

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165308	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/04/2025
NAME OF PROVIDER OR SUPPLIER  West Ridge Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE  1904 West Howard Street Knoxville, IA 50138	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.  (continued on next page)

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on clinical record review, staff interview, policy review, and resident interviews, the facility failed to protect the resident's right to a dignified existence by failing to carry out perineal cares in a timely manner after incontinence episodes for 1 of 1 residents reviewed for incontinence care assistance (Resident #1) and for multiple, random residents affected, as reported by multiple staff members. The facility reported a census of 74 residents. Findings: 1. The Minimum Data Set(MDS) assessment tool, dated 10/24/25, listed diagnoses for Resident #1 which included hemiplegia(one-sided paralysis), anxiety, and depression. The MDS stated the resident was frequently incontinent with bowel and bladder and stated the resident was dependent on staff assistance for toileting hygiene. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 14 out of 15, indicating intact cognition. The facility policy Dignity, revised February 2021, stated the facility would care for residents in a manner that promoted and enhanced well-being, satisfaction with life, and feelings of self-worth. The facility directed staff to treat residents with dignity and respect at all times and to promptly respond to a resident's request for toileting assistance. A 10/21/25 Care Plan entry stated the resident required the assistance of 2 staff for personal hygiene. A 7/22/24 Corrective Action Form for Staff A Certified Nursing Assistant(CNA) stated that a resident was found soaked in urine from his head to his knees and the incontinent brief was (wet) beyond the point of falling apart. The form directed Staff A to complete rounds every 2 hours and check and change residents assigned to her. A 10/25/25 Grievance/Concern Investigation Form for Staff A CNA stated Resident #1 required a complete bed strip and Staff A stated there was no point in changing his sheets if he's just going to do it again. The resident sat in saturated sheets until (other) staff assisted him. On 10/29/25 at 2:22 p.m., when queried as to if she had had problems with other staff members completing rounds on night shift, Staff B CNA stated she had problems with Staff A CNA for a really long time. Staff B filled out multiple grievances related to Staff A and her completion of rounds on the night shift. She stated the Director of Nursing(DON) or the Administrator were supposed to come in on the night shift to audit rounds but this did not happen. On 10/29/25 at 3:53 p.m , the Administrator stated she had allegations in the past that Staff A had left residents wet and she coached her. She stated she had no grievances in the last 6 months though related to Staff A. She stated she did not receive anything this week about Staff A. She stated she would start an investigation and would suspend her. On 11/4/25 at 8:40 a.m., Staff C CNA stated that when she followed Staff A on the day shift after she had worked overnight, the residents were wet. She stated residents had visibly soiled briefs which were dark in color because they were wet for several hours. She stated she talked to the DON about it approximately a month ago. She stated the resident rooms have odors and the bed pads have rings(of urine). She stated staff should change residents every 2 hours. On 11/4/25 at 8:49 a.m., Staff D CNA stated after Staff A worked the night shift, half of her residents were soaked, He stated she did not go room to room to complete rounds like they were supposed to but instead left the building. He stated at times he found a clean bed pad under residents but the layer under that was wet. He stated this happened for the last year and a half and he spoke to charge nurses about it. On 11/4/25 at 9:23 a.m., Staff F Registered Nurse(RN) stated staff reported to her that Staff A left residents wet in bed. Staff F stated she herself filled out a grievance form within the last couple of months related to this concern. On 11/4/25 at 9:28 a.m., Staff E Licensed Practical Nurse(LPN) stated staff found residents soaked in beds requiring a bed strip when they took over care for Staff A. She stated she filled out some grievances but she was not sure on the time frame. On 11/4/25 at 9:37 a.m., the Director of Nursing(DON) stated she had not had any encounters with Staff A since 2024 when Staff A ripped up a disciplinary action sheet she gave to her. The disciplinary action was regarding residents being left wet when day shift took over for her. The DON stated she was directed by the Administrator to let her(The Administrator) handle Staff A. She stated last week, Staff G CNA told her she had a complaint about Staff A doing the same thing again, leaving resident's wet. She stated because the Administrator handled Staff A, she didn't know what happened regarding this. She stated she did not come in on the night shift and was unsure if anyone else had. She stated she felt like there were grievances filled out regarding Staff A. On 11/4/25 at 9:55 a.m., the Regional Director of Clinical Services stated the facility located a grievance related to Staff A, dated 10/25/25. She stated they interviewed residents and educated staff related to denial of critical care. The facility implemented a new box to place grievances in and they conducted education related to rounding. The facility lacked documentation of follow-up to the 10/25/25 grievance from 10/25/25 to 10/29/25. The facility also lacked any additional documentation of grievances filled out by staff concerning</p>		