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	04/29/2026

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 0689 Level of Harm - 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** Based on clinical record review, resident interview, staff interviews, and facility record review, the facility failed to provide safe and adequate mechanical lift transfer to prevent an injury to the resident's forehead for 1 out of 3 residents reviewed (Resident #18). The facility reported a census of 77 residents. Past Noncompliance determined during the annual recertification survey of a facility incident that occurred on 4/15/26 regarding deficiency F689 with a scope and severity of a Level G. The facility provided evidence of education to the staff member directly involved in the facility incident that occurred on 4/15/26. The remainder of the nursing staff received education on 4/16/26. The facility was found to be in substantial compliance of F689 during the annual survey process that occurred on 4/19/26 through 4/29/26.Findings include:The Minimum Data Set (MDS) assessment dated [DATE] for Resident #18 documented diagnosis of fracture of left leg, muscle wasting and abnormalities of gait and mobility. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. The MDS identified Resident #18 showed the resident dependent for chair to bed and toilet transfers. The Care Plan initiated on 2/26/26 for Resident #18 required two staff members to use a mechanical lift for transfers, due to activity as nonweight-bearing to the left leg. The update on 4/15/26 mandated to approach the wheelchair straight on and explicitly prohibited side approaches. Additionally, staff were instructed to have Resident #18 bend the right leg and turn away from the lift during the transfer. The Progress Note dated 4/15/26 at 11:08 AM for Resident #18 documented the following:During transfer the resident's head was hit on the lift. Assessment completed. The resident has a bruise to left forehead that measures 1.21 centimeters (cm) x 2.07 cm. Assessment completed pictures taken and applied ice to forehead. Neurological checks are negative. The resident and staff educated on proper placement of the lift. The Progress Note dated 4/15/26 at 11:47 AM for Resident #18 documented the following:Only use lift straight on with wheelchair transfers, do not come in sideways. Have the patient bend her right leg and turn the patient away from the lift pole prior to moving to bed. The Incident Report dated 4/15/26 at 8:00 AM for Resident #18 documented the following:During transfer the resident head was hit on the lift. Assessment completed. The resident has a bruise to the left forehead that measures 1.21 cm x 2.07 cm. The immediate action taken indicated staff was educated on proper placement of lift. The untitled skin sheet dated 4/15/26 for Resident #18 showed a protruding bump from forehead that measured 1.21 cm x 2.07 cm x 2.04 cm.In an interview on 4/21/26 at 1:42 PM, Resident #18 reported Staff H, Certified Nursing Assistant (CNA) and Staff I, CNA, transferred Resident #18 using the lift. The CNA's positioned the lift at the side of the wheelchair and began the lift. The lift tipped, hitting Resident #18's forehead with the part that held the sling. Resident #18 reported she sustained a large protruding bump on her forehead that was tender for multiple days. Both staff members prevented the lift from completely falling to the floor but required additional assistance to return it to an upright position. A physical therapy staff member informed Resident #18 that staff must place the mechanical lift directly in front of the wheelchair for transfers, not at the side. When asked if since then staff have used the lift correctly, the resident reported one (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	of the aides positioned the lift at the side of the wheelchair but another CNA corrected the positioning. As a result, they performed the lift properly.In an interview on 4/22/26 at 1:46 PM, Staff H, CNA, report herself and Staff I, CNA, attempted a wheelchair transfer using the lift when the lift almost tipped, injuring Resident #18's forehead. Staff H and other staff prevented the lift from falling to the floor. Staff H reported she did not know the cause, but hypothesized the left wheels caught on a bar under the wheelchair because they used the lift from the side.In an interview on 4/22/26 at 1:59 PM, Staff I, CNA, reported assisting with the lift transfer when Resident #18 almost fell as the lift tipped. When asked why the lift tipped, Staff I stated, I don't know but we were thinking the lift might have got caught on the bars under the wheelchair. When asked how the CNA positioned the lift, the CNA stated, it was from the side. We were educated not to use the lift from the side. The resident has a brace that keeps her leg straight, she didn't want us hitting her leg on the lift so we the lift from the side like she asked. Now we know we can't and it's okay to tell her we can't do it that way because it's for safety. When asked what part of the lift hit the resident in the forehead, Staff I stated, the part that holds the sling. The In-Service Form dated 4/16/26 mandated the following for use of the mechanical lift: The lift must be operated straight forward only. The wheelchair must be positioned directly in front of the resident, ensuring straight-on alignment. Staff must avoid approaching or transferring the resident from the side.The undated Operator's Instructions for the mechanical lift instructed to position the bar spreader so the two sling hanger bars are parallel to the resident's body and to adjust the legs of the lift to go around the wheelchair- picture indicated the lift is in front of the wheelchair. In an interview on 4/23/26 at 2:03 PM, the Director of Nursing (DON) stated the proper procedure for a safe mechanical lift transfer. The DON explained that staff should position the mechanical lift directly in front of the wheelchair, rather than to the side. The DON also noted that physical therapy staff provided immediate education following the incident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, resident interview, staff interview, and policy review the facility failed to assist residents with activities of daily living for 5 of 8 residents reviewed (Residents #3, #1, #11, #27, and #85). The facility reported a census of 77 residents. Findings include:1. Review of Resident #3's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognitive functioning. The MDS further indicated Resident #3 was dependent on staff for personal hygiene. The MDS then revealed diagnoses of renal insufficiency, stroke, hemiplegia (a severe or total paralysis on one side of the body caused by brain or spinal cord damage), and seizure disorder. Observation 4/20/26 at 8:09 AM Resident #3 was observed to be unshaven at this time. Resident #3 revealed that he is getting his showers, but he doesn't get shaved every time. Interview 4/21/26 at 9:05 AM with Resident #3 revealed that he would like to be shaved more during his showers, but some staff just don't like to do it. Resident #3 was observed to be unshaven at this time. Resident #3 further revealed that he needs help to shave since he had a stroke. Review of a facility provided document titled, Weekly Shower Tracker dated 3/9/26 -3/15/26 indicated Resident #3 had a shower, but was not shaved. Review of another facility provided document titled, AM Bath List dated 4/13/26-4/17/26 indicated Resident #3 had a shower on 4/15/26 but did not indicate if Resident #3 was shaved or not. Interview 4/21/26 9:42 AM with Staff E Certified Nursing Assistant (CNA) revealed that she used to be a bath aid, and sometimes residents would refuse to be shaved during a shower. Staff E further revealed that the facility used to have bath sheets that stated when nails were clipped or male residents were shaved. Staff E then revealed that the facility no longer has that sheet, and she wishes they did as the bath aides would be more on top of residents getting shaved and nails clipped. Interview 4/21/26 9:48 AM with Staff F CNA revealed that she is the shower aide now. Staff F then stated that they used to mark on the bath sheets when shaving and fingernails were trimmed. Staff F then indicated that the new bath sheets don't have that, and the staff just initial when the baths/showers are completed. Staff F then confirmed that there were only two sheets for Resident #3 in the bath/shower book Interview 4/21/26 at 10:05 AM with the Director of Nursing (DON) revealed that when showers are completed staff should be offering, and assisting male residents with shaving. The DON further revealed that it should be documented when it is completed or if it is refused. Review of a facility provided policy titled, Shaving the Resident with a revision date of February 2018 indicated staff should record if the resident refuses, or if the task was performed. The policy further indicates staff should notify the supervisor if the resident refuses the procedure. 2. The MDS assessment dated [DATE] for Resident #1 documented muscle weakness, diabetes and hip fracture. The MDS showed the BIMS score of 4 indicating severe cognitive impairment. Review of the care plan with a revision date of 2/3/26 revealed resident is an extensive assist of 1 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with bathing and would like only 1 bath a week. Review of Follow Up Question Report dated 2/10/26-4/21/26 for ADL Self Care- Shower/Bath Wednesday/Friday am revealed the following: Resident received a bath on February 24 and again on March 13. Resident went 17 days without a bath. Resident received a bath on March 13 and again on April 1. Resident went 19 days without a bath. 3. The MDS assessment dated [DATE] for Resident #11 documented depression, hypertension and anemia. The MDS showed the BIMS score of 3 indicating severe cognitive impairment. Review of Resident #11's task list revealed bathing as needed and scheduled for Wednesday morning and Friday afternoon. Review of the care plan with a revision date of 1/15/25 revealed need of assistance with bathing and lacked frequency of bathing. Review of Follow Up Question Report dated 2/10/26-4/21/26 for ADL Self Care- Shower/Bath Wednesday morning Friday afternoon revealed the following: Resident received a bath on January 31 and again on February 6. Resident went 6 days without a bath. Resident received a bath on February 10 and again on February 16. Resident went 6 days without a bath. Resident received a bath on March 13 and again on April 1. Resident went 18 days without a bath. 4. The MDS assessment dated [DATE] for Resident #27 documented depression, hypertension and anemia. The MDS showed the BIMS score of 3 indicating severe cognitive impairment. Review of Resident #27's task list revealed bathing as needed and scheduled for Monday and Thursday afternoon. Review of the care plan with a revision date of 2/3/26 revealed resident need 1 or 2 assist with bathing and would only like 1 bath a week. Review of Follow Up Question Report dated 2/24/26-4/21/26 for ADL Self Care- Shower/Bath Wednesday morning Friday afternoon revealed the following: Resident received a bath on February 24 and again on March 14. Resident refused her bath on 3/13. Resident went 19 days without a bath. Resident received a bath on March 14 and again on April 6. Resident refused her bath on 4/9. Resident went 20 days without a bath. 5. The MDS assessment dated [DATE] for Resident #85 documented hypertension, depression and (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	need for assistance with personal care. The MDS showed the BIMS score of 15 indicating no cognitive impairment. Interview on 04/19/2026 at 1:27 p.m., with Resident #85 revealed she did not get 2 baths last week and would like to have them. Review of the care plan with a revision date of 12/31/25 revealed the resident is dependent for bathing and lacked frequency of bathing. Review of Resident #85's task list revealed bathing as needed and scheduled for Monday morning and Wednesday afternoon. Review of Follow Up Question Report dated 2/24/26-4/21/26 for ADL Self Care- Shower/Bath Monday morning and Wednesday afternoon revealed the following: Resident received a bath on February 24 and again on March 4. Resident went 12 days without a bath. Resident received a bath on March 4 and again on March 11. Resident went 7 days without a bath. Resident received a bath on March 14 and again on April 1. Resident went 18 days without a bath. Resident received a bath on April 13 and again on April 20. Resident went 7 days without a bath. Review of facility provided policy titled Bath, Shower/Tub with a revision date of February 2018 revealed the purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken. The signature and title of the person recording the data. Interview on 04/21/2026 at 12:15 p.m., with the Regional Nurse Consultant revealed the bathing should be completed as scheduled.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview, and policy review the facility failed to properly secure and store medications to minimize loss or access for 1 of 4 medication carts. The facility reported a census of 77 residents. Findings include:During continuous observation 4/19/26 at 2:12 PM a treatment cart was left unlocked with the computer screen left on with identifiable information left on the screen by Staff D Licensed Practical Nurse (LPN) for 4 minutes. Staff C Regional Consultant then was observed to come down the hall, and shut off the screen of the computer and lock the treatment cart. Staff C then revealed that she would like to see the treatment cart locked when it is not attended with the screen shut off so identifiable information is not showing. Interview 4/21/26 at 8:46 AM with the Director of Nursing (DON) revealed that she would have liked to have seen the med carts locked, and the computer screen locked when not in use or staff are not around. Review of a facility provided policy titled, Security of Medication Cart with a revision date of April 2007 indicated the nurse must secure the medication cart during medication pass to prevent unauthorized entry.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on previous CMS-2567 review, staff interview and facility policy review the facility failed to ensure a comprehensive, effective Quality Assessment and Performance Improvement (QAPI) program. The facility reported a census of 77 residents. Findings include: Review of the Department of Inspections, Appeals and Licensing (DIAL) website under the facility's visit history revealed repeated deficient practices identified during the facility's annual survey and complaint investigation on 3/27/25 and the facility's annual survey, complaint and facility reported incident investigation on 4/19/26. The repeat deficiencies cited included: F689- Free of Accident Hazards/Supervision/Devices. This deficiency was repeated in the previous three consecutive annual surveys. F880- Infection Prevention and Control. This deficiency was repeated in the previous four consecutive annual surveys. The QAPI Plan documented that the facility will review sources of information to determine if gaps or patterns exist in the systems of care that could result in quality problems or if there are opportunities to make improvements.In an interview on 4/23/26 at 1:28 PM, the Administrator acknowledged F689 and F880 repeated in previous surveys. The Administrator reported the facility would review and discuss plans to improve.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, and policy review the facility failed to provide food at an appetizing temperature to 2 of 15 residents (Residents #3, and #94) reviewed. The facility reported a census of 77 residents.Findings include:1. Review of Resident #3's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognitive functioning. Interview on 4/19/26 at 1:49 PM with Resident #3 revealed that the food is not always warm. Resident #3 continued that he loves ice cream and when he ordered it, it was almost the consistency of chocolate milk. 2. Review of Resident #94's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognitive functioning. Interview on 4/19/26 at 1:50 PM with Resident #94 revealed that the hot food is never hot in the dining room, but it was today. Resident #94 further revealed there has only been one other time that the food has been hot. During continuous observation on 4/21/26 from 12:45 PM until 12:56 PM first Staff B (Dietary Services) prepared room trays for delivery. It was observed that the first room trays were sent to be delivered at 12:52 PM. A sample tray was obtained and the food had a temperature check completed at this time. The lemon chicken had a temperature of 130 degrees, and the broccoli had a temperature of 105 degrees. Interview on 4/21/26 at 1:13 PM with the Regional Dietician revealed that food temps should be warmer when served, and at a minimum of 135 degrees.IInterview on 4/21/26 at 1:16 PM with the Certified Dietary Manager (CDM) revealed that she would like to see the food temps served at 135 degrees or warmer.Review of a facility provided policy titled, Food Preparation and Service with a revised date of April 2019 indicated proper hot and cold temperatures are maintained during food service/distribution.

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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. Based on observations, record review, staff interviews and policy reviews, the facility failed to provide proper hand hygiene during catheter care for 2 of 3 residents reviewed (Resident #12 and #15). The facility reported a census of 77 residents. Findings include:1. During observation on 4/21/2026 at 11:07 am Staff J, a Certified Nursing Assistant (CNA), completed catheter care for Resident #12. Staff J then emptied and rinsed the urine collection containers. The CNA removed the gown and soiled gloves and failed to perform hand hygiene. Staff J retrieved the trash bag from the receptacle, tied it, and placed the bag on the floor. Next, Staff J removed the roll of garbage bags from the bottom of the trash container and deposited the roll into the basket behind the sink. Staff J placed a new bag into the receptacle then shut off the bathroom light. Following this, the CNA opened the resident's door, obtained hand sanitizer with one hand, rubbed the sanitizer across her hand using that hand, and then entered the locked utility room.2. During observation on 4/22/2026 at 9:35 AM for Resident #15 showed Staff H, CNA completed cath care for Resident #15. Staff H then removed soiled gloves, failed to perform hand hygiene then donned new gloves. Staff H then emptied the urine collection containers, removed gown and soiled gloves, and failed to perform hand hygiene. Staff H then adjusted the resident's bedside table, opened the resident's door and exited the room. The Hand Hygiene Policy last updated in August 2019 identified hand hygiene is required immediately before donning and doffing gloves. During an interview on 4/22/26 at 2:16 PM, the Infection Preventionist indicated staff are expected to perform hand hygiene prior to putting on gloves, immediately after removing gloves, and when the staff leave the resident's room.During an interview on 4/23/26 at 1:49 PM, the Director of Nursing (DON), reported she expected staff to perform hand hygiene immediately before applying gloves and when staff removed gloves.