiene before donning new gloves. Staff A assisted Resident #74 to pull up his pants, and sit upright on the side of the bed. Staff A removed all PPE, discarded PPE, failed to perform hand hygiene, then adjusted Resident #74 ' s bed controls. Staff A brought Resident #74 his walker, assisted the resident to a standing position, then ambulated with the resident to the recliner by holding the back of the resident's pants. After the transfer, Staff A removed the garbage bag from the receptacle, held the bag while he conversed with the resident, and used his other hand to run his fingers through his hair. Staff A exited the room, failed to perform hand hygiene, then used the keypad and door knob to access the dirty utility room and discard the garage. The Hand Hygiene policy last revised September 2018 identified hand hygiene should be performed before and after direct contact with residents, and is the final step after removing and disposing of personal protective equipment. In an interview on 6/5/24 at 1:35 PM, the Director of Nursing (DON), reported staff should have performed hand hygiene after the removal of PPE, including gloves, and when leaving a resident ' s room. 50500 2. The MDS dated [DATE] for Resident #21 documented a BIMS score of 9 which indicated moderately impaired cognitive status. Resident #21 was dependent on staff for all cares and bed bound. Medical diagnoses include cerebral infarction and epilepsy. A feeding tube noted which provided >51% of total calorie needs. Clinical record review indicated Resident #21 had a diet order of nothing by mouth (NPO). Dietary needs and medications are provided through a percutaneous gastric tube (PEG). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medication administration was observed for Resident #21 on 6/4/24 with Staff H, Licensed Practical Nurse (LPN). A physician order to provide all crushed medications at once was verified as well as a 30ml water flush before and after medication administration. Staff H, LPN, put on gown and gloves after entering the resident's room. Once the protective equipment was on, Staff H, LPN, rearranged Resident #21's blankets/sheets and the nasal canula. Staff H, LPN, also repositioned Resident #21 so they could sit up more. Staff H, LPN, then proceed with medication administration with the same gloves used to reposition the resident and readjust medical equipment and bedding. On 6/6/24 at 9:00 am, the Director of Nursing and the Regional Nurse Consultant were made aware of the above situation as staff completed two different resident tasks with the same gloves (repositioning/arranging and mediation administration). Both acknowledged that the same gloves should not have been worn. Staff should have changed gloves out before proceeding with the enteral medication administration. The Enhanced Barrier Precautions policy, revised on 3/28/24, directs staff to use personal protective equipment when performing high-contact care activities for residents with .indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes . The policy further outlines high-contact care activities to include changing linens, transferring, and device care or use.