STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Retirement Community	5501 Gordon Drive East Sioux City, IA 51106

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 - 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. (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement safe transfer techniques for 1 of 2 residents. In an observation of the use of the mechanical lift, E-Z Stand, it was discovered that Resident #46 was not standing firmly on the platform and she expressed that she was having pain in her knees. Staff failed to ensure that the resident was strong enough to complete a safe transfer with the E-Z Stand. The facility reported a census of 67 residents. Findings include:According to the Minimum Data Set (MDS) dated [DATE], Resident #46 was unable to complete a Brief Interview for Mental Status (BIMS) screening. She had short and long-term memory problems and had impaired decision-making skills. The resident required partial assistance for lower body dressing, sit to stand and toilet transfer, and supervision only for walking 10 feet. The Care Plan updated on 8/4/25 showed that staff were to transfer Resident #46 with a pivot transfer to wheelchair only due to falls related to knee pain/weakness. She had advanced dementia and increased assistance was needed with activities of daily living. On 9/08/2025 at 1:17 PM, Staff E, Certified Medication Aide (CMA) and Staff F, (CNA in training) positioned the mechanical lift, E-Z stand, in front of Resident #46 and instructed her to put her feet on the platform. They attached a lift sling around her back, and to the machine. Staff E connected a second strap to the machine (Fanny Seat). The residents left arm was on the outside of the Fanny strap. While the CNA's moved the machine to the commode, the resident said several times that her knees hurt and she rested her buttocks on the Fanny seat. The Fanny Seat was unhooked while the resident was sitting on the commode. At 1:25 PM, she said she was done and they lifted her to semi-standing position, cleaned her bottom and resident said they should hurry, because she was having trouble standing. The staff failed to attach the Fanny seat strap before transferring back to the recliner. The resident said ouch several times, and was bearing weight in her arm pits with her elbows straight out, parallel to the floor. Once the resident was back in the recliner Staff E said that she had been having more pain in her knees and had recently upgraded from a pivot transfer to E-Z Stand. The following was found in the Nursing Progress Notes:a. On 8/20/25 at 11:22 AM, frequent urination/urgency incontinence, strong odor, increased confusion and frequently getting angry at staff, redirection difficult. b. On 8/25/25 at 9:17 AM, due to bilateral lower extremity weakness, resident would be an E-Z stand for all transfer for safety. c. On 8/31/25 at 2:37 AM, does not tolerate E-Z stand well, she lets go of the handle and yells out.d. On 9/4/25 at 2:49 AM, Resident does not do well with E-Z stand. Lets her arms go loose and bottom drops, does not assist with standing. She vocalizes discomfort and puts most of her weight on the safety strap. e. On 9/4/25 at 10:32 AM, the resident does not tolerate E-Z Stand will, yells out and screams, tells staff they don't know what they are doing and will let go of the handles on the machine.f. On 9/5/25 at 10:36 AM, the CNAs reported resident was having bad transfers with E-Z stand, won't stand up straight and elbows were flared out, this caused resident to slide down. CNAs were able to safely transfer resident at the end. g. On 9/9/25 at 5:40 AM, the resident did poorly with E-Z stand, calls out through transfer and picks up feet at times, sags bottom while in strap. On 9/9/25 at 11:00 AM Staff D CNA said that she had been transferring Resident #46 and noticed that she wasn't tolerating it very well. She said she did tell the nurse but the reason they haven't changed her to a Hoyer transfer is because she used the commode and don't know how they would get her on the toilet with a Hoyer. On 9/10/2025 at 8:16 AM, Staff C, Registered Nurse, (RN) said that he had been noticing that the resident hadn't been tolerating the E-Z stand very well. He said that they used two people and the extra strap under her which helps some but sometimes she doesn't want to hang on or she will lift her feet. There were times when she just doesn't want to get up so she will complain of pain and elbows out like chicken wings. When asked about use of Hoyer he agreed she's about getting there He said that it would be a nursing judgement to upgrade transfer status. On 9/10/2025 7:34 AM Staff A, RN said that the resident had a change in condition so they went from pivot transfer to sit to stand. They had recently discovered that she was not bearing weight, having difficulty determining where to put her hands so they went to two assists with sit to stand. The CNAs this morning, that transferred the resident that morning had her come in and watch the transfer and she said they would have a discussion about going to a Hoyer because her knee pain and difficulty bearing weight and chicken winging they have a toileting sling they can use for her on the commode. She will discuss with Unit Manager. The Care Plan for Resident #46 was updated on 9/10/25 to include the use of the E-Z stand for all transfers with 2 people. On 9/11/2025 at 8:29 AM, the Director of Nursing (DON) said that they have weekly meetings with the therapy department and discuss residents that

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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 after resident care for 1 of 2 residents reviewed (Resident #9). The facility reported a census of 67 residents.Findings include: Observation on 9/10/25 at 12:55 PM showed Staff H, Certified Nursing Assistant, (CNA) performed hand hygiene, donned personal protective equipment (PPE) of a gown and gloves then provided catheter care. When finished Staff H removed the soiled gloves, failed to perform hand hygiene, and donned new gloves. Staff H then rearranged the wheelchair, opened the door and exited the room. Staff H doffed PPE, failed to perform hand hygiene then proceeded down the hall. The Hand Hygiene policy last updated January 2025 identified hand hygiene should be performed and consistent with accepted standards of practice. In an interview on 9/11/25 at 1:10 PM, Staff I, Registered Nurse, Unit Manager reported the CNA should have performed hand hygiene in between glove changes and immediately after doffing PPE.