

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 03/27/2025
NAME OF PROVIDER OR SUPPLIER Westwood Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474</p> <p>Based on clinical record review and staff interview the facility failed to revise and update care plans to include and address high risk medications and side effects to watch, PASARR recommendations, oxygen usage and fluid restrictions for 4 out of 20 sampled residents reviewed for comprehensive care plans (Resident #20, #45, #72 and #231). The facility reported a census of 87 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #20 documented diagnoses of anxiety disorder, depression and vascular dementia. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment.</p> <p>Review of Resident #20's March Medication Administration Record revealed the following orders:</p> <ol style="list-style-type: none"> Sertraline (antidepressant medication) 1 tablet daily for depression with a start date of 11/17/24. Morphine Sulfate (opioid medication) three times daily for pain with a start date of 3/13/25. Haloperidol (antipsychotic medication) as needed for agitation with a start date of 3/19/25. Lorazepam (anti-anxiety medication) twice daily for anxiety with a start date of 3/6/25. <p>Review of the Care Plan dated 3/13/25 lacked information regarding antipsychotic medication usage, side effects and non-pharmacological interventions for usage. The Care Plan lacked information on opioid medication, side effects and non-pharmacological interventions for usage. The Care Plan lacked non-pharmacological interventions to use prior to anti-anxiety medications. The Care Plan lacked non-pharmacological interventions for antidepressant medication.</p> <p>2. The MDS assessment dated [DATE] for Resident #72 identified a BIMS score of 15 which indicates no cognitive impairment. The MDS documented diagnosis included renal failure, need for assistance with personal care and anemia.</p> <p>Observation on 3/16/25 at 2:31 p.m., noted Resident #72 wearing oxygen via nasal cannula. Resident #72 reported he wears oxygen all the time.</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #72's Order Review History Report signed by the physician on 3/25/25 revealed the following orders:</p> <ul style="list-style-type: none"> a. Oxygen as needed to keep saturation levels above 90% with a start date of 3/13/25. b. Change oxygen tubing weekly and as needed with a start date of 3/13/25. c. Visually inspect oxygen concentrator to ensure clean and free of debris every shift with a start date of 3/13/25. d. Check oxygen concentrator filter weekly and as needed with a start date of 3/13/25. e. Fluid restriction of 1500 ml's per day with a start date of 3/17/25. <p>Review of Resident #72's March Medication Administration Record revealed the following orders:</p> <ul style="list-style-type: none"> a. Oxygen as needed to keep saturation levels above 90%. b. Change oxygen tubing weekly and as needed. c. Visually inspect oxygen concentrator to ensure clean and free of debris every shift. d. Check oxygen concentrator filter weekly and as needed. e. Fluid restriction of 1500 ml's per day. <p>Review of the Care Plan dated 2/24/25 lacked information regarding Resident #72 being on a fluid restriction and oxygen usage.</p> <p>3. The MDS assessment dated [DATE] for Resident #231 identified a BIMS score of 15 which indicates no cognitive impairment. The MDS documented diagnosis included unsteadiness on feet, need for assistance with personal care and repeated falls.</p> <p>Review of facility provided document titled Incidents by Incident Type dated 3/26/25 revealed Resident #231 had witnessed fall incidents on 12/7/24, 12/13/24 and 12/16/24.</p> <p>Review of the Care Plan with a cancelled date of 3/10/25 lacked interventions to prevent further falls on 12/7/24 and 12/13/24.</p> <p>Interview on 3/26/25 at 1:30 p.m., with the Director of Nursing revealed the Care Plan should include side effects and non-pharmacological interventions for high risk medications, fluid restrictions, interventions for falls and oxygen usage.</p> <p>47673</p> <p>4. The MDS dated [DATE] for Resident #45 documented a BIMS of 3 indicating severe cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of document dated 4/4/24 titled Notice of PASRR Level II Outcome documented the nursing facility will be required to Care Plan in a PASRR compliant fashion for all identified services including Specialized Services and Rehabilitative Services. Community Placement Supports must be included in the Care Plan in a PASRR compliant fashion if the individual has received a Short Term PASRR approval, the individual at any time states they wish to return to a lower level of care, and/or the MDS Section Q-500 indicates that the individual wishes to discharge to a lower level of care.</p> <p>Review of Care Plan revealed no focus, goal or interventions / tasks suggested in the document titled, Notice of PASRR Level II Outcome.</p> <p>On 3/18/25 at 1:43 PM Staff A, Regional Nursing Consultant stated she would expect a Care Plan in place with the Level II Outcome approved and the recommendations included in Resident #45's Care Plan.</p> <p>On 3/24/25 at 12:51 PM the DON stated the care planning recommendation from PASARR should be addressed on Resident #45's Care Plans in the focus, goal or interventions / tasks. The DON acknowledged Resident #45's care plan lacked the recommendations from the document titled, Notice of PASRR Level II Outcome.</p> <p>Review of Policy revised 12/16 titled, Care Plans, Comprehensive Person-Centered documented A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and fictional needs are developed and implemented for each resident. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The IDT included other appropriate staff or professionals as determined by the resident's needs or as requested by the resident.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673</p> <p>Based on Electronic Health Records (EHR) review, staff interviews, resident interview and policy review the facility failed to provide an opportunity for bath or shower to 1 of 4 residents reviewed (Resident #21). The facility reported a census of 81 residents.</p> <p>Finding include:</p> <p>1. The Minimum Data Set (MDS) dated [DATE] for Resident #21 documented a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment.</p> <p>On 3/17/25 at 10:14 AM Resident #21 stated that his doctor recommended baths Sunday, Monday, Wednesday and Friday. Resident #21 revealed he would like a bath 4 times a week. Resident #21 said he had told staff at the facility that he wanted a bath 4 times a week. Resident #21 stated the Administrator asked him why he needed it 4 times a week.</p> <p>Resident #21's MDS dated [DATE] indicated independence with bathing.</p> <p>Review of Resident #21 Medication Administration Record - Treatment Administration Record (MAR-TAR) documented a Physician's Order for showers only, not tubs or hot tubs. Give showers one time a day every Tuesday and Friday for bathing directions.</p> <p>Review of Resident #21's Electronic Health Records (EHR) titled, Tasks documented under the activities of daily living Resident #21 Shower/Bathe self on Monday, Wednesday, and Friday.</p> <p>Review of Resident #21's EHR titled, Tasks documented from 2/17/25 - 3/19/25 Resident #21 received a shower on 2/21, 2/24, 2/28, and 3/10.</p> <p>On 3/18/25 at 8:03 AM Staff G, Housekeeper / Certified Nursing Assistant (CNA) stated Resident #21 wanted baths at night and the bath aides complained about doing baths at night.</p> <p>On 3/24/25 at 2:36 PM the DON stated she had not heard that he wanted baths 4 times a week. The DON stated she would have expected that Resident #21 would have had a bath at least twice a week. The DON acknowledged Resident #21's EHR titled, Task reflected baths were completed 2/21, 2/24, 2/28, and 3/10.</p> <p>On 3/24/25 at 2:59 PM the Administrator stated that he could not recall Resident #21 asking for baths 4 times a week. The Administrator stated the facility's expectation was that Resident #21 would have been bathed at least 2 times a week.</p> <p>Review of policy revised 3/18 titled, Activities of Daily Living (ADL's), Supporting documented appropriate care and services would be provided for residents who are unable to carry out ADL's independently, the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene, bathing, and grooming.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474</p> <p>Based on clinical record review, staff interviews, and facility policy review, the facility failed to provide adequate nursing supervision to prevent falls for 1 of 3 residents reviewed (Resident #231). The facility reported a total census of 87 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] for Resident #231 documented diagnoses of unsteadiness on feet, need for assistance with personal care and repeated falls. The MDS showed a Brief Interview for Mental Status (BIMS) score of 15 which indicates no cognitive impairment.</p> <p>Review of facility provided document titled Incidents by Incident Type dated 3/26/25 revealed Resident #231 had witnessed fall incidents on 12/7/24, 12/13/24 and 12/16/24.</p> <p>Review of the Care Plan with a cancelled date of 3/10/25 revealed the following information:</p> <p>a. Lacked interventions to prevent further falls on 12/7/24 and 12/13/24.</p> <p>b. Ambulation/Mobility 2 assist with gait belt and 1 assist with mobility in my room using bilateral platform walker with an initiated date of 10/25/24.</p> <p>c. Transfer 2 assist with gait belt initiated date of 10/25/24.</p> <p>Review of Incident Report dated 12/7/24 at 7:10 a.m., revealed the following information:</p> <p>a. Incident description, called to resident room per Certified Nursing Assistant (CNA) states that during pivot transfer resident leg got stuck and resident was lowered to floor.</p> <p>b. Staff statement dated 12/11/24 revealed resident states that at times her left leg does not move the best with transfer, but the CNA did not have gait belt on her when transferring, does have gait belt in room at this time, provided with another gait belt and placed in drawer to ensure available.</p> <p>c. Notes dated 12/11/24 gait belt was not in use, use of gait belt ads better assistance and control with transfers, staff educated.</p> <p>Review of Incident Report dated 12/13/24 at 8:40 p.m., revealed the following information:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. Incident description, CNA called a nurse to the resident's room. CNA states she lowered the resident to the floor. Upon entering room this nurse seen resident lying on the floor on her left side facing the bed while holding the bed rail with her right hand. CNA and this nurse assisted resident into bed. Denies hitting head. Denies abuse. Complains of severe left shoulder pain. CNA states she lowered to the floor on her butt. Nurse was in room next door when CNA got me. Resident could only have been on the floor at most a minute maybe two. Not sure what happened other than she slid out of the chair and that her left shoulder really hurts.</p> <p>b. Notes dated 12/16/24 revealed Resident can be unstable on feet at times and knees give out on resident. Gait belt is to be with transferring resident and resident slipped off bed with CNA there to lower to ground.</p> <p>Review of Incident dated 12/16/24 at 4:00 p.m. revealed the following information:</p> <p>a. Incident description, Resident slid down to floor during transfer between wheelchair and recliner.</p> <p>b. Immediate action taken, 2 person maximal assistance provided to assist resident from floor to recliner.</p> <p>c. Statements dated 12/16/24 by Staff R revealed Resident #231 had her light on, said she needed to go to the bathroom really bad. I positioned her wheelchair and made sure she had shoes on to stand without slipping. I forgot the gait belt, but she she seemed frantic about going to the bathroom, and I am used to one assisting her with the belt on but not using it. Halfway through the assist, Residents knees buckled and we couldn't fully get her back in the chair before simply lowered her down as safely as I could before getting the nurse.</p> <p>d. Notes dated 12/19/24 Resident not as strong as she use to be and knees give out. They are starting to use mechanical lift due to lowering to floor due to weakness. Therapy recommendations for this time. With increase pain to shoulder therapy does not want to use sit to stand lift. 2 assist with all transfer and gait belt with transfers. Gait belt behind door hanging at all times.</p> <p>Review of facility provided policy titled Gait Belts (for use in ambulation and transfer) dated January 2015 revealed gait belts should be used by all staff, to allow for easier handling of residents which should help to avoid injuries, both to residents and staff.</p> <p>Interview on 3/27/25 at 9:59 a.m., with the Director of Nursing revealed the resident did have 3 falls close together. She revealed with the 12/7/24 fall she made sure there was a gait belt in the room for the staff to use. After the 12/13/24 fall she realized there was a gait belt usage problem and all the staff was educated and there were several gait belts that were put out for the staff to be using. After the 12/16/24 incident she went straight to disciplinary action with any staff not using gait belts. All staff are to be using gait belts to transfer residents with no exceptions.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673</p> <p>48004</p> <p>Based on observation, document review, resident interview, staff interview, and policy review the facility failed to follow the menu and prepare food to meet the nutritional needs for 19 of 81 residents reviewed. The facility reported a census of 81 residents.</p> <p>Findings include:</p> <p>1. Observation on 3/25/25 at 12:07 PM to 12:27 PM during continuous observation no wheat rolls were delivered with the first 18 plates served in the dining room.</p> <p>Review of a document titled Menu for the Week of 3/23/25 through 3/29/25 revealed that lunch on 3/25/25 consisted of BBQ pork, American fried potatoes, baked beans, wheat roll, and fresh orange slices.</p> <p>Interview on 3/25/25 at 1:01 PM with the Certified Dietary Manager (CDM) revealed her expectations would be for menus to be followed.</p> <p>2. The Minimum Data Set (MDS) dated [DATE] for Resident #66 documented a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment.</p> <p>On 3/17/25 at 11:37 AM Resident #66 stated she is shy and ate in her room and she was the last in the facility served. Resident #66 revealed the food was at best lukewarm and never hot ever. Resident #66 said food items are always missing. Resident #66 acknowledged she filled out the menu. Resident #66 stated the morning of 3/17/25 she had grape juice listed and did not get grape juice. Resident #66 revealed she did not get anything in its place.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48004</p> <p>Based on clinical record review, observation, resident interview, staff interview, and policy review the facility failed to provide food at an appetizing temperature to 4 of 5 residents reviewed (Residents #4, #28, #36, and #50). The facility reported a census of 81 residents.</p> <p>Findings include:</p> <p>1. Review of Resident #28's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition.</p> <p>Interview on 3/16/25 at 3:09 PM with Resident #28 revealed the food is often cold when it should be hot.</p> <p>2. Review of Resident #36's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition.</p> <p>Interview on 3/16/25 at 2:10 PM with Resident #36 revealed the food is cold. Resident #36 revealed the biscuits were cold that morning.</p> <p>3. Review of Resident #50's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition.</p> <p>Interview on 3/17/25 at 10:50 AM with Resident #50 revealed the food has been cold several times instead of hot since Resident #50 had gotten here.</p> <p>Interview on 3/16/25 at 11:50 AM with Staff P cook revealed that the hot plate warmer has not worked in almost a year, and food was not served hot.</p> <p>During an observation on 3/25/25 at 12:56 PM a sample room tray was obtained. The American fried potatoes' temperature was taken and was 101.9 degrees, the BBQ pulled pork had a temperature of 124.7 degrees.</p> <p>Interview on 3/25/25 at 1:01 PM with the Certified Dietary Manager (CDM) revealed her expectation would be for food temps to be at the appropriate levels.</p> <p>Review of a facility provided policy titled, Food Preparation and Service with a revision date of April 2019 revealed:</p> <p>a. Proper hot and cold temperatures are maintained during food service.</p> <p>47673</p> <p>4. The MDS dated [DATE] for Resident #66 documented a BIMS of 15 indicating no cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 3/17/25 at 11:37 AM Resident #66 stated she is shy and ate in her room and she was the last in the facility served. Resident #66 revealed the food was at best lukewarm and never hot ever. Resident #66 said food items are always missing. Resident #66 acknowledged she filled out the menu. Resident #66 stated the morning of 3/17/25 she had grape juice listed and did not get grape juice. Resident #66 revealed she did not get anything in its place.</p> <p>On 3/25/25 at 11:55 AM Staff C, Certified Nursing Assistant (CNA) stated Resident #66 complained about her food being cold frequently.</p> <p>On 3/25/25 at 4:13 PM Staff D, Certified Medication Assistant (CMA) stated she had heard residents complain about the temperature of food. Staff D explained she had heard residents complain about the temperature of the food more often than not. Staff D acknowledged the residents complained about the food being too cold. Staff D revealed room trays are complained about more than the dining room.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>48004</p> <p>Based on observation, staff interview, and policy review the facility failed to prepare, serve and distribute food in accordance with professional standards. The facility reported a census of 81 residents.</p> <p>Findings include:</p> <p>During the initial kitchen walk through on 3/16/24 at 11:45 AM it was observed that there were four drawers when first entering the kitchen by the coffee machine. Inside the drawers was noted to have multiple dark colored stains and miscellaneous debris along with lids for cups, and straws.</p> <p>During continuous observation on 3/25/25 from 12:07 PM until 12:24 PM it was observed that Staff P cook donned a glove on the left hand and then opened a bag with buns inside. Staff P then reached into the bag and removed a bun with the same gloved hand and placed the bun onto a plate for service. The glove was then doffed and hand hygiene was completed.</p> <p>During an interview on 3/25/25 at 1:01 PM with the Certified Dietary Manager (CDM) revealed her expectations would be for the kitchen area and drawers to be clean, and for staff to change gloves at the appropriate times.</p> <p>Review of a facility provide policy titled, Sanitization with a revision date of October of 2018 revealed:</p> <p>a. All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects.</p> <p>b. Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime.</p> <p>Review of another facility provided policy titled, Food Preparation and Service with a revision date of April 2019 revealed:</p> <p>a. Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673</p> <p>Based on resident interview, resident family interviews, staff interview, electronic health records (EHR), document review and policy review the facility failed to maintain medical records on each resident that were complete and accurate by failing to document a fall in the electronic health records and not keeping an accurate up to date resident inventory list for 2 of 8 residents reviewed (Resident #21 and #231). The facility reported a census of 81 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) dated [DATE] for Resident #21 documented a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment.</p> <p>On 3/17/25 at 10:16 AM Resident #21 stated he told a nurse he was missing a hearing aid and the nurse asked if he looked under his bed but the hearing aid was never found. Resident #21 stated he took the hearing aid out and went to bed. Resident #21 stated he took both out with one hand and laid them on the table then in the morning one was there and the other was not. Resident #21 stated the incident happened about a month ago.</p> <p>Review of an undated document titled, Inventory of Personal Effects for Resident #21 revealed no hearing aids.</p> <p>Review of a document dated 2/1/24 titled, Chart Notes for Resident #21 documented Resident #21 was seen for a hearing loss evaluation. Resident #21 had previous hearing aid experience but lost them. Hearing aids were recommended and would be ordered once authorization was obtained. Resident #21 would return in 3 weeks for hearing aid fitting.</p> <p>Review of document dated 5/9/24 titled, Resident #21's Appointment Notes documented Resident #21's hearing aids were checked, cleaned, with reviews of how to properly insert, and addressed left fit concerns.</p> <p>Review of document dated 8/8/24 titled, Resident #21's Appointment Notes documented Resident #21 was seen for hearing aids. Resident #21 requested wire receivers are longer with settings updated.</p> <p>Review of document dated 9/5/24 titled, Resident #21's Appointment Notes documented Resident #21 had a cerumen impaction. Cerumen debridement bilaterally with hearing aid recheck completed.</p> <p>Review of Resident #21's Electronic Health Records (EHR) titled Progress Notes dated 3/28/24 at 4:09 PM entered by Staff K, Licensed Practical Nurse (LPN) documented Resident #21 went out of the facility to see ENT today and returned without injury or incident. They adjusted hearing aids because they were too loud. Follow up in 1 month appt reminder given to resident placed on appt calendar.</p> <p>Review of Resident #21's EHR titled Progress Notes dated 2/1/24 at 11:05 AM entered by Staff L, Registered Nurse (RN) documented Resident #21 returned from ENT Consultants. No new orders, note for hearing aides when insurance returns authorization.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the following EHR titled Progress Notes for Resident #21 documented no hearing aides:</p> <p>a. On 2/7/25 at 10:51 AM Staff M, RN documented residents communication: Clear. Hearing aids: No</p> <p>b. On 11/18/24 at 8:50 AM Staff M, RN documented residents communication: Clear. Hearing aids: No</p> <p>c. On 10/18/24 at 3:48 PM Staff N, RN documented residents communication: Clear. Hearing aids: No</p> <p>d. On 10/10/25 at 5:06 PM Staff O, RN documented residents communication: Clear. Hearing aids: No</p> <p>On 3/18/25 at 8:03 AM Staff G, Housekeeper / Certified Nursing Assistant (CNA) stated at one point Resident #21 mentioned he was missing a hearing aid. Staff G said he had not been on the floor since November of 2024. Staff G stated he did not know Resident #21 was currently missing a hearing aid.</p> <p>On 3/24/25 at 10:53 AM Staff E Social Worker stated hearing aides would be on the resident inventory sheet. Staff E stated Resident #21 had hearing aids for about 2 or 3 years. Staff E stated the facility was working with Resident #21's son and Resident #21's insurance to try to replace the hearing aid. Staff E stated there was a grievance filled out but she was not sure if the facility would pay for the hearing aids since they are so expensive.</p> <p>On 3/24/25 at 11:50 AM Staff A, Regional Nursing Consultant stated the admissions agreement states the facility does not replace items unless it is determined to be the facility's fault. Staff A stated her expectation was that even if the family took Resident #21 to the appointment the facility staff should have documented the hearing aid on Resident #21's inventory sheet.</p> <p>On 3/24/25 at 11:04 AM the Administrator stated the facility's expectation was that staff would have documented Resident #21's hearing aids on the resident inventory list upon return to the facility from the appointment he received them at.</p> <p>Request for policy from administration revealed no policy on completion of resident property / inventory list.</p> <p>44474</p> <p>2. The MDS assessment dated [DATE] for Resident #231 documented diagnoses of diabetes mellitus, repeated falls and unsteadiness on feet. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment.</p> <p>Review of facility provided Incident Report dated 12/7/24 at 7:10 a.m., called to resident room per CNA. Stated during stand pivot transfer resident leg got stuck and resident was lowered to the floor.</p> <p>Review of the electronic medical chart (EMR) Progress Note lacked documentation of the residents incident on 12/7/24.</p> <p>Interview on 3/26/24 at 3:24 p.m., with Staff A, RN revealed the incident should have been documented in the Progress Notes.</p>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>47673</p> <p>Based on the Center for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report (October 1 - December 31) review, facility staffing reports review, and staff interviews, the facility failed to submit accurate staff reports for the PBJ Staffing Data Report. The facility reported a census of 81 residents.</p> <p>Findings include:</p> <p>The PBJ Staffing Data Report run date 3/13/25 for Quarter 1 2025 triggered for excessively low weekend staffing and one star staffing rating.</p> <p>Review of weekend staffing schedules for Quarter 1 months of October, November, and December revealed equal floor staffing during the week and the weekend. Decreased management staffing reported on the weekend.</p> <p>On 3/26/25 at 2:05 PM the Administrator stated Monday through Friday more management were present at the facility and the MDS Coordinator's hours went into floor staffing. The Administrator revealed the facility had 2 ADON's as well as a DON that works during the week. The Administrator said the DON was coming in to help with a few call in's on the weekend. The Administrator stated the hours she worked had been reported inaccurately.</p> <p>Review of a policy revised 10/17 titled, Reporting Direct-Care Staffing Information (Payroll-Based Journal) documented staffing and census information would be reported electronically to CMS through the Payroll-Based Journal system in compliance with 6106 of the Affordable Care Act. Direct-care staffing information includes staff hired directly by the facility, those hired through an agency, and contract employees. Staffing information was collected daily and reported for each fiscal quarter no later than 45 days after the end of the reporting quarter. For auditing purposes, reported staffing information was based on payroll records, or other verifiable information.</p>

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>44474</p> <p>Based on record review, interview, and facility policy the facility failed to have the minimum number of required members for their quarterly Quality Assessment and Assurance (QAA) meetings. The facility reported a census of 87.</p> <p>Findings include:</p> <p>Review of the facility documentation titled Quality Assurance Committee Meeting Sign-In sheet date 11/12/24 lacked signatures of one other staff member present.</p> <p>Review of facility provided policy titled Quality Assurance and Performance Improvement (QAPI) Program-Governance and Leadership revised March 2020 the following individuals serve on the committee include the Administrator, Director of Nursing, Medical Director, Infection Preventionist and representative of other departments as requested by the Administrator.</p> <p>Interview on 3/27/25 at 2:44 p.m., with the Administrator revealed the appropriate number of staff should have been at the meeting as required.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673</p> <p>Based on observation, Electronic Health Record (EHR) review, policy review, resident interview and staff interview the facility failed to provide appropriate infection prevention practices by not donning appropriate Personal Protective Equipment (PPE) and failed to provide appropriate infection prevention practices during administration of medications for 3 of 8 residents reviewed (Resident #51, #57, and #72). The facility reported a census of 81 residents.</p> <p>Finding include:</p> <p>1. The Minimum Data Set (MDS) dated [DATE] for Resident #51 documented a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. The MDS indicated Resident #51 received dialysis treatments.</p> <p>On 3/16/25 at 1:42 PM Resident #51 stated staff never wear gowns in her room when they provide personal care for her.</p> <p>Review of Resident #51's Medication Administration Records - Treatment Administration Records documented a Physician's Order for enhanced barrier precautions due to dialysis port every shift ordered 9/12/2024.</p> <p>On 3/18/25 at 8:23 AM continuous observation of Resident #51's room revealed the door to the room closed. Continued observation revealed door opened and Staff H, Certified Nursing Assistant (CNA) left Resident #51's room. Staff H had no garbage bag in hand.</p> <p>On 3/18/25 at 8:24 AM Staff H stated she was just getting Resident #51 out of bed. Staff H stated Resident #51 liked to get dressed after she goes to the restroom. Staff H stated Resident #51 went to the bathroom and just wanted to wait for the bath aide. Staff H stated Resident #51 just got up and was ready for breakfast. Staff H revealed Resident #51 usually takes a bath right after she is done eating breakfast.</p> <p>On 3/18/25 at 8:28 AM an observation of the garbage cans in Resident #51's room revealed no gown but gloves present in the garbage can.</p> <p>On 3/18/25 at 9:15 AM Staff H asked Resident #51 in room if she wanted to get dressed and closed the door to the residents room. At that time an observation of Resident #51 in a hospital gown. The observation revealed Staff H left the room and Resident #51 no longer wore a hospital gown but was dressed for the day. An observation of gloves in the garbage but no gown.</p> <p>On 3/18/25 at 9:25 AM Resident #51 stated Staff H did not wear a gown getting her up this morning or when she just got her dressed.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A continuous observation on 3/18/25 at 9:53 AM revealed Staff I, Bath Aide entered Resident #51's room. Staff I wheeled Resident #51 down to the shower room. Staff I applied a gait belt to Resident #51. Staff I completed hand hygiene, applied gloves, and Resident #51 was assisted with transfer to the shower chair. Staff I applied no gown, removed residents pants, removed brief and removed Resident #51's shirt.</p> <p>On 3/27/25 at 10:08 AM Staff J Licensed Practical Nurse (LPN) / Assistant Director of Nursing (ADON) / Infection Preventionist (IP) stated she was the person who educated the staff for Enhanced Barrier Precautions (EBP). Staff J stated she was familiar with Resident #51. Staff J acknowledged Resident #51 was on EBP related to her need for dialysis treatments. Staff J acknowledged Resident #51 had a port. Staff J stated during dressing, bathing, and toileting the staff caring for Resident #51 should utilize PPE. Staff J stated the PPE should include a gown with dressing and showering. Staff J stated she would not expect any gowns to be worn when Resident #51 was taken to the toilet because the port was covered. Staff J stated when the staff dressed Resident #51 a gown should have been worn. Staff J stated during the shower she would have expected the staff to apply a gown and wear proper PPE.</p> <p>On 3/27/25 at 10:04 AM the DON stated appropriate PPE including a gown should have been worn during all cares with Resident #51. The DON stated the facility's expectation was that a gown and gloves would be worn with baths, cares, toileting, and dressing.</p> <p>Review of policy with effective date of March 28, 2024 titled, Enhanced Barrier Precautions documented an order for EBP would be initiated for resident with any fo the following: wounds and/or indwelling medical devices even if the resident was not known to be infected or colonized with a MDRO. Personal Protective Equipment (PPE) for enhanced barrier precautions was only necessary when performing high-contact care activities such as: dressing, bathing, transferring, providing hygiene, changing brief or assisting with toileting.</p> <p>44474</p> <p>2. The MDS assessment dated [DATE] for Resident #57 identified a BIMS score of 15 which indicated no cognitive impairment. The MDS documented diagnosis included hypertension, malnutrition and respiratory failure.</p> <p>Observation on 3/26/25 at 10:30 a.m., of Staff N, RN entered Resident #57's room to hook up her tube feeding. Staff N entered the room with no PPE on. Staff N checked the tube placement and flushed the tube with water. Staff N hooked up the feeding and started the machine. After exiting the nurse revealed she knew what EBP was and she should have been wearing it when she hooked up tube feeding.</p> <p>3. Observation on 3/26/25 at 7:35 a.m., Staff Q, Licensed Practical Nurse (LPN) entered into Resident #17's room to administer artificial tears. Staff Q took the box of artificial tears and laid the box on the bed without a barrier under the box. Staff Q administered the artificial tears after Resident #17 took her medication. Staff Q took the box of artificial tears and placed them back into the medication cart without cleaning the outside of the box.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility provided policy titled Infection Control with revised date of October 2018 revealed the facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.</p> <p>Review of the facility provided policy titled Enhanced Barrier Precautions dated 4/28/24 revealed the following information:</p> <p>An order for EBP will be initiated for residents with any of the following:</p> <p>Wounds, and or indwelling medical devices (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO.</p> <p>Interview on 3/26/25 at 10:43 a.m., with the Director of Nursing revealed staff should be wearing EBP when caring for people that have indwelling devices and should not be laying medication on the residents personal items without a barrier.</p>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673</p> <p>Based on policy review, document review, and staff interview the facility failed to provide training to their staff that at a minimum educates staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property and procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property. The facility reported a census of 81 residents.</p> <p>Findings include:</p> <p>On [DATE] at 10:34 AM Staff A, Regional Nursing Consultant stated after Staff B, Registered Nurse (RN) was suspended. Staff A explained it was identified that Staff B's training for dependent adult abuse / mandatory reporter expired and the facility did not want him to complete the course during suspension.</p> <p>On [DATE] at 1:47 PM the Administrator stated the facility's expectation was that the training for mandatory reporters would have been completed prior to the expiration date unless the staff was suspended. The Administrator acknowledged that Staff B's mandatory reporter training was not current. The Administrator stated Staff B worked at the facility while his mandatory reporter training had expired. The Administrator acknowledged Staff B's mandatory reporter training had expired [DATE].</p> <p>Review of a document titled Iowa Department of Health and Human Services DS 168 Dependent Adult Abuse Mandatory Reporter Training for Staff B documented completion of training was [DATE] and the next mandatory reporter required training was a one hour refresher course within the next 3 years.</p> <p>Review of a policy revised ,d+[DATE] titled, Identifying Types of Abuse documented it was understood by the leadership at the facility that preventing abuse requires staff education, training, and support, and a facility-wide culture of compassion and caring.</p>		