STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Park Place	2401 East Eighth Street Des Moines, IA 50316

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and policy review, the facility failed to provide a clean, comfortable and homelike environment. The facility also failed to maintain and ensure adequate supplies of the appropriate sized briefs to meet the needs of all residents who used briefs and pull-ups, and failed to ensure an adequate supply of resident care supplies and linens for two of two units. The facility identified a census of 59 residents.Findings include: Observations on the North Hall on 9/3/25 starting at 12:34 PM revealed the following: a. The window air conditioner (AC) vent in room [ROOM NUMBER] had a black substance that appeared to be mold and dirt inside the vents. The AC was on during this time. b. The window AC unit in room [ROOM NUMBER] had a black substance that appeared to be mold in the vents. The room smelled musty. c. room [ROOM NUMBER]- the bathroom floor in front of the toilet had a black non-skid strip missing and particles of old glue on the floor. The wall base was missing by the bathroom door entrance exposing the drywall. d. room [ROOM NUMBER] - the wall base was missing in the bathroom. e. room [ROOM NUMBER]- the bathroom ceiling had heavy patches of spackling.f. room [ROOM NUMBER]- the air mattress had stains and what appeared to be dried fluids on the surface. g. room [ROOM NUMBER] -the sheets on the bed (by the door) had a wet yellow and brown stain in the middle of the bed. The sheets along the side of the bed (by the window) had brownish stains. A urinal filled with urine hung on the trashcan of each resident assigned to this room. The North Hallway had a strong smell of ammonia resembling an odor of urine on 9/3/25 at 12:49 PM and 3:40 PM, and again on 9/4/25 at 12:20 PM and 9/8/25 at 10:00 AM. Observations on 9/4/25 at 7:35 AM revealed: a. The hallway in the basement had carts and equipment lined up along the wall. The air smelled musty. b. The ceiling tiles and the drop ceiling apparatus had fallen down in the activity supply room and housekeeping office. A dry, brown liquid streamed down the wall from the ceiling toward the floor. c. The laundry room had a pail of what appeared to be soiled rags or washcloth and black specks of what appeared to be mouse droppings on the soiled cloths. d. The laundry room had a black/brown liquid substance running down the wall near the clean clothes rack.e. The Exit door near the kitchen had open cracks on the side and under the door. Observations on the South Hall on 9/4/25 starting at 8:30 AM revealed heavily soiled and stained mattresses on beds in rooms 7, 8, 10, and 21The South Shower room had the following: a. The ceiling had peeling paint and two areas of the ceiling falling down. b. The shower stall area had a grayish and brown mud-like debride on the shower tiles and the floor. The wall tiles in the shower area were cracked. c. The shower chair strap appeared worn and had strands of hair on it.On 9/8/25 at 3:20 PM, the top of the headboard in room C2 was dusty. The stand-up fan had a heavy build-up of dust.On 9/11/25 at 8:35 AM, Staff E, certified nursing assistant (CNA), lifted up the mats on the floor in room [ROOM NUMBER]. Crumbs, dirt, and debride were observed under the mats lying on the floor. The mats surrounded a resident lying on a mattress on the floor in this room.Observations of the North Shower Room on 9/11/25 at 8:44 AM revealed:a. Cracked and missing floor tile just outside the shower area and by the toilet.b. The shower drain cover was partially off and the drain had an excessive amount of biofilm. c. Parts of non-skid strips in the shower were missing and areas of the nonskid strips had curled up edges.d. The cabinet under the sink had a black substance that appeared to be mold. e. The wall behind the entrance door to the shower room had a large open hole in the dry wall. Observations of supplies revealed the following: a. On 9/3/25 at 12:36 PM, the North Hall clean utility room had one XL (extra large) package of briefs and three packages of cleansing wipes. The clean utility room lacked other sizes of briefs or pull-ups or boxes of gloves. At 12:38 PM, a staff person pushed a cart to the North clean utility room.At 12:50 PM, the surveyor checked the North Hall clean utility room after the staff person had stocked the room. Observation revealed only 6 boxes of large (L) gloves, 2 boxes of medium (M) gloves, 3 packages of XL briefs, and 4 packages of cleansing wipes on the shelves. The matrix provided by the facility on 9/3/25 after the surveyor's entrance revealed 28 residents resided on the North Hall. The North Hall had no residents on hospice services. b. On 9/3/25 at 5:35 PM, the Central Supply room (by the therapy room) with Staff A, certified nursing assistant (CNA), revealed a pile of cardboard boxes broken down and lying on the floor. The shelf had 4-5 packages of briefs in various sizes (3XL 2XL, XL, L, M) and boxes of gloves with 10 boxes of gloves in each box in sizes XL, L and M. Two boxes of cleansing wipes were located on the lower shelf. c. On 9/4/25 at 8:20 AM, the North Clean Utility Supply room had the following: 6 boxes of L gloves2 boxes of M gloves1- package of XL and 1 package of L briefs 2 packages of wipes 21 washcloths8 towels9 sheets6 fitted sheets d. On 9/8/25

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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)

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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, resident and staff interviews, manufacturer instructions, and policy review the facility failed to lock brakes on a bed when staff repositioned and provided cares for 1 of 3 residents observed (Resident #12), and failed to operate a mechanical lift safely for 2 of 3 residents observed for transfers (Resident #12 and #1). The facility reported a census 59 residents. Findings include: 1.The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had diagnoses of left above the knee amputation, fracture, muscle weakness, morbid obesity, and anxiety disorder. The MDS recorded the resident had no falls since re-entry to the facility on 3/14/25. The MDS documented the resident had dependence on staff for transfers. The Care Plan revised 1/24/25 revealed the resident had a risk for injury related to falls. The Care Plan revealed staff directives to use a mechanical lift and two staff for transfers. The care plan documented the resident had a fall out of bed 12/30/24 and diagnosed with a left distal fracture. The resident verbalizes she thought she was too close to the edge of her mattress when she repositioned. On 9/8/25 at 11:42 AM, the Regional Nurse reported to surveyor she would be observing staff when the surveyor was in the room. During observation on 9/8/25 at 11:45 AM, Staff E, certified nursing assistant (CNA), used a mechanical lift to lift Resident #12 from a wheelchair. Staff E and Staff F, agency CNA, transferred the resident from the wheelchair and lowered the resident into bed. As Staff E and Staff F provided incontinence care for the resident, the bed kept moving. The surveyor observed the brakes on the bed were not locked. Resident #12 voiced concern she was going to fall. Staff F reassured the resident she had her and she would not let her fall. The resident's right leg and left stump were near the edge of the bed. The Regional Nurse, who was observing staff in the room at the time, walked over and stood in front of the resident lying in the bed. Staff E continued to cleanse the resident's buttocks with disposable wipes. At 12:01 PM, Staff E attempted to lock the bed. Staff E and Staff F continued to roll the resident back and forth on the bed to get her pants on. In an interview 9/10/25 at 10:45 AM, the Regional Nurse reported on the day she observed staff perform cares on Resident #12, she went and stood by the bedside in front of the resident because she was scared for her. The resident was so close to the edge of the bed and she did not want her to fall. The Regional Nurse confirmed the brakes were not on the bed and there were a number of things that didn't go well while she observed staff provide cares for Resident #12. She spoke with the management team afterward and told them they needed to do something different. They ended up getting Resident #12 a bari (bariatric) (large) bed and moved the resident to another room. The Regional Nurse reported she expected staff to lock the brakes on the bed whenever a resident in bed. In an interview on 9/10/25 at 11:55 AM, Resident #12 reported she got a bigger bed and staff moved her to a different room this week. The resident confirmed she sometimes felt like she was going to fall out of bed when staff performed cares on her but she felt safe since she got the new bed.2.The MDS assessment dated [DATE] revealed Resident #1 had diagnoses of dementia, a fractured right lower leg, and morbid obesity. The MDS indicated the resident had dependence on staff for transfers. The Care Plan revised on 8/21/25 revealed the resident had a self-care deficit in ADL's (activities of daily living) related to a fractured right lower leg (ankle). The Care Plan directed staff to use a mechanical lift and assistance of two staff for transfers. During observation on 9/8/25 at 2:18 PM, Staff E, CNA, and Staff G, CNA, attached a sling under Resident #1 to a mechanical lift as the resident sat in a wheelchair. Staff E took the remote for the lift and raised the resident up in the mechanical lift. The sling strap was looped around the armrest of the wheelchair. Staff E, CNA, stopped raising the resident in the lift, adjusted the strap, then continued to raise the resident up from the wheelchair. The mechanical lift leg bar remained together as the resident was raised up and transferred toward the bed. As Staff E pushed the mechanical lift under the bed, the lift hit the cords under the bed. Staff E instructed Staff F, CNA, to pull the cords back. Staff E pushed the lift under bed and lowered the resident into bed. In an interview on 9/10/25 at 10:45 AM, the Regional Nurse reported the spread bar needed to be out whenever a resident transferred in a mechanical lift from one surface to another. The Regional Nurse reported they were going to do survey preparation but had not done any kind of competency audits such as transfers with the staff. In an interview 9/11/25 at 11:40 AM, the Director of Nursing (DON) reported their policy did not have information on whether the bars on the mechanical lift should be in or out when a resident transferred in a mechanical lift. The DON reported she thought it depended on where the lift was used and where the resident was being transferred to. The resident rooms were small and the mechanical lift needed to fit in the space that the staff were going

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident and staff interviews, call light reports, resident council meeting notes, and policy review the facility failed to provide sufficient staff to meet resident needs with toileting assistance and answering call lights (within 15 minutes) for 2 of 2 units. The facility reported a census of 59 residents. Findings include:1.The Quarterly MDS assessment dated [DATE] revealed Resident #15 had diagnoses of a hip fracture, cerebrovascular accident (CVA) (Stroke), muscle weakness and a history of falls. The MDS revealed the resident had a Brief Interview for Mental Status score of 12 out of 15 indicating moderately impaired cognition. The resident had dependence on staff for transfers. The Care Plan revised 8/21/25 revealed Resident #15 had an ADL impairment related to impaired mobility and a recent surgical repair of her hip fracture. The resident had a fall with major injury on 8/21/25. The Care Plan directed staff to be sure to respond promptly to all requests for assistance. During continuous observation on 9/9/25 at 11:38 AM, a resident was heard hollering as the surveyor walked down the hall. Resident #16 (Resident #15's roommate), yelled she needs help. Surveyor entered the room to find Resident #15 sitting on the toilet with her catheter bag hung above the level of the bladder. Resident #15 reported she needed help. She had been sitting on the toilet for 1/2 hour and she couldn't sit there any longer. The emergency call light was flashing (on), and the call light was lit in the room. Resident #16 reported she pushed the call light too because nobody was coming. No staff were observed in the area. At 11:42 AM, Resident #10 hollered out to the surveyor. Resident #10's room was next to Resident #15's room. Resident #10 pointed to the bathroom and told the surveyor somebody needed to help the little boy in there. The boy had been hollering to get out for over 20 minutes. At the time of the observation, the bathroom doors were partially open on both sides leading to each of these residents' room At 11:43 AM, Staff C, CNA, stood by the desk and looked at the monitor screen with activated call lights and stated she needed to figure out where to go next. Staff C reported she was floating between the halls and assisting. At 11:44 AM Staff C, CNA, entered Resident #15's room. Staff C asked Resident #15 who helped her to the bathroom. Resident #15 reported she couldn't wait any longer and got up to go to the bathroom. Staff C donned a pair of gloves and began looking for supplies. At 11:47 AM, Staff C placed a gaitbelt and assisted the resident to stand up. Staff C then provided pericare and transferred the resident to a wheelchair. A large indentation and redness was noted to the resident's outer buttocks from sitting on the toiletseat for an extended time.2.Observations revealed the following: On 9/8/25 on 11:15 AM, Resident #12 sat in a motorized wheelchair outside her room in the North hallway. At 11:20 AM, another resident walked down the hall and asked Resident #12 what she was doing. Resident #12 responded I am waiting to get changed. Resident #12 then said they (staff) are always doing something. She thought maybe the staff would help her if she sat in the hall. At 11:22 AM, Resident #12 drove her motorized wheelchair back into her room. At 11:26 AM, Resident #12 maneuvered herself in the motorized wheelchair back into the hall outside her room and parked the wheelchair along the railing. At 11:35 AM, Staff E, certified nursing assistant (CNA), and Staff F, agency CNA entered Resident #12's room. At 11:37 AM, the Regional Nurse entered Resident #12's room and reported she planned to observe staff. Staff F then left the room and talked with the Regional Nurse who now stood in the hallway. At 11:38 AM, Staff E reported he was waiting for Staff F. At 11:39 AM, Staff F stood at the end of the hall and was observed talking with the DON. At 11:43 AM, Staff F entered the room and washed her hands as Staff E connected the sling straps to the mechanical lift. Staff E then left the room to get a towel. At 11:44 AM, Staff E returned to the room. At 11:45 AM, Staff E began to raise the resident up with a mechanical lift and transferred the resident from the wheelchair to the bed. The resident and the air in the room reeked of urine. Staff E removed the resident's brief and provided pericare. Resident #12's brief was notably wet and soiled with liquid stool. 3. On 9/9/25 at 1:51 PM, Resident #1 reported she put her call light on but staff came in and shut it off and said it would be awhile. Review of the call light report revealed the resident's call light was activated on 9/9/25 at 1:16 PM and turned off within 49 seconds. On 9/9/25 at 2:01 PM, Resident #1 reached behind her and pushed the call light located in the recliner chair behind her. 4. During an interview on 9/4/25 at 10:05 AM, Resident #1 reported it took a long time for someone to come when she pushed her call light. Her roommate yells help, help but staff still do not come to help. During an interview on 9/4/25 at 12:24 PM, Resident #6 reported he had to have two staff to transfer and change him. It took up to two hours before staff came and helped him. He did not get changed right away and he got upset because he did not get sufficient

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Based on direct observation, clinical record review, resident and staff interview, and facility policy review, the facility failed to maintain the kitchen in a safe and hygienic manner that is free from pests and protects food safety and prevents food borne illness. It further failed to maintain regular kitchen and dietary cleaning logs to maintain and ensure cleanliness in the kitchen. The facility reported a census of 59. The Stage Agency informed the facility of the Immediate Jeopardy (IJ) on 09/03/2025 at 03:55 PM. The IJ began on at least 04/29/2025. Facility Staff removed the Immediate Jeopardy on 09/04/2025. The facility staff removed the IJ by implementing the following actions:1. Facility ceased operations of food service from the kitchen on 9/3/25 at 3:55pm. Facility will order outside meals, and ensure diet orders are followed.2. No residents will be impacted as kitchen operations ceased on 9/3/25.3. CDM was educated on kitchen sanitation policy on 9/3/25 at 4:00pm. Facility staff to clean/sanitize kitchen on 9/3/25. Dietary staff will be educated on 9/3/25 or prior to the start of their next shift worked.4. A contract service was brought in at 4:30 PM on 09/03/2025 to implement pest control plan. They confirmed mitigation efforts and confirmed that control measures had been effective. 5. Ceiling Repairs were completed on 09/03/2025. 6. A monitoring system was put into place with the following details; Administrator will monitor kitchen sanitation, pest control, and ceiling tiles weekly x/3 weeks, then monthly x 3/months. Kitchen sanitation audits will be completed and reviewed by administrator weekly x/3 weeks then monthly x/3 months.The scope lowered from a L to a F at the time of the survey after ensuring the facility implemented education and their policy and procedures.Findings include: The initial kitchen observation on 09/03/2025 at 12:30 PM revealed the following:1. The kitchen and basement area appeared to have significant water damage, revealing numerous missing ceiling tiles, collapsing ceiling tiles, and ceiling tiles that showed significant signs of water damage. One tile, near the food preparation area, was moist and drops of water were observed beading on the tile. 2. Several strong smells permeated the kitchen, one smelled of spoilage and the other smelled damp. 3. The entire floor of the kitchen appeared caked in sticky substances and food particles. The grout appeared black in color in areas of use and was a light grey color in areas that were inaccessible to staff. 4. Numerous sticky traps were found, with one of them showing what appeared to be rodent droppings, light grey fur, and numerous insects near the kitchen dry storage area. 5. Peaches with an expiration date of 08/24/2025 were found in one of the refrigerators, the Director of Food Services confirmed they had been served for breakfast the morning of 09/03/2025. 6. What appeared to be small, worm-like insects in the floor drain were found near the HVAC Unit. What appeared to be insect eggs were found on the floor near the drain. The drains had food debris inside of them.7. What appeared to be rodent droppings were also found under and in front of the oven. 8. What appeared to be a collection of coffee creamers and sponges behind a dish washing sink with what appeared to be a mold-like-substance with a strong smell growing on it. This mold-like substance was also found in all of the kitchen floor drains. 9. The equipment throughout the kitchen appeared to be covered in a layer of grime, the flattop cooking surface was visibly blackened and appeared to not have been cleaned in some time. 10. There were two unlabeled bags of food in one of the freezer units, one of which was open to the air of the freezer. A direct observation on 09/03/2025 at 04:44 PM revealed what appeared to have been fresh rodent droppings near the stove and in the dry storage area of the kitchen, as they were not present during the initial kitchen observation at these locations. Staff L, Cook, confirmed she had swept the floor already and was seen actively cleaning at the time. She confirmed at this time to the surveyor that she had seen a mouse in the kitchen just minutes before the observation. Review of pest control documents from the facility contracting service dated 02/28/2025, 04/14/2025, 05/23/2025, 06/17/2025, 08/21/2025, and 09/04/2025 revealed pest control measures had been in place since the first date, but also documented facility sanitation issues. They included; Excess water pooled in the downstairs hallway and kitchen with large standing pools of water were noted on 05/23/2025, easy access to garbage with unlocked and unclosed dumpster was found on 4 of 6 service dates. The service records do not document pest activity. This finding is discrepant from staff and resident interviews. Review of kitchen cleaning logs since January of 2025 documented the last kitchen cleaning log for cooks was filled out on 05/31/2025. The last documented dietary aide cleaning log was dated 04/29/2025. In an email from the Regional Director of Operations (RDO), sent on 09/08/2025 at 09:56 AM she stated the dietary manager and herself were unable to find additional cleaning log documentation. In an interview on 09/03/2025 at 12:39 PM with Staff M, Dietary Aide, he stated that he has seen mice or rodents in the kitchen every single day since he started, and revealed he believed

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview on 09/08/2025 at 10:40 AM with Staff O, dietary Aide, she stated the kitchen has been in bad shape since she started with the facility, which was in Spring of 2025. She stated the facility leadership knew how unclean the kitchen was and shut it down for a deep cleaning in the summer before they were allowed to use the kitchen again. She stated it helped for a while, but that they have fallen behind on cleaning again. In an interview on 09/08/2025 at 11:03 AM with Staff P, Dietary Aide, she stated she has seen mice in the kitchen, and has been told by other staff there are mice in the kitchen. She was unable to recall when the problem started. In an interview on 09/08/2025 at 08:41 AM with a pest services contractor who serviced the facility. He stated he did not see pests while he was serving the building as part of the IJ removal plan on 09/04/2025. He stated he was shown a picture of a glue board that did not show evidence of pest infestation, and did not see signs of pests at the time of his inspection. The surveyor shared pictures of the glue boards that were present in the kitchen on 09/03/2025 and he confirmed that the pictures showed what he called significant evidence of infestation. He said he could clearly see mouse droppings, what appeared to be mouse fur attached to a glue board. He further stated he could see what appeared to be a cockroach. He confirmed he was not shown this glue board by the facility, and if he had his report would have indicated signs of pest activity. He stated the facility has had past issues with mice, and he visits the facility once a month. He revealed he was last in the facility on 08/21/2025 for a targeted cockroach inspection. He does not believe he saw evidence of cockroaches at that time, but did not look for signs of rodent infestation. When he comes monthly for his inspection he looks for any products that have been chewed on, and droppings on the floor. He stated that droppings in high human traffic areas are a sign of significant infestation. He stated that typically when he visits the facility the kitchen has been recently cleaned, but even on his most recent visit was in poor condition. He stated when he arrived in the kitchen on 09/04/2025 it was the best shape he had ever seen the kitchen in. He stated the kitchen often smells of mildew, but on 09/04/2025 smelled like a bleaching agent had been used recently. In a subsequent interview on 09/08/2025 at 09:53 AM with the Dietary Manager, he confirmed his hire date as 08/07/2025 and stated his first date on the floor was either 08/18/2025 or 08/25/2025. He stated he has personally found at least 8+ mice on sticky traps within the facility with other mice seen free roaming the facility since he started. He stated he asks maintenance to dispose of the mice on the sticky traps, and asked maintenance to dispose of the mouse nest that he found. He acknowledged that his expectations on kitchen sanitation are not being followed, and he feels it is a result of “years of neglect”. In an interview on 09/08/2025 at 11:43 AM with the Registered Dietician, she stated that she rarely goes into the kitchen but it has been disorganized in the past few months. She stated she knew the kitchen was in need of significant cleaning. In an interview on 09/08/2025 at 02:46 PM with the Director of Maintenance, with the RDO present, he confirmed he has been disposing of mice on sticky traps, and he was aware that mice were a problem in the kitchen. He stated personally disposed of 4 baby mice and 3 adult mice in the week before surveyors entered the building, but that count might be off by one, give or take. In an interview on 09/08/2025 at 03:11 PM with Staff E, Certified Nurse Aide (CNA), they stated they have seen cockroaches and mice in the basement and kitchen for months now. They stated they had talked to the facility management several times in the past but management downplayed the issue and told them the cockroaches were just water bugs and the mice weren't a problem. They stated they had noticed an increase in emesis (vomiting) and loose stools (diarrhea) in the resident population they served in the last month. They had been reporting this to their charge nurse. They also noted numerous residents have complained about the quality of their meals in the last month. In an interview on 09/08/2025 at 12:00 PM with Resident #8, he stated that while he has not seen mice in his room he sees flies all the time. He stated the food is “gross” sometimes. In an interview on 09/09/2025 at 03:20 PM with Resident #11, she stated the food does not taste good. In a subsequent interview on 09/10/2025 at 03:40 PM with the Housekeeping Supervisor, she stated again she has seen mice for months downstairs and in the kitchen. She also stated she had seen mice droppings in the laundry room downstairs, and had seen mice personally while cleaning at least two resident rooms in their dressers in the recent past. In an interview on 09/10/2025 at 09:51 AM with Staff B, Licensed Practical Nurse (LPN), she stated she was asked to remove a mouse in a mouse trap on 09/07/2025 from the kitchen. She stated she has also heard staff and residents talking about mice. She also reported a bout of diarrhea and emesis that impacted multiple residents in the month of August, though she did not know the source.

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Azria Health Park Place	2401 East Eighth Street Des Moines, IA 50316

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 9/8/25 at 10:16AM the Infection Preventionist (IP) stated she tracks nausea/diarrhea if it's multiple days, if it's one day episode they don't typically track it. The IP reported not track any increase in gastrointestinal symptoms last month. A Mcgeer Criteria for Gastrointestinal Tract Infection Surveillance dated 6/3/25 documented Resident#22 had diarrhea and vomiting. A Mcgeer Criteria for Gastrointestinal Tract Infection Surveillance dated 6/4/25 documented Resident#23 had vomiting with nausea, and abdominal pain or tenderness. A Mcgeer Criteria for Gastrointestinal Tract Infection Surveillance dated 6/6/25 documented Resident#22 had abdominal pain or tenderness, and diarrhea and was admitted to the hospital with colitiis (can be caused by infections).Review of a facility provided document titled “Sanitation”, with a last revised date of November 2022, stated all kitchens, kitchen areas, and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects. An article from the National Parks Service (NPS), last updated 05/10/2023, warns that rodents transmit a number of pathogens that can cause human disease in the United States. These diseases are noted to be hantavirus, leptospirosis, rat bite fever, and salmonellosis. It noted that humans can become infected through various routes, including contact with food contaminated with rodent feces, urine, or saliva. It further warned rodents also serve as hosts for ectoparasites such as ticks and fleas which can transmit further diseases. It instructs the public to properly store of food and properly dispose of trash. The website cdc.gov/health-pets/rodent-control/index.html included a topic titled Controlling Wild Rodent Infestations dated April 8, 2024 included the following key facts; Rodents can carry many diseases that can spread directly or indirectly to people. Rodent droppings, urine, and saliva can spread by breathing in air or eating food that is contaminated with rodent waste. Rodents can also carry ticks, mites, or fleas that can spread disease. Many disease do not cause any apparent illness in rodents. This means you cannot tell if a rodent is carrying a disease just by looking at it Rodents can spread both bacterial and viral diseases some of which can cause death. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A tour of the main kitchen (located in the facility's basement) on 9/4/25 starting at 7:40 AM revealed the following: a. The shelves across from the food prep table had peeled and chipped paint and a scuffed appearance. b. The shelves by the food prep table and across from the food prep table had a blackened and scuffed appearance, as well as what appeared to be worn, rusty, exposed metal. c. The bottom drawer by the food prep counter had particles and crumbs of food debride and what appeared to be dead maggots and mouse droppings. d. Large bulk containers labeled “sugar” and “thickener” had contents inside and had black specks of what appeared to be mouse droppings on the top. e. The steam oven had a brown, sticky residue on the door and wall of the oven inside. f. The bottom and inside of the oven had a black charred appearance and a heavy build-up of liquid drippings/debride. g. The shelves in the dry storage area were empty. h. The dry storage area had two sticky rodent traps lying on a plastic crate. i. The Arctic Air freezer had an unlabeled bag of what appeared to be frozen eggs. The bag was open and not sealed. In an interview 9/3/25 at 5:10 PM, Staff B, LPN, reported there had been 1 to 2 weeks when residents at the facility had an illness. It was the week leading up to the Labor Day weekend. They ran out of briefs that weekend. In an interview 9/3/25 at 5:25 PM, Staff A, CNA, reported she could not eat the food at the facility. She had diarrhea all day when she ate the food at the facility. Staff A stated over the past weekend and Monday (8/30/25 to 9/1/25), there were several residents that had diarrhea and vomiting. On 9/4/25 at 7:50 AM, the DM reported they replaced the ceiling tile in the kitchen, pulled everything out and cleaned behind the refrigerators and freezers. He was at the facility until 9:30 PM on 9/3/25 with management cleaning the kitchen. The DM reported they had Service Master coming to clean the floors. In an interview on 9/4/25 at 8:05 AM, the RDO reported she had worked as the RDO since 3/2025, then became the acting Administrator on 4/11/25. When the surveyor asked when the last time she had been to the kitchen, the RDO stated she had not been to the kitchen in a while. The facility had hired a DM who had been at the facility for two weeks. The RDO reported there had been a lot of staff turnover. She had a Kitchen Cleaning Party on 7/17/25. Staff came in and helped clean the kitchen for 4 ½ hours, but she thought they needed to have another cleaning event to do the rest of the kitchen. The RDO reported she left the facility at 10:45 PM on 9/3/25 and came back to the facility at 3:30 AM on 9/4/25 to continue cleaning the kitchen. The RDO reported since 9/3/25 after the IJ, the ceiling tiles got replaced, everything was pulled out of the kitchen and they sanitized the kitchen. All of the dishes got washed, the freezers and shelves got pulled out and cleaned, everything was thrown out in dry storage area, and the floor had been swept and mopped several times. The Surveyor told the RDO the kitchen cleaning logs were requested 9/3/25 but no cleaning logs were received. The RDO said she would look for the cleaning logs and get them to the surveyor. In an interview on 9/4/25 at 10:05 AM, Resident #1 reported she had diarrhea all of the time. She didn't have diarrhea until she came to the facility. On 9/4/25 at 11:25 AM, the RDO asked if the surveyors needed anything. The surveyor advised the RDO we were still waiting on the kitchen cleaning logs, as these were requested twice on 9/3/25 and again on 9/4/25 AM. The RDO reported they were still working on it. At this time, the surveyor told the RDO to provide whatever cleaning logs they had found. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 9/3/25 at 11:35 AM, the RDO sent an email with the cleaning logs attached. The most recent [NAME] Cleaning Log was dated 5/31/25 and the Dietary Aide Cleaning Log was last completed on 4/29/25. In an interview 9/4/25 at 12:24 PM, Resident #6 reported he had projectile vomiting for three weeks. In an interview on 9/8/25 at 3:20 PM, Resident #14 reported the food at the facility was not that great. She could not eat the tomato soup at the facility because it made her have diarrhea. She ate tomato soup at home without having diarrhea but that was not the case at the facility.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observations, resident, and staff interviews, Centers for Disease Control (CDC) website data, and resident council meeting notes the leadership of the facility failed to provide adequate management of the facility. The Administrative team failed to provide adequate incontinent supplies, linen supplies and a comfortable homelike environment free of vermin. In addition, the facility failed to provide the residents with a clean kitchen. The facility identified a census of 59 residents. Findings include:Observations conducted on 9/3/25 at 12:34 PM revealed the following concerns during a walk through the North hallway; black like substances on vents of two air conditioners in two resident rooms, missing wall base in two resident rooms, minimal incontinent supplies in the North Clean Utility room (1 package XL briefs, 3 packages of wipes), room22 bathroom ceiling with spackling /heavy patches. Also, during the initial walk through the building resident mattresses were noted to been stained, a strong foul smell was noted in different areas of the building, stained linen on beds, and several beds were unmade. Observation of the south end supply room conducted on 9/3/25 at 5:35PM revealed the following; carboard boxes broken down on the floor, 4 to 5 packages of incontinent briefs in various sizes (3XL, 2XL, XL, L, and M) 10 boxes of gloves in sizes XL, L, and M, and a couple boxes of cleansing wipes. In an interview 9/3/25 at 5:25 PM, Staff A, CNA, reported the facility did not have enough supplies such as gloves, wipes, and briefs. If the facility ran out of supplies, she used whatever was available, such as a washcloth. If a resident used a 3 XL brief but the facility did not have those, then they had to use a 2XL brief or whatever they had available. She sometimes used a pull-up and tied up the sides of the pullup to make it work when they did not have briefs. Staff A stated the facility did not always have enough linens. They ran out of clean linens all of the time. She let the nurse know whenever supplies or linens ran low or out. The nurse could call whoever was on-call but staff did not always get what was needed right away, and the on-call person did not always come in. Running out of briefs and linens happened all of the time when she worked. She just did the best she could to make it work. On 9/8/25 at 3:11PM Staff E, C.N.A stated that there have definitely been times where once or twice a week they run out of supplies. On 9/9/25 at 3:20PM Resident#11 reported that staff told her that they were running out of clean linens. On 9/3/25 a 4:05PM Resident#17 reported the staff that does showers runs out of linen. On9/3/25 at 5:02PM Resident#19 reported that towards the end of the week incontinent supplies get short, and her room only gets cleaned once a week. On 9/3/25 at 4:10PM Staff H, C.N.A reported told management about the backup on the ice machine, mice, ants and water bugs. Staff H stated that there is a resident that does not have big enough incontinent briefs, the resident is a bigger person she sits in urine since the briefs are not big enough. Staff H reported she stapled 2 incontinent briefs together to put on the resident. In an interview on 09/03/2025 at 02:23 PM with The Housekeeping Supervisor (HS), stated she has also seen mice frequently near the kitchen, though she noted she rarely goes into the kitchen, she said the entire basement smells of mildew. The HS further reported that she knew of the issue with the linens in the building, Certified Nurses' Aides (CNA) have used folded up linens as incontinence pads for residents, because they report to her that they don't have enough supplies. The HS showed the surveyor a bin filled with soiled linens with deep brown stains and stated those couldn't be cleaned and have to be disposed of, that's a why they're short on linens. On 9/3/25 at 12:43PM the smell and general state of the kitchen was enough to nauseate the surveyor. In an interview on 09/03/2025 at 12:39 PM with Staff M, Dietary Aide, he stated that he has seen mice or rodents in the kitchen every single day since he started, and revealed he believed he started around January 2025. He stated he had brought this up with management staff on a number of occasions, but nothing had been done. He stated it is extremely hard to clean the kitchen, and pointed out the years of what he described as crusted gunk covering the floor. He stated the kitchen floods, and seriously flooded in August, though he did not know the exact date. He stated he has seen what he believes to be cockroaches in the kitchen for a long time as well, though he's been told by other staff they are crickets. He also sees a significant number of flies, and that has been an ongoing issue. In an interview on 09/03/2025 at 1:01 PM with Staff L, Cook, she stated she had seen one to two mice a day in the kitchen. She stated this has been ongoing for months now, and that she has told at least two different managers about the pest issue. She says that management has done nothing about the issues in the kitchen. She further stated the kitchen has also had issues with ants, and what she has been told are crickets. She stated she has been directed by the previous dietary manager to push food debris and mop water down the floor drains, and confirmed at this time the drains appeared to have fly larvae in them. She expressed frustration with the situation, and stated

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on review of Certification and Survey Provider Enhanced Report (CASPER) from the Centers for Medicare & Medicaid Services (CMS), staff interview, and review of the facility QAPI (Quality Assurance Performance Improvement) plan, the facility failed to ensure an effective process to address previously identified quality deficiencies. The facility reported a census of 59 residents.Findings Include:The CASPER Report for the facility identified the facility had previously received an Infection control deficiency in 2023 and 2024. A Safe, clean, and homelike environment deficiency in 2023 and 2024. At the conclusion of the complaints survey on 09/11/2025 the facility was cited again for Infection control and Homelike environment. The Facility's QAPI Plan, revised 2/05/2025, identified a monitoring process which included multiple sources of data. The QAPI Plan failed to identify a process to address previously identified quality deficiencies. Review of the QAPI minutes since 11/27/2024 identified repeat deficiencies and deficient practices from the last standard survey, but did not document follow through and showed numerous repeated issues addressed during QAPI meetings. In an interview on 09/11/2025 at 01:12 PM with the Director of Nursing (DON), the acting QAPI designee, she could not explain why there are repeated issues documented in the QAPI meetings, and could not explain where the follow through was documented. She stated her expectation is for the follow through to be documented and for issues to not be repeated. In that same interview, the Regional Director of Operations (RDO), she acknowledged the previous facility leadership had not followed through with the QAPI plan created due to the results of the last standard survey.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on direct observation, clinical record review, resident and staff interview, and facility policy review, the facility failed to provide incontinence care and transfers in a manner that promotes hygiene and protects residents from the spread of disease when they failed to change contaminated gloves and used another residents mechanical lift sling without sanitizing it first for 3 of 4 residents reviewed. (Resident #1, #8, and #12). In addition, the facility failed to utilize Enhanced Barrier Precautions (EBP) when providing care to a resident with an indwelling catheter (Resident #8). The facility reported a census of 59.Findings include: 1. The significant change Minimum Data Set (MDS) for Resident #8, dated 10/15/2024, documented the residents Brief Interview for Mental Status (BIMS) Score as 14, indicating intact cognition. It documented the following relevant diagnosis of indwelling catheter. It also documented the residents dependency on staff for transfers and the use of a wheelchair for mobility. The care plan for Resident #8, last revised on 07/03/2025, documented the resident required two-person assistance with a mechanical lift for transfers. A direct observation on 09/08/2025 at 03:21 PM revealed Staff G, Certified Nurse Aide (CNA), and Staff E, CNA, transferring Resident #8 via a mechanical lift. Before Staff E arrived to assist, Staff G attempted to place Resident #8 on a mechanical lift sling. This was discovered to be the wrong size, and Staff G pulled a mechanical lift sling from the resident's neighbor's room. No sanitation of the sling was witnessed. During the transfer neither Staff G nor Staff E wore enhanced barrier precautions. In an interview on 09/08/2025 at 02:27 PM with Staff R, Registered Nurse (RN), she stated if she is transferring a resident with an indwelling medical device, such as a catheter, she is required to wear enhanced barrier precautions. In an interview on 09/10/2025 at 09:51 AM with Staff B, Licensed Practical Nurse (LPN), she stated staff are required to wear enhanced barrier precautions while transferring a qualifying resident. She stated qualifying residents include those with catheters, but also wounds of any kind. She acknowledged that a transfer is considered a high contact activity because of the direct contact staff members make during assisted transfers. In an interview on 09/10/2025 at 11:23 AM with the Infection Preventionist, she stated each resident should have their own clean mechanical lift sling. She stated her expectation is for staff to not grab a lift sling from another residents room. She acknowledged staff should have been wearing enhanced barrier precautions when they transferred Resident #8. In an interview on 09/10/2025 at 11:41 PM with the Director of Nursing (DON) she stated her expectation is for staff members to use clean slings from bulk storage, and not take slings from another resident's room. She stated slings must be sanitized before being used between residents. She confirmed staff should be wearing enhanced barrier precautions during transfers as it is considered a high contact activity. 2. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had diagnoses of chronic obstructive pulmonary disease, left above the knee amputation, and moisture associated skin disorder (MASD). The MDS documented the resident had incontinence and had dependence on staff for toileting hygiene and dressing. The Care Plan revised 4/29/25 revealed the resident had bowel and bladder incontinence. The care plan directed staff to clean the peri-area with each incontinence episode. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 9/8/25 at 11:45 AM, Staff E, certified nursing assistant (CNA), and Staff F, CNA, used a mechanical lift to move Resident #12 from a wheelchair to the bed. The resident and the air in the room reeked of urine. Staff rolled the resident onto the left side and removed her pants. Staff E changed gloves then removed the brief tabs and proceeded to spray peri-wash over the resident's periarea. Staff E took disposable wipes and cleansed the periarea. Staff rolled the resident onto her right side. Staff F, agency CNA, wiped the resident's left buttock in a downward manner from the upper buttock toward the leg. Staff F touched and opened the drawers on a bedside table, then opened a cabinet door and obtained a clean brief. Staff F then changed her gloves and sanitized her hands. Staff F rolled the resident onto her left side. Staff E removed the soiled brief and sling, then took disposable wipes and cleansed the resident's lower back and buttocks. A large amount of liquid stool was present. Staff E continued to cleanse the resident's buttocks with disposable wipes. Staff E placed the soiled linens into a plastic bag, then placed the bag of soiled linens on top of a trashcan. Staff rolled the resident onto her right side then onto her back and attached the tabs on the brief. Staff F removed gloves and sanitized his hands. At 12:08 PM Staff E bagged up the trash and wheeled the mechanical lift to the common area by the nurse's station. 3.The MDS assessment dated [DATE] revealed Resident #1 had diagnoses of dementia, a fractured right lower leg and morbid obesity. The MDS recorded the resident had incontinence. The Care Plan revised 8/21/25 revealed the resident had incontinence and required assistance of two staff for toileting. During observation on 9/8/25 at 2:18 PM, Staff E, CNA, removed Resident #1's brief and sprayed cleansing foam onto the resident's abdominal fold and periarea. Staff E provided pericare, then rolled the resident onto her left side. Staff E removed the sling and soiled brief under the resident. Staff E took the bottle of foam cleanser and sprayed the cleanser to the resident's buttocks area. Staff E took disposable wipes and cleansed the buttocks area. Staff G, CNA, rolled the resident, placed a clean brief on the resident then removed her gloves. Staff E did not change gloves or sanitize hands during cares. In an interview 9/10/25 at 10:45 AM, the Regional Nurse reported she expected staff to change gloves whenever the gloves were dirty. In an interview 9/10/25 at 3:40 PM, with the Infection Preventionist (IP), the Regional Nurse sat in the room as the surveyor interviewed the IP and stated she was present to observe. The IP reported gloves needed to be changed in-between contact with residents, whenever staff did a check and change, and during cares. The IP stated gloves needed changed especially if the gloves were soiled. She expected staff to sanitize their hands every time gloves were taken off and staff could use hand sanitizer up to 3-5 times then hands needed to be washed. The IP reported staff should disinfect equipment in-between each use. In an interview 9/11/25 at 11:40 AM, the Director of Nursing reported she expected gloves changed if soiled or in-between going from a dirty to clean area or task. The facility's Infection Control Policies and Practices revised 7/2014 revealed the infection control policies were intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Standard Precautions policy revised 9/2022 revealed standard precautions presume that all blood, body fluids and excretions may contain transmissible infectious agents. Hand hygiene performed with alcohol-based hand rub or soap and water before and after contact with a resident, before moving from work on a soiled body site to a clean body site on the same resident, and after removing gloves. Gloves changed as necessary during the care of a resident to prevent cross-contamination from one body site to another such as when moving from a dirty site to a clean site. Resident care equipment are handled in a manner to prevent transfer of microorganisms to other residents and the environment.