

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2025
NAME OF PROVIDER OR SUPPLIER Azria Health Prairie Ridge		STREET ADDRESS, CITY, STATE, ZIP CODE 608 Prairie Street Mediapolis, IA 52637	

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff, resident and family interviews, the facility failed to make an attempt to meet resident needs prior to issuing emergency discharges for 2 of 2 residents (Resident #1 and Resident #5) reviewed. After a resident to resident altercation the facility issued emergency discharges to Resident #1 and Resident #5 upon their transfer to the hospital for an evaluation. The facility reported census was 57. Findings include: 1. According to a Minimum Data Set (MDS) with a reference date of July 17, 2025, Resident #1 had a Brief Mental Status (BIMS) score of 14 of 15, indicating an intact cognitive status. Resident #1 was coded independent to needing supervision assistance with transfers, mobility, dressing, toilet use and personal hygiene needs. Resident #1's diagnoses included coronary artery disease, atrial fibrillation and was always continent of bladder and bowel. According to the facilities Notice of Resident Transfer or Discharge form dated Sept. 16, 2025, directed to Resident #1's guardian, the form indicated Resident #1 was being discharged due to the safety of individuals in the facility being endangered due to the clinical or behavioral status of the resident. The form includes the placement facility and rights to appeal to the State agency with address and contact number along with other related advocacy agencies, addresses and numbers. The form was initialed by Resident #1. Clinical record review revealed Resident #1 was admitted on [DATE] and had a total of five recorded altercations with his peers. Altercations per the clinical record: a. On May 24, 2025 described as a disagreement with no threats of violence. Residents were moved to different rooms. b. On July 4, 2025 described as arguing about the TV being too loud. Residents were deescalated and volume turned down. c. On July 5, 2025 residents continued to argue and were moved to different rooms. d. On Sept. 12, 2025 arguing with roommate which escalated to both residents threatening to fight each other. The residents were separated and moved rooms. e. On Sept. 16, 2025 described as a verbal dispute with threats of violence leading to the facility doing an emergency discharge on both residents. 2. According to a Minimum Data Set (MDS) with a reference date of Sept. 16, 2025, Resident #5 had a Brief Mental Status (BIMS) score of 14 of 15, indicating an intact cognitive status. Resident #5 required maximal assistance with dressing and toileting hygiene and supervision with transfers, mobility and personal hygiene needs. Resident #5's diagnosis included coronary artery disease and atrial fibrillation. Resident #5 was coded as occasionally incontinent of bladder. According to the facilities Notice of Resident Transfer or Discharge form dated Sept. 16, 2025, directed to Resident #5's father or sister, the form indicated Resident #5 was being discharged due to the safety of individuals in the facility being endangered due to the clinical or behavioral status of the resident. The form includes the placement facility and rights to appeal to the State agency with address and contact number along with other related advocacy agencies, addresses and numbers. The form was initialed by Resident #5. In an interview on [DATE] at 5:30 p.m. the Administrator explained her reasoning to discharge Resident #1 and Resident #5 on Sept. 16, 2025. The Administrator stated there had been two resident to resident altercations days earlier involving Resident #1 and Resident #6 in a verbal and threatening altercation on Sept. 13, 2025 and Resident #5 and Resident #7 in a verbal and threatening altercation on Sept. 15, 2025. In both situations, the residents were roommates and the intervention were to separate by changing rooms, which eventually resulted in Resident #1 and Resident #5 becoming roommates and leading to the third verbal and threatening altercation on Sept. 16, 2025. The facility received orders for an emergency psychiatric evaluation and Resident #5 was the first to be sent out to the hospital #1 emergency department (ED), however the emergency room (ER) physician refused to complete an evaluation and wanted the resident returned to the facility. The Administrator stated she and the Director of Nursing (DON) decided to transport Resident #1 to a different hospital #2 emergency room. The Administrator explained what was happening and the ER physician stated they could do a psychiatric evaluation, but thought Resident #1 was fine. Hospital #2 staff then told the Administrator they could leave and they would be in contact with them. When Hospital #2 called the facility, the Administrator stated they had no more available rooms to accommodate residents with these behaviors and felt she had no choice but to discharge them. The Administrator stated Resident #1's guardian was called and informed and Resident #5's father and sister were called but never answered and the emergency discharge was explained to Resident #5 and signed by him. In an interview on Sept. 30, 2025 at 8:40 a.m. The Director of Nursing (DON) stated on the late evening of Sept. 16, 2025, she and the Administrator were called into the facility regarding a resident to resident conflict between Resident #1 and Resident #5. The two residents had gotten into a</p>		