

| | | | |
|--|--|---|--|
| 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 01/30/2026 |
| 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) |
|--|---|
| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on clinical record review, facility policy review, and staff interviews the facility failed to ensure that residents remained free from resident to resident altercations for 1 of 9 resident records reviewed (Resident #2). The facility reported a census of 62 residents. Findings include: Review of a Facility Reported Incident, dated 12/24/25 revealed (resident name redacted, Resident #1) was sitting in front of doorway to the nurses' station when (resident name redacted, Resident #2) was trying to pass by him. As Resident #2 passed by, Resident #1 swung back hitting her in the upper back twice. This was witnessed by Restorative Aide (name redacted, Staff A) and (name redacted, Staff B, Registered Nurse (RN)). When altercation started, (name redacted, Staff A) tried to stop (name redacted, Resident #1) from hitting (name redacted, Resident #2) by holding arm, (name redacted, Resident #1) then hit (name redacted, Staff A) in the shoulder and grabbed at her abdomen pinching it and causing a bruise. Immediately separated, head to toe skin assessment and pain assessment completed. Primary care provider, Power of Attorney (POA) and law enforcement notified. Review of the Minimum Data Set (MDS) assessment, dated 11/14/25 revealed a list of diagnoses for Resident #1, which included cerebrovascular accident (a stroke), hemiplegia (paralysis on 1 side of the body), aphasia (inability or difficulty with speech), adjustment disorder with depressed mood, and a history of falls and diabetes. The Brief Interview for Mental Status (BIMS) score 9 out of 15 indicted a moderate cognitive impairment. The MDS indicated the resident usually able to make himself understood, usually able to understand others, and had behaviors from 1 to 3 days of the 7 days that preceded the assessment date that did not impact the resident or others. The MDS indicated Resident #1 required substantial staff assistance to reposition in bed, transfer to and from bed or chair, dressing, toileting and bathing, unable to stand or ambulate and wheelchair used as primary mode of transportation. Review of Resident #1 Care Plan revealed a problem labeled I have alteration in mood and behaviors, I often do not want to have clothes on, I can be verbally aggressive, initiated 11/11/25. The plan directed staff to: a. Administer medications as ordered. Monitor/document side effects and effectiveness, initiated 11/11/25. b. Anticipate and meet the resident's needs, initiated 11/11/25. c. Assist the resident to develop the most appropriate methods of coping and interacting. Encourage the resident to express feelings appropriately, initiated 11/11/25. d. Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by, initiated 11/11/25. e. If reasonable, discuss the resident's behavior with them. Explain/reinforce why behavior is inappropriate and/or unacceptable, initiated 11/11/25. g. Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm and controlled manner. Redirect. Remove from situation and take to alternate location as needed, initiated 11/11/25. A Nursing Progress Note transcribed by the Director of Nursing (DON) on 12/24/25 at 3:20 p.m. stated, in part: Resident watching another resident (name redacted, Resident #2) propelling self in her wheelchair around the nurse's station, as (name redacted, Resident #2) was trying to pass Resident #1 swung his arm back hitting</p> <p>(continued on next page)</p> |

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 |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: Facility ID: 165220 | If continuation sheet Page 1 of 6 |

| | | | |
|--|--|---|--|
| 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 01/30/2026 |
| 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) | | |
| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>(name redacted, Resident #2) in the upper back twice. A CNA (Certified Nursing Assistant) intervened holding Resident #1's arm and (name redacted, Resident #2) was able to get by. Resident #1 then hit the CNA in right shoulder and grabbed at her abdomen pinching her skin and causing a reddish/blue mark. Resident #1 was separated from (name redacted, Resident #2) and was placed on 1:1, Nurse Practitioner (NP) and law enforcement were notified. A Nursing Progress Note transcribed by the DON on 12/24/25 at 4:32 p.m. described the primary care provider was notified of Resident #1's transfer to the county jail by a Sheriff's vehicle. Review of Iowa Courts Online electronic records/data repository revealed Resident #1 arrested and taken into custody by the county Sheriff's office on 12/24/25, where he remained for the duration of the State Agency investigation. Resident #1 charged with assault on persons in certain occupations with bodily injury, and older individual assault. 2. The MDS assessment for Resident #2, dated 12/18/25, revealed a list of diagnoses that included non-Alzheimer's dementia, cognitive communication deficit, adjustment disorder with mixed anxiety and depressed mood. The BIMS score of 6 out of 15 points indicated a severe cognitive impairment. The MDS indicated Resident #2 sometimes able to make herself understood and sometimes able to understand others. The MDS revealed Resident #2 unable to stand or ambulate, and used a wheelchair as primary method of transport. Review of the Care Plan revealed a problem labeled Resident has impaired cognitive function/dementia or impaired thought processes related to Dementia diagnosis, initiated 1/19/25. The plan directed staff to: a. Ask yes/no questions in order to determine the resident's needs, initiated 1/19/25. b. Cue, reorient and supervise as needed, initiated 1/19/25. c. Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion, initiated 1/19/25. d. Present just one thought, idea, question or command at a time, initiated 1/19/25. A Nursing Progress Note in Resident #2's record, transcribed by the DON on 12/24/25 at 3:57 p.m. documented, in part: Resident was propelling self in her wheelchair around the nurse's station as per her routine every evening. When she was trying to pass (name redacted, Resident #1) he slung his arm back hitting her in the upper back twice. A CNA intervened and the resident was able to get by. Upon skin assessment no issues (redness, pain, or marks) were found, resident stated she had no pain. During an observation on 1/12/26 at 3:24 p.m., Resident #2 used her feet to self-propelled her wheelchair in the hallway near the Nurses Station area. During an interview on 1/12/26 at 12:20 p.m., Staff A, Certified Nursing Assistant (CNA) and Restorative Aide (RA) stated Resident #1 would become irritable if staff redirected him. On the afternoon of 12/24/25 Resident #2 self-propelled her wheelchair in the hall, and tried to get by Resident #1, while he talked on the phone at the nurse's station. Staff A stated she could not get to Resident #1 before he struck Resident #2 with his fist, twice on her back, as Resident #2 leaned forward in her wheelchair and continued to self-propel her wheelchair past him. Resident #1 then stood up and turned in the direction of Resident #2. Staff A stated she thought he was going to go after Resident #2, but was able to redirect him and asked him to sit down. Staff A stated that is when Resident #1 hit her with a closed fist on her right shoulder area, and then pinched her in the abdomen area. Staff A stated she was bruised on her shoulder and abdomen. During an interview 1/12/26 at 2:32 p.m., Staff B, Registered Nurse (RN) stated she worked on 12/24/25 and witnessed Resident #1 strike Resident #2 twice on the back. Staff B explained Resident #2 self-propelled her wheelchair around Resident #1 while he was on the phone at the nurse's station. Staff B stated Resident #1 then hit Resident #2 on her back. She stated it all happened so fast. She explained Resident #1 stood up, and Staff A, CNA/RA was able to stop him from hitting Resident #2 again. Staff B stated she then was able to direct Resident #1 to sit back down, and that is when he hit and pinched Staff A. Staff B stated they were able to get Resident #1 seated and separated from</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| 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 01/30/2026 |
| 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) | | |
| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Resident #2, and notified the DON immediately. During an interview on 1/12/26 at 2:55 p.m., Staff I, CNA, stated Resident #1 had behaviors, explaining sometimes he was redirectable but other times he acted like he didn't understand staff and when redirected or a direction repeated, he would get agitated. Staff I stated she worked on 12/24/25 but did not witness the incident between Resident #1 and Resident #2. During an interview on 1/8/26 at 12:40 p.m., the DON stated Resident #1 had not had any physical altercations with any of the residents. She stated the resident planned to transfer to another facility on 12/29/25 to be closer to his family. The facility notified law enforcement of the incident on 12/24/25, county deputies arrived shortly after that and took the resident into custody and there were charges against him related to the incident. The DON stated they had re-assessed Resident #1's BIMS about 2 weeks before the incident and it was 13 at that time (indicated no cognitive impairment). The DON stated nursing staff assessed Resident #2 for injuries after the incident, and none were found. Review of the facility's policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention policy, dated 10/2023 directed staff: a. Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. b. This policy consists of a facility-wide commitment and resource allocation to support the following objectives that include, but are not limited to: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, and any other individual. c. Develop and implement policies and protocols to prevent and identify abuse, neglect, or mistreatment of residents, and/or theft, exploitation or misappropriation of resident property. d. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems. e. Provide staff orientation and training/orientation programs that include topics such as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. f. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. g. Investigate and report any allegations within timeframes required by federal requirements. h. Protect residents from any further harm during investigations.</p> | | |

| | | | |
|--|---|---|--|
| 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 01/30/2026 |
| 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) | | |
| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and staff interviews the facility failed to ensure that residents are free from financial exploitation for 1 of 9 residents (Resident #3) reviewed. The facility reported a census of 62 residents. Findings include: Review of Resident #3 Minimum Data Set (MDS) assessment, dated 8/11/25 revealed a diagnoses list that included adult failure to thrive, type 2 diabetes with unspecified complications, alcoholic cirrhosis of liver without ascites (fluid accumulation in the abdomen), anxiety, and depression. The Brief Interview for Mental Status (BIMS) score of 10 out of 15 points indicated a moderate cognitive impairment. The MDS indicated Resident #3 always able to make herself understood and always understood others. The MDS identified the resident totally dependent on staff for substantial assistance to reposition in bed, transfer to and from bed or chair, and unable to stand or ambulate. Review of a Facility Self-Reported Incident, dated 12/7/25, revealed When having a discussion with Resident [name redacted, Resident #3], bims of 13. It was brought to the Administrators attention that [name redacted, Resident #3] let CNA [name redacted, Staff H, Certified Nursing Assistant (CNA)] her food stamp card to spend on herself. Review of Resident #3 Care Plan revealed a problem labeled I have actual and/or the potential for inability to cope with my lifestyle changes, limitations in my functional abilities and my husband no longer being able to act as my caregiver due to his own health complications, initiated 8/29/25. The plan directed staff to: a. Assist the resident to identify, access and use support systems of family, initiated 8/29/25. b. Encourage and allow me time to express my feelings re: difficulty coping with lifestyle changes. Allow me time to grieve, initiated 8/29/25. c. Encourage the resident to express feelings of anger, frustration and/or concerns, as appropriate. She likes 1:1 conversation, initiated 8/29/25. d. The resident needs assistance with problem solving, initiated 8/29/25. The Care Plan included a new problem labeled Involved in an allegation of misappropriation of funds by staff member, initiated 12/9/25, which directed staff to: a. Psychosocial wellbeing check in 2x a week for 2 weeks, then as needed, initiated 12/10/25. b. Resident education completed that only administrative staff will use personal money cards for personal items. Resident understood and agreed with education, initiated 12/9/25. During an interview 1/12/26 at 12:14 p.m., Resident #3 stated she had an EBT (Electronic Benefits Transfer) Food Stamp card for several years. She stated she received \$171 monthly in benefits. Resident #2 stated she didn't always like the food served at the facility and wanted some snacks, so she asked Staff H, CNA to use her EBT Food Stamp card to purchase some snacks for her. She told Staff H that she could buy some things for herself with the card as well. Resident #3 stated she did not give Staff H an amount that she could spend and didn't know what she'd purchased for herself. Resident #3 stated she recalled the total purchased was for a little over \$100, and Staff H returned the EBT Food Stamp card. Resident #3 stated she didn't think she did anything wrong, as she didn't think she had any way to get the food and Staff H was helping her. The resident stated she didn't want anyone to be in trouble over this and after it happened was when she found out there were staff at the facility that could have shopped for her. During another interview on 1/14/26 at 1:10 p.m., Resident #3 stated some of the items purchased required refrigeration, she didn't have access to the refrigerator and sort of lost track of those items. She stated Staff H, CNA gave her the receipt for the purchase but she didn't have it any more. During an interview on 1/8/26 at 12:40 p.m., the Director of Nursing (DON) stated they learned Resident #3 gave her EBT Food Stamp card to Staff H, CNA when a nurse reported the situation after a conversation with the resident. The DON explained Resident #3 stated she gave the card to Staff H to get food items for her and told Staff H she could get some food for herself. The DON stated Staff H</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|---|--|
| 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 01/30/2026 |
| 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) | | |
| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>was questioned and she stated she got food for the resident and for herself. DON stated Staff H didn't say what she spent on herself. The DON added that Staff H was terminated as a result and the facility reported the matter as required to the State Agency and the local police. During an interview on 1/14/26 at 10:30 a.m., Staff H, CNA, stated the resident wanted some snacks and asked her to take her [Resident #3's] EBT Food Stamp card to the store, purchase food for her [Resident #3] and said she [Staff H] could buy some food for herself as well. Staff H stated this occurred in October and she shopped at a grocery store located in [NAME]. Staff H stated she spent a little over \$100 and used the resident's EBT Food Stamp card for the purchase. Staff H stated the resident checked the balance on the card before she gave it to her and it was \$230 or \$300. Staff H couldn't recall what she purchased for herself, then said it was a bag of chips, a 20-ounce soda and she couldn't remember what else, but was only a few items. Staff H stated she brought the resident's requested groceries to the facility in 4 or 5 grocery bags, refrigerated items were placed in the refrigerator in the beauty shop, and she returned the EBT Food Stamp card to the resident with the receipt. Staff H stated she had been a CNA since 2014, and had education on dependent adult abuse and didn't think she had done anything wrong because the resident told her she could purchase items for herself with the EBT Food Stamp card. During an interview on 1/12/26 at 12:20 p.m. Staff A, CNA and Restorative Aide (RA) stated she did not know about the situation with the resident's EBT Food Stamp card until after it occurred. She stated she was questioned by management staff. Staff A stated she knew it was wrong to use a resident's resources or accept gifts from a resident and that information was covered in the dependent adult abuse education that she received prior to employment at the facility. During an interview on 1/14/26 at 12:21 p.m., Staff L, [NAME] President of Operations for the facility's corporation stated they reimbursed the resident \$25 for the items Staff H purchased for herself with the resident's EBT Food Stamp card, and would reimburse the total amount to the resident once known. Staff L stated the resident and staff were educated on dependent adult abuse that included financial exploitation, and there were designated staff at the facility that could shop for residents and who should shop for the residents when the need arose. A document received from Staff L, [NAME] President of Operations dated 1/30/26 described both she and the facility Social Worker met with the resident on 1/28/26, reviewed the purchases on the grocery store receipt dated 10/8/25 with the resident, the resident identified several items that she did not ask Staff H to purchase, those items totaled \$115.96 and believed to be what Staff H had purchased for herself with the resident's EBT Food Stamp card. Review of a grocery store receipt dated 10/8/25, obtained by the State Agency on 1/22/26 revealed a total of 68 items purchased with Resident #3 EBT Food Stamp card for a total of \$268.93. The facility's Abuse, Neglect, Exploitation and Misappropriation Prevention policy, version 10/2023 directed staff: a. Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. This policy consists of a facility-wide commitment and resource allocation to support the following objectives that include, but are not limited to: a. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, and any other individual. b. Develop and implement policies and protocols to prevent and identify abuse, neglect, or mistreatment of residents, and/or theft, exploitation or misappropriation of resident property. c. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral,</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| 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 01/30/2026 |
| 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) | | |
| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>cognitive or emotional problems.d. Provide staff orientation and training/orientation programs that include topics such as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior.e. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property.f. Investigate and report any allegations within timeframes required by federal requirements.g. Protect residents from any further harm during investigations.</p> | | |