DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **165252**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/09/2026**
NAME OF PROVIDER OR SUPPLIER **Westview Acres Care Center**		STREET ADDRESS, CITY, STATE, ZIP CODE **203 S W Lorraine , Leon, Iowa, 50144**	

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F0000 Ok ✓ Lg	INITIAL COMMENTS Correction Date: 7-30-26 The following deficiencies resulted from the facility's annual recertification survey conducted on July 6, 2026 to July 9, 2026. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. This Plan of Correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements.	7-30-2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F0550		

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 reverse for further 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 ✓
Rose Saxton	Administrator	7-30-26

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F0550 SS = D	Continued from page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, clinical record review, resident and staff interview, the facility failed to maintain dignity for 1 of 13 residents (#17) by not cutting a resident's fingernails when he requested. The facility reported a census of 37 residents. Findings include: Resident #17's Minimum Data Set (MDS) assessment dated 4/27/26 identified a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of diabetes mellitus with neuropathy (nerve damage), anxiety, depression, and hypothyroidism (underproductive thyroid that causes weak, brittle nails). It revealed he required supervision with showering and shower transfers and was independent with all other Activities of Daily Living (ADLs) and mobility. The Care Plan dated 4/30/26 included the resident's type II diabetes mellitus and directed the nurse to trim/cut the resident's fingernails and toe nails as needed. On 7/09/26 at 9:37 AM, Resident #17 stated he asked Staff A, Certified Nurse Aide (CNA) on 7/08/26 to tell Staff B, Registered Nurse (RN) he wanted his fingernails trimmed. He also stated Staff B told him she would not cut his fingernails because he refused his heart medication that morning. His fingernails were noted to be untrimmed. On 7/09/26 at 9:48 AM, Staff A, Certified Nurse Aide (CNA) confirmed the resident requested his fingernails to be cut on 7/08/26 and she notified Staff B. On 7/09/26 at 9:51 AM, Staff B, RN stated Resident #17 requested to have his nails trimmed on 7/08/26.	F0550	F0550 On 7/09/26, the nursing staff promptly addressed Resident #17's request by trimming his fingernails. This action was completed by Staff B, Registered Nurse (RN), to ensure the resident's dignity was maintained. The resident was informed that his nails had been trimmed, and he expressed satisfaction with the action taken. On 7/10/26, the Director of Nursing (DON) conducted a 100% audit of all residents' care plans and identified that all residents receiving assistance with Activities of Daily Living (ADLs) have the potential to be affected. The review included an assessment of residents' requests for personal care services to ensure compliance with their care plans. On 7/30/26, training was provided for nursing staff on the importance of maintaining resident dignity and responding to personal care requests. Staff were educated on the facility's expectations regarding resident rights and care plan adherence. The Director of Nursing (DON) will conduct audits of resident care plan adherence and staff response to personal care requests, monthly. Findings will be reviewed at the QAPI/Quality Assurance August 2026 meeting and thereafter per the facility's QAPI review schedule for 3 months to ensure continuous improvement and compliance.	

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F0550 SS = D	Continued from page 2 She also stated she asked him if he was sure he wanted staff to trim his nails because he didn't want his medications, so was he sure he wanted them to trim his nails. She further stated she asked him that because he keeps saying he doesn't have rights. She said Resident #17 responded "forget it" and walked away. She revealed she didn't return to ask him about his nails before she finished her shift. She further stated she assumed that if he wanted it done, he would ask again. She indicated she reported the interaction to the oncoming nurse. On 7/09/26 at 11:45 AM, the Director of Nursing (DON) stated the resident's medication refusal should not affect trimming his nails. The facility did not have a policy specific to resident dignity.	F0550		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, and staff interview, the facility failed to refer 1 of 1 resident (#2) with a negative Level I Pre-Admission Screening and Resident Review (PASRR), to the appropriate state-designated authority for an evaluation and determination review after the resident experienced hallucinations and delusions. The facility reported a census of 37 residents.	F0644	F0644 On 7/08/26, the Social Worker Designee submitted an updated PASRR for Resident #2, which included the resident's hallucinations and delusions. This action was completed to ensure the resident's current condition was accurately represented to the state-designated authority. On 7/09/26, the social worker conducted a comprehensive review of all residents with a history of mental health diagnoses. This audit determined that all residents receiving antipsychotic medications have the potential to be affected by similar issues regarding PASRR submissions. On 7/11/26, the social worker designee reviewed PASRR training for timely and accurate PASRR submissions, focusing on identifying and documenting hallucinations and delusions. This training will ensure staff are aware of the necessary protocols for residents with mental health conditions. The Administrator and/or designee will conduct audits of PASRR submissions and related documentation monthly to ensure compliance with state requirements. Findings will be reviewed at the QAPI/Quality Assurance August 2026 meeting and thereafter per the facility's QAPI review schedule for3 months to ensure continuous improvement and compliance.	-

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F0644 SS = D	Continued from page 3 Findings include: Resident #2's quarterly Minimum Data Set (MDS) assessment dated 6/09/26 identified a Brief Interview for Mental Status (BIMS) score of 06 out of 15 which indicated severely impaired cognition. It included diagnoses of Alzheimer's disease and non-Alzheimer's dementia. It included the resident had delusions and was taking an antipsychotic medication within the 7-day look-back period. The Electronic Health Record (EHR) included a physician's orders dated 6/10/26 and 6/24/26 for an antipsychotic medication three times per day and as needed for agitation and dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; respectively. A Health Status Note Progress Note dated 5/29/26 at 6:09 PM indicated the resident believed she spoke to her deceased son on the phone. She also believed he was in the room beside hers. A Health Status Note Progress Note dated 6/02/26 at 2:45 PM revealed the resident was in her room but believed she was in her brother's room and wanted a room of her own. The EHR included five (5) previously submitted PASRRs dated 3/29/22, 3/29/24, 1/27/25, 3/11/25, and 6/09/26 that did not include the resident's hallucinations or delusions. The Care Plan revised 6/11/26 indicated the resident had increased anxiety, restlessness, and agitation and directed staff to contact a family friend to help calm her down. On 7/08/26 at 11:20 AM, the Director of Nursing (DON) stated the previous PASRRs included the resident's current medical diagnosis linked to the resident's behaviors. Upon realizing the previous PASRRs did not include the resident's hallucinations and delusions, the DON clarified an updated PASRR should've been submitted. On 7/08/26, the facility submitted an updated PASRR with the resident's delusions and hallucinations. The PASRR indicated no PASRR level II was required (no status change from previously submitted PASRRs). The facility did not have a policy specific to PASRRs.	F0644		

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F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must	F0880	F0880 On 7/07/26, the Director of Nursing (DON) ensured that a transmission-based precautions sign was immediately posted outside Resident #9's room to notify staff and visitors of the isolation requirements. Additionally, staff were reminded to adhere to the use of Personal Protective Equipment (PPE) when entering the resident's room. This action was completed by the DON and the nursing staff on the same day. On 7/08/26, the nursing staff conducted a 100% audit of all residents with wound infections to determine potential exposure to transmission-based precautions. The audit confirmed that all residents receiving wound care were assessed for compliance with isolation protocols, ensuring that no other residents were affected by similar concerns. On 7/30/26, All staff were educated on the importance of transmission-based precautions and proper use of PPE. Staff were educated on the protocols for notifying visitors and maintaining compliance with infection control measures. The Director of Nursing (DON) will conduct audits of compliance with transmission-based precautions and PPE usage weekly for 3 months. Findings will be reviewed at the QAPI/Quality Assurance August 2026 meeting and thereafter per the facility's QAPI review schedule for 3 months to ensure continuous improvement and compliance.	

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F0880 SS = D	Continued from page 5 prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, clinical record review, staff interview, and policy review, the facility failed to notify visitors and staff of and failed to follow transmission-based precautions for 1 resident (#9) who had a wound infection with a clinically significant organism (MRSA – methicillin resistant staphylococcus aureus). The facility reported a census of 37 residents. Findings include: Resident #9's Minimum Data Set (MDS) assessment dated 5/26/26 identified a Brief Interview for Mental Status (BIMS) score of 09 out of 15 which indicated moderately impaired cognition. It included diagnoses of peripheral vascular disease, non-Alzheimer's dementia, and a right lower leg ulcer. It indicated he required setup assistance with oral and personal hygiene, supervision with dressing and shower transfers, moderate assistance with bathing, and was independent with all other Activities of Daily Living (ADLs) and mobility. It indicated the resident's wound was not present at the time of the assessment. A Health Status Note Progress Note dated 6/26/26 at 10:03 AM indicated the resident was placed on contact precautions due to identified staph infection in his wound.	F0880		

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F0880 SS = D	Continued from page 6 A wound culture dated 6/26/26 at 2:10 PM confirmed the resident's wound contained MRSA. The Care Plan dated 6/30/26 included the resident's wound infection with MRSA and directed all staff to wear a gown and gloves when assisting me with all personal cares like changing my clothes, bedding, showers. On 7/07/26 at 11:31 AM, there was no transmission-based precautions sign observed to notify staff of the resident's isolation requirement. Staff C, Housekeeping Supervisor (hskg) entered the resident's room without wearing Personal Protective Equipment (PPE) and changed his bed linen. On 7/09/26 at 11:45 AM, the Director of Nursing (DON) stated the lack of a transmission-based precautions sign was an isolated incident she wasn't aware it had not been posted. An undated document titled "Airborne, Contact, and Droplet Isolation (Modified from CDC Guidelines)" directed staff to wear a gown when entering resident area if you anticipate that you will have substantial contact with the resident, resident items, or environmental srurfaces or if the resident is incontinent.	F0880		