STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165220	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Prairie Ridge	608 Prairie Street Mediapolis, IA 52637

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and residents interviews, record review, and the facility policy, the facility failed to treat residents in a dignified manner for 3 of 3 residents (Resident #11, Resident #21, and Resident #33) reviewed for dignity. The facility reported a census of 53 residents, Findings include: 1.The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 scored a 5 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition severely impaired. The MDS indicated the resident required supervision or touching assistance with eating. The MDS revealed medical diagnoses for stroke, aphasia following cerebral infarction. The Care Plan revealed a focus area revised on 6/25/25 for difficulty swallowing and pocketing food status post cerebral vascular accident. The intervention revised on 7/16/25 indicated distant supervision; Resident #11 will pocket solids and liquids, he is able to clear when allowed. Please do not instruct Resident #11 to swallow or prevent him from taking the next bite or sip, if Resident #11 holds his food or liquid for a really long time, you many ask him to put his chin down, this triggered a swallow. The interventions revised on 7/30/25 indicated regular diet with thin liquids with mechanical soft texture. During an interview on 7/29/25 at 10:06 AM, Resident #11 stated staff told him to chew and swallow his food, but Resident #11 couldn’t remember their names. During an interview on 7/29/25 at 11:03 AM, the Speech Therapist stated Resident #11 continued to voice that staff told him to chew and swallow. The Speech Therapist stated she witnessed staff take Resident #11 plate away from him. The Speech Therapist stated she approached the staff and staff admitted taking away the plate, and educated staff on the proper approach. The Speech Therapist stated she wrote multiple recommendations and explained to the staff member what worked better for Resident #11. The Speech Therapist stated she believed Resident #11 and had not been diagnosed with dementia and he was able to have a conversation. During an interview on 7/30/25 at 9:18 AM, Resident #11 stated multiple people told him to chew and swallow. Resident #11 stated the staff took his plate away. Resident #11 stated staff rubbed his cheek and told him to chew. Resident #11 showed how the staff rubbed his cheek. Resident #11 stated it made him feel disgusting. Resident #11 stated staff told him to chew and swallow in a mean tone. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/31/25 at 2:26 PM, Staff G, CNA (Certified Nurse Aide) queried on what type of assistance Resident #11 required and Staff G stated staff watched Resident #11 eat in the dining room. Staff G stated Resident #11 pocketed his food and Staff G would slid his plate away from him sometimes when his mouth was too full. Staff G stated the speech therapist told Staff G to hold back from cueing but the pocket got to big and Staff G was aware Resident #11 would choke. Staff G asked if she ever rubbed Resident #11 cheek when Staff G assisted him with eating and she stated yes and told Resident #11 to chew and swallow. During an interview on 8/4/25 at 11:09 AM, the Physical Therapist (PT) queried if she had any concerns with staff interactions with Resident #11 eating and PT stated she witnessed staff get frustrated with Resident #11. PT stated therapy staff would then tell Resident #11 to tuck his chin. PT stated she heard staff tell Resident #11 to chew and swallow and Resident #11 can’t have anymore food until he swallowed. PT asked if she ever seen staff rub Resident #11 cheek and PT stated Staff G rubbed his cheek and said swallow. PT stated the verbiage sounded aggressive and PT felt anytime someone rubbed someone’s cheek it was aggressive. During an observation on 8/4/25 at 12:31 PM, staff in the dining room next to Resident #11. Staff asked him if he was going to save his food like a chipmunk and asked him to swallow his food. Resident #11 made slow movements and then took another bite. Resident #11 ate his meal independently. During an interview on 8/4/25 at 4:15 PM, Staff J, CNA queried on the type of assistance Resident #11 required for eating and Staff J stated it depended on the day. Staff J stated sometimes Resident #11 took more cueing to make sure he swallowed between bits. Staff J stated if Resident #11 not swallowing, she moved his plate away from him and gave him something to drink. During an interview on 8/6/25 at 9:43 AM, the Director of Nursing (DON) stated Resident #11 didn’t want to swallow and telling Resident #11 to swallow was a trigger word. The DON stated staff needed to tell Resident #11 to tuck his chin. The DON stated when staff told Resident #11 to slow down, he filled both his cheeks with food. The DON stated it was not appropriate to rub Resident #11 cheeks and she told the aide who did, not to touch his cheek. The DON confirmed staff should not be touching Resident #11 plate either. 2. The MDS assessment dated [DATE] revealed Resident #21 scored a 15 out of 15 on the BIMS exam, which indicated cognition intact. During an interview on 7/28/25 at 3:33 PM, Resident #21 stated one of the staff members on the third shift was on her phone the whole shift. Resident #21 stated in her opinion, the staff didn’t want to be here and it made her feel beneath them and bad for asking for help. During an interview on 7/31/25 at 2:19 PM, Staff G, CNA asked about staff phone use and Staff G stated she witnessed staff walking down the hallway with a resident and answered a video chat. Staff G stated she told the Assistant Director of Nursing (ADON) and the DON and they discussed it in meetings. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/5/25 at 8:12 AM, Social Services queried if staff used their personal phones when doing resident cares and Social Services stated yes, she walked into the rooms and the staff would hurry up and put their phones in their pockets. Social Social stated all the staff had their phones on them and the residents got very irritated about it because the residents wanted staff to talk and take care of them, not someone else. During an interview on 8/05/2025 at 2:29 PM, Staff L, Registered Nurse (RN) stated CNAs would text and watch videos in the hallways when the residents slept, but not during cares. Staff L stated she wouldn’t allow staff to use their phones when call lights were going off. During an interview on 8/6/25 at 9:58 AM, the ADON stated the facility had a phone policy and the ADON went over it several times with staff. The ADON stated she understood when residents requested to see family photos, but the staff should not be showing [NAME] and tik toks. The ADON stated she instructed staff to engage with the residents during cares not with each other. The ADON stated the maintenance staff would see staff with phones and tell them to put them away or he would write them up. The ADON stated phone use was not expectable even at night because they had tasks they needed to do. During an interview on 8/6/25 at 9:58 AM, the DON stated staff should not be their phones and the same goes for all the shifts. During an interview on 8/6/25 at 11:05 AM, Staff M, Qualified Nurse Aide (QMA) queried if staff use their phone during resident cares and Staff M stated yes and even though Staff M wasn’t in a leadership roll, she told her coworkers to wait until they were done with cares. Staff M stated some of the residents got upset. Staff M stated some staff answer personal calls and facetime calls in front of residents. Review of the facility Cell Phone Policy dated 12/1/24 revealed the following: a. Personal cell phones and electronic devices are only permitted in patient care areas for authorized business purposes and only in compliance with HIPAA. Using personal cell phones for calls and texting is not permitted during working hours but may be used on break and in designated break areas. All cell phones must be on silent ringer or vibrating mode. Personal cell phones and phone earpieces are not to be carried or worn during working hours. Use of cameras or audio recordings, including camera phones, are prohibited on Company property unless authorized in writing by your supervisor or Human Resources. 3. Review of the MDS assessment for Resident #33 dated 4/24/25 revealed the resident scored 14 out of 15 on a BIMS exam, which indicated intact cognition. Per this assessment, the resident was always incontinent of bowel and bladder. Review of the resident's Care Plan did not have a focus area for incontinence. Review of Resident #33's current task documentation revealed, B&B (bowel and bladder)- Bladder Elimination: resident incontinent wears Large briefs. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/29/25 at 12:07 PM, Resident #33 observed in their room, and interview conducted. Resident #33 explained facility would run out of briefs, and no one should ever be without the size they wear. Resident #33 stated right now the facility ran out of size need, and had to borrow some until Thursday. The resident expressed he did not feel like well cared for with the briefs, and reiterated that nobody should be without the size they need, ever. Per Resident #33 they were last changed 2 to 3 hours ago, and got a couple brief borrowed before that didn't have any. Per the resident, there had been times had to wear a brief two sizes too big. On 7/31/25 at 2:01 PM, Staff G, CNA explained the facility did not have enough supplies, and were told when run out to tell the nurse, and on call would be notified who would take care of it. Per Staff G, there was a weekend when they took the last tab brief, Staff G notified the nurse, and the nurse was going to notify on call. Per Staff G, they did not get any until Wednesday when the truck came. Staff G further explained if did not have the right size residents would go in a different size, and per Staff G would get red, raw, sores. Per Staff G, if no tab briefs put all in pull ups, and had residents so mad. On 7/31/25 at 3:40 PM, observation of the stock room completed with Staff F, Staffing Coordinator present. Present in the stock room were large briefs, extra large, and sizes larger than extra large. When queried about running out of briefs, Staff F confirmed. Staff F believed this occurred because staff went to the room next door to get briefs which caused the facility to run out. When queried why she felt staff were going to the resident rooms next door for briefs, Staff F explained because she would come in and residents were in wrong size or briefs they had never been in, pull up versus tab brief, etc. On 7/31/25 at 5:10 PM, the DON explained she ordered every week, and followed the formulary. Per the DON, the biggest complaint was never enough. Per the DON, the facility had a cart for depends, and were supposed to take as went and did rounds. The DON explained the facility always had the size needed, and felt not getting used like it should have been. The Facility Resident Rights Guidelines for all Nursing Procedures Policy dated October 2010 revealed the following: a. Prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on resident rights, including: 1. resident dignity and respect.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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F 0580 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 staff interviews, record review, and the facility policy, the facility failed to notify the physician of a resident's weight loss for two different occurrences for 1 of 3 residents reviewed for nutrition (Resident #7). The facility reported a census of 53 residents. Findings Include: The MDS assessment dated [DATE] revealed Resident #7 scored a 15 out of 15 on the BIMS exam, which indicated cognition intact. The MDS revealed a loss of 5% or more in the last month or loss of 10% or more in 6 months and on a therapeutic diet. The MDS revealed resident took an diuretic. The Care Plan revealed a Focus area revised on 8/6/25 for I am at nutritional risk s/p (status post) acute on chronic CHF (Congestive Heart Failure) with h/o (history) Type 2 DM (diabetes mellitus), COPD (Chronic Obstructive Pulmonary Disease), morbid obesity, gout, hypothyroidism, hyperlipidemia, pneumonia.8/1/25- significant weight loss over 6 months. The Interventions dated 1/2/24 revealed meal enrichment/planned snacks: at least 1 cup of white milk at each meal and weight at least weekly x 1 month after admit, then at least monthly or as recommended. The interventions dated 7/24/25 revealed to offer supplements as ordered. Review of the Weight Summary document as of 8/6/25 revealed on 02/06/2025, the resident weighed 228 lbs. (pounds). On 07/18/2025, the resident weighed 203.6 lbs. (pounds) which is a -10.7% Loss.The Dietary Progress Note dated 4/9/25 at 11:16 PM, revealed significant Weight LOSS: (-) 5.2 % X 1 mo. (month). Dietitian Observations/Recommendations: Wt. (weight)-219#(4/07) [BMI(body mass index) = 41.4, 95% UBWR (Usual Body Weight Range) of 230# +/- 3# from admit to [facility name redacted] to hospitalization on 3/27. Resident s/p (status post) hospitalization for metabolic encephalopathy and was started on IV (intravenous) antibiotics then most recently treated with a Nystatin mouth wash started on 4/4 for erythema which contributed to poor meal intakes of 25- 30% and weight loss. Per Charge Nurse--this RD (Registered Dietician) talked to tonight--mouth looks much improved and RD notes meal intakes have improved to ~60 - 65% which were usual intakes. Would suggest weekly weights X 2 weeks and RD will follow. See significant weight loss Fax to clinician.The Family Practice Note dated 4/18/25 at 3:51 PM revealed weight measured of 107.3 kg (4/3/25 at 3:54 AM) and weight estimated on 3/27/25 at 2:46 AM. The Family Practice Note did not address a significant weight loss. Review of the Weight Summary documented revealed weights completed on 4/10/25, 5/29/25, 6/5/25, 7/1/25, 7/18/25, and 8/1/25. The Dietary Note dated 6/1/25 at 3:53 PM, revealed RD notes Significant Weight LOSS: (-) 5.0% X 1 mo.[actual is 49 days as reference wt. is 219#(4/10)]], (-) 8.7% X 3 mos.[actual is 109 days as reference wt. is 228#(2/09)]. Dietitian Observations/Recommendations: Wt. - 207.5#(5/29)[BMI = 39.3] Resident is on Consistent Carbohydrate Diet and diet has returned to usual at ~65-70% s/p recent death of husband. Previous significant weight loss fax was sent to clinician in April s/p hospitalization where resident was on IV ATB and developed oral candidiasis which decreased intakes. Resident is on a meal enrichment strategy and RD will follow weights as available. RD notes that yesterday resident ate 85-90% of meals. See weight change notification fax to clinician.The EHR (electronic health record) revealed the following Physician Orders: Nutritional supplement 4 ounces one time a day with a start date of 7/30/25. Per email on 8/4/25 at 10:46 PM, the Regional Nurse Consultant communicated she did not see the notification for Resident #7 weight, but she was her own person. During an interview on 8/4/2025 at 11:42 AM, Resident #7 stated she lost weight, probably around 50 pounds. Resident #7 stated she just lost her husband and the food tasted terrible. Resident #7 stated she drank a shake.During an interview on 8/6/25 at 10:18 AM, the ADON (Assistant Director of Nursing) stated she was still digging through things to find the notification to the doctor for her significant weight loss. Per email from the Regional Nurse Consultant dated 8/4/25 at 12:56 PM, the RD [name redacted] wrote out faxes that the DM faxed out with the notifications on them. The RD and the Dietary Manager that worked during April to June no longer worked at the facility. The facility failed to supply documentation the physician notified/aware of the weight losses. Review of a facility policy titled, Change in a Resident's Condition or Status dated February 2021 revealed the following:a. The nurse will notify the resident's attending physician or physician on call when there has been a(an): 1. significant change in the resident's physical/emotional/mental conditionb. A significant change of condition is a major decline or improvement in the resident's status that: 1. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); 2. requires interdisciplinary review and/or revision to the care plan

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **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 update Care Plans to reflect two residents had a significant weight loss and one resident no longer received dialysis services for 3 of 18 (Resident #7, Resident #11 and Resident #3) reviewed for Care Plans. The facility reported a census of 53 residents. Findings include: 1.The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 scored a 15 out of 15 on the Brief Interview of Mental Status (BIMS) exam, which indicated cognition intact. The MDS revealed a loss of 5% or more in the last month or loss of 10% or more in 6 months and on a therapeutic diet. The MDS indicated Resident #7 took a diuretic (often called a water pill, a medication to help the body eliminate excess salt and water). Review of the Care Plan revealed a Focus area revised on 8/6/25 for I am at nutritional risk s/p (status post) acute on chronic CHF (Congestive Heart Failure) with h/o (history) Type 2 DM (diabetes mellitus), COPD (Chronic Obstructive Pulmonary Disease), morbid obesity, gout, hypothyroidism, hyperlipidemia, pneumonia…. 8/1/25- significant weight loss over 6 months. The Interventions dated 1/2/24 revealed meal enrichment/planned snacks: at least 1 cup of white milk at each meal and weight at least weekly x 1 month after admit, then at least monthly or as recommended. The interventions dated 7/24/25 revealed to offer supplements as ordered. Review of the Weight Summary dated 8/6/25 revealed on 02/06/2025, the resident weighed 228 lbs. (pounds). On 07/18/2025, the resident weighed 203.6 lbs. which is a -10.7% Loss. During an interview on 8/6/25 at 10:18 AM, the (Assistant Director of Nursing) ADON stated Resident #7 Care Plan should be updated with the significant weight loss. 2.The MDS assessment dated [DATE] revealed Resident #11 scored a 5 out of 15 on the BIMS exam, which indicated cognition severely impaired. The MDS indicated the resident required supervision or touching assistance with eating. The MDS revealed medical diagnoses for stroke, aphasia following cerebral infarction. The MDS indicated resident not had a weight loss of 5% in one month or 10% in 6 months and not on a therapeutic diet. Review of the Care Plan revealed a Focus area revised on 5/15/25 for nutrition: Resident #11 at nutritional risk due to s/p (status post) cerebral infarction, stenosis of right carotid artery, UTI (Urinary Tract Infection), hyperlipidemia, HTN (hypertension), Vitamin D Deficiency, Hernia. Review of the Weight Summary document dated 7/29/25 revealed on 02/21/2025, the resident weighed 161 lbs. On 07/01/2025, the resident weighed 137 lbs which is a -14.91% Loss. During an interview on 8/6/25 at 9:08 AM, the MDS Coordinator queried on who updated the nutrition areas of the care plans, and she stated the dietician used to update it and the dietician recently left the facility. The MDS Coordinator stated she hadn’t gotten with the interim, who works remotely to review who would update the care plan. The MDS Coordinator confirmed the Focus area for risk for nutrition should be updated to significant weight loss for Resident #7 and Resident #11. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/6/25 at 9:52 AM, the ADON confirmed Resident #11 care plan needed updated to reflect a significant weight loss. 3.Review of the MDS assessment for Resident #3 dated 6/26/25 revealed a BIMS score of 15 out of 15 which indicated intact cognition. Per this assessment, the resident was not on dialysis while a resident. Review of the Care Plan, dated dated 6/14/24, revised on 6/29/25, revealed a Focus area to address I have an alteration in in my renal functioning d/t (due to) I have CKD (chronic kidney disease) stage 3 and require dialysis. During an interview on 7/30/25 at 1:25 PM, Resident #3 explained he had been on dialysis probably six to eight weeks, and he didn't know why it had been shut off. Per Resident #3, when he went to the hospital he had been started on it. Resident #3 confirmed he was no longer on dialysis. On 7/30/25 at 3:07 PM, the MDS Coordinator queried if Resident #3 on dialysis now, and she responded the resident is no longer on dialysis. Per the MDS Coordinator the resident had refused dialysis. When queried if the resident had been off dialysis for awhile, the MDS Coordinator responded she did not know if had been on dialysis, and further explained when the resident first admitted a little over a year or so ago dialysis had been recommended and resident said no. The MDS Coordinator explained the resident may have had treatment in the hospital, and did not believe resident had been on it since at facility. During an interview on 7/30/25 at 3:12 PM, the MDS Coordinator explained she would go fix the resident's Care Plan. During an interview on 7/31/25 at 5:00 PM, the facility's Regional Nurse Consultant (RNC) explained Resident #3 not on dialysis, and the Care Plan was now fixed. Review of the facility policy titled, Care Plans, Comprehensive Person-Centered, dated 12/23, revealed the following: a. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents’ conditions change. b. The interdisciplinary team reviews and updates the care plan: 1. when there has been a significant change in the resident’s condition;

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 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, clinical record review, facility policy review, and resident and staff interviews, the facility failed to follow speech therapy recommendations for eating assistance for 1 of 18 residents reviewed for following provider orders (Resident #11). The facility reported a census of 53 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 scored a 5 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition severely impaired. The MDS indicated the resident required supervision or touching assistance with eating. The MDS revealed medical diagnoses for stroke, aphasia following cerebral infarction. The MDS indicated resident not had a weight loss of 5% in one month or 10% in 6 months and not on a therapeutic diet. Review of the Care Plan revealed a Focus area revised on 6/25/25 for difficulty swallowing and pocketing food status post cerebral vascular accident. The Intervention revised on 7/16/25 indicated distant supervision; Resident #11 will pocket solids and liquids, he is able to clear when allowed. Please do not instruct Resident #11 to swallow or prevent him from taking the next bite or sip, if Resident #11 holds his food or liquid for a really long time, you many ask him to put his chin down, this triggered a swallow. The Interventions revised on 7/30/25 indicated regular diet with thin liquids with mechanical soft texture. Review of the EHR (Electronic Health Record) revealed an order for PT/OT/SP (physical therapy/occupational therapy/speech therapy) to evaluate and treat as indicated. Revision Date 7/7/25. The Speech Therapist recommendations dated 4/25/25 revealed the following for Resident #11: Feeding/Dietary: Recommend continued mech (mechanical soft diet) soft solids and nectar liquids. Please do not cue patient to swallow or touch him. He will pocket food but he is able to clear on his own. It is okay to ask him to tuck his chin, this will elicit a swallow. He has swallowing apraxia- so the more you say to him the worse it gets. Per [name redacted]. Distant supervision. The Speech Therapist recommendations dated 5/5/25 revealed the following for Resident #11: Feeding/Dietary: Recommend regular solids with the exception of raw vegetables. Recommend thin liquids, distant supervision. He can be occasionally cued to put his chin down and swallow if needed. He will pocket his food but he will clear it. Please do not cue him. The Speech Therapist recommendations dated 7/9/25 revealed the following for Resident #11: Feeding/Dietary: Recommend continued regular solids and thin liquids. Distant supervision. [NAME] will pocket solids and liquids- he is able t clear when allowed. Please do not instruct him to swallow or prevent him from taking the next bit or sip. If he shows holding food or liquid for a really long time- you may ask him to put his chin down- this will trigger a swallow.During an interview on 7/29/25 at 11:03 AM, the Speech Therapist stated if Resident #11 had to stop and think about the process, Resident #11 would stop eating. The Speech Therapist stated if she gave quiet cues, he did good. The Speech Therapist stated she completed education with the staff on how to help Resident #11 with eating and written multiple recommendations. During an interview on 7/30/25 at 9:18 AM, Resident #11 stated multiple people told him to chew and swallow. Resident #11 stated the staff took his plate away. Resident #11 stated they rubbed his cheek and told him to chew.During an interview on 7/31/25 at 2:26 PM, Staff G, CNA (Certified Nurse Aide) queried on what type of assistance Resident #11 required and Staff G stated they watched Resident #11 eat in the dining room. Staff G stated Resident #11 pocketed his food and Staff G would slid his plate away from him sometimes when his mouth was too full. Staff G stated the speech therapist told Staff G to hold back from cueing but the pocket gets to chew. Staff G queried on what direction Staff G was given for assistance with Resident #11 and Staff G stated a mix of things. Staff G stated the nurses told her not to let Resident #11 put more food in his mouth, but the speech therapist said it was alright for the resident to put more food in his mouth.During an interview on 8/4/25 at 11:09 AM, the Physical Therapist (PT) queried if she had any concerns with staff interactions with Resident #11 eating and PT stated she witnessed staff get frustrated with Resident #11. PT stated the therapy staff told Resident #11 to tuck his chin. PT stated she heard staff tell Resident #11 to chew and swallow and Resident #11 can't have anymore food until he swallowed.During an interview on 8/4/25 at 11:09 AM, Physical Therapist (PT) queried if their recommendations were orders and PT stated they get an order to treat from the provider and the therapy department assessed and gave recommendations, and since they had the order to treat, the recommendations were orders. The PT stated the nursing staff could downgrade the order when a resident struggled, but could not upgrade orders, therapy could only do that.During an observation on 8/4/25 at 12:31 PM, staff in the dining room next to Resident #11. Staff asked Resident #11 if he was going to save his food like a chipmunk and asked him to

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Azria Health Prairie Ridge	608 Prairie Street Mediapolis, IA 52637

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 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, clinical record review, facility policy review, and resident and staff interviews, the facility failed to provide an intervention in a timely manner for a resident who complained of a rash and associated discomfort for 1 of 18 residents (Resident #21) reviewed for assessment and intervention. The facility reported a census of 53 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 scored a 15 out of 15 on the Brief Interview for Mental Status exam, which indicated cognition intact. The MDS indicated resident required partial/moderate assistance with upper body dressing; and substantial/maximal assistance with shower/bathing self. Review of the Care Plan revealed a Focus area revised on 7/29/25 for increased risk for impairment of skin integrity and potential pressure ulcer development related to fragile skin, history of pressure wounds and mobility impairment.The interventions dated 7/21/25 revealed avoid scratching and keep hands and body parts from excessive moisture. During an interview on 7/28/25 at 3:44 PM, Resident #21 stated she was told she would see the doctor last Thursday and she didn't. Resident #21 stated she wanted them to get ahold of her personal doctor so Resident #21 could get her standing prescriptions. Resident #21 stated it is red under her breasts and she told the nurses. Resident #21 lifted her shirt and under her left breast was reddened. Review of the EHR (electronic health record) revealed a N Adv-Skin Check note entered on 7/30/25 at 9:34 AM revealed seven different skin issues assessed. The reddened area under Resident #21 left breast not an assessed area. During an interview on 7/31/2025 at 12:40 PM, Resident #21 stated she just saw the doctor and she had to chase her down all morning. Resident #21 stated she shown the doctor and Central Records. Resident #21 stated her chest was seeping now and under both breasts. Review of a Nurse's Notes entered on 8/2/25 at 3:15 AM, revealed Pt (patient) called asking for Tylenol she was in pain due to her rash and her buttocks. Pt has a rash that extends from both breast down the middle of chest and onto abdomen. Pt rash is red and raised from skin. No odor noted. Pt bumps looks wet/moist like fluid but not like sweat in the folds of skin. Pt states it hurts. Pt state that it itches sometimes PCP (primary care provider) faxed for follow up and [end of note] Review of a N ADV Skilled Evaluation note, entered on 8/2/25 at 3:18 AM, revealed #006: New skin Issue. Location: Chest - generalized. Laterality / Orientation: Circumferential. Issue type: Other skin issue. Other skin issue description: Redden raised bumps with fluid Wound acquired in-house. Painful: Yes. Wound pain (Frequency): Continuous. Pain description: Sharp. The N ADV Skilled Evaluations continued to document the new skin issue on the resident's chest until 8/5/25. During an interview on 8/5/25 at 10:54 AM, Resident #21 stated her breast area was improved. Resident #21 stated in the shower, the old skin came off and new skin present. Resident #21 stated she took care of it herself and put a cream on it. Resident #21 stated she knew she was not supposed to be doing that. Review of the EHR revealed a Nurse's Note entered on 8/6/25 at 11:32 AM revealed - PCP (primary care provider) notified that res (resident) cont (continued) to have red raised rash on torso with complaints of occasional itching. New verbal orders received: 1. Mometasone 0.1% daily to rash until resolved and then DC (discontinue). Res (resident) is aware unable to reach family at this time. Review of Physician Orders revealed an order for Mometasone Furoate External Cream 0.1 % (Mometasone Furoate)- apply to rash topically every day shift for wound care DC when resolved- ordered 8/6/25. During an interview on 8/6/25 at 10:07 AM, the Assistant Director of Nursing (ADON) stated Staff L, Registered Nurse (RN) said something to the ADON on Saturday, but the ADON did not see the rash. The ADON reviewed the progress notes and stated the communication noted, but not the documentation for a response. The ADON stated the doctors usually respond quickly. During an interview on 8/5/25 at 2:22 PM, Staff L, RN stated she took care of Resident #21 last weekend and put a note in for the provider. Staff L stated she didn't know what came of it because Staff L went on vacation. Staff L stated she heard about Resident #21 rash from Staff Q, Licensed Practical Nurse (LPN) and Staff Q stated he put a cream on it and Staff L stated Staff L needed an order to put cream on Resident #21. Staff L stated the rash was circumferential and getting worse. During an interview on 8/5/25 at 3:02 PM, Staff Q, LPN stated he saw Resident #21 and used stock medication of petroleum jelly on Resident #21 rash on her chest and sent a note to the provider for Nystatin. Staff Q stated he was not sure if Resident #21 got an order for the cream or not. During an interview on 8/6/25 at 12:32 PM, Central Records stated Resident #21 was not on the list to see the provider on Thursday, but Resident #21 came into Central Records office and lifted her shirt and showed Central Records and the provider her chest. The Nurse Practitioner (NP) asked Resident #21 if it

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and staff interview, the facility failed to implement a restorative nursing program per guidance from therapy for 1 of 1 resident (Resident #25) reviewed for positioning and mobility. The facility reported a census of 53 residents. Findings include: Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Per this assessment, the resident had no impairment to upper extremities, and had impairment to one side of lower extremities. During an interview on 7/29/25 at 9:33 AM, Resident #25 stated she had done restorative exercises one time. Review of the Care Plan last revised 7/18/25 revealed a Focus area to address Restorative Programming required to maintain current level of functional mobility (Ax2 with walker and gait belt for stand pivot transfers), to preserve joint integrity, preserve strength/ROM, and to prevent decline and/or falls. An Intervention, dated 8/10/18 included See Restorative Manual for specific program. Review of a document titled Restorative Care Program sheet, effective date 6/18/25 revealed: The Patient is discharged from: PT (physical therapy). Goals for Restorative Program: Maintain CLOF (current level of functioning) 3-5x/week. Approach/recommendations for implementation of above Yes/No (Circle one) [neither circled]. [Name brand seated bike redacted] l2-L4 10-15 min. Sit to Stand activities at grab bars or FWW (four wheeled walker). Seated B (bilateral) LE (lower extremity) strengthening 2-4 lbs. (pounds) ankle weights – hamstring curl, LAQ (long arc quad, an exercise of seated knee extension), hip abduction, hip adduction, marching. Seated B LE stretching – hamstrings gastric/calf (muscle area in calf). Precautions or comments to this program: Requires encouragement to push herself. May need assistance for sit to stand. During an interview on 7/31/25 at 8:57 AM, Staff A, Restorative, CMA/CNA (Certified Medication Aide and Certified Nursing Assistant) explained Resident #25 is in the rotation for Restorative programming. Staff A stated sometimes she is pulled from Restorative programming for resident care. She stated today she was pulled to do showers. When queried how she did restorative programming if worked the floor, Staff A stated she is unable to explain. Staff A stated activities of daily living could be restorative, and if completed a shower could count as restorative. Staff A stated there were no other staff who were officially assigned do Restorative programming. She stated there was another staff who would sometimes assist. Staff A stated she followed therapies recommendations, and Staff B, Central Supply was the Restorative Nurse. On 7/31/25 at 9:10 AM, Staff B queried about their involvement in Restorative programming, and she stated she helped Staff A put stuff in the computer. She explained, Staff A would come to her with any issues with any of the residents, and Staff A did the weekly charting. Staff B denied doing any Restorative programming with residents. Staff B stated if Staff A was not available sometimes another CNA covered. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/25 at 10:30 AM, the Regional Nurse Consultant (RNC) explained she had talked to Staff B about what to do with restorative, writing, signing off, and checking. Per the RNC, the facility didn't have what considered a technical restorative program, so what they did was follow the recommendations three to five days week as allowed. On 7/31/25 at 5:09 PM, the Director of Nursing (DON) explained they would expect the nurse to fill in if Staff A was gone, or to assign someone else. Review of the facility policy, titled Restorative Nursing Services dated 7/2022 revealed: a. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services (e.g., physical, occupational or speech therapies). b. Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a medication error rate of less than five percent when three medication errors were observed from twenty-seven opportunities for 3 of 6 residents reviewed for medication administration (Resident #28, Resident #33, Resident #36). This deficient practice resulted in facility medication error rate of 11.11%. The facility reported a census of 53 residents. Findings include: 1.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Per this assessment, the resident took insulin for four of the last seven days. The Physician Order dated 7/1/25 revealed, Insulin Lispro Inject as per sliding scale: if 0 - 60 = 0 Units Follow Hypoglycemia Protocol; 61 - 140 = 0 Units; 141 - 180 = 1 Unit; 181 - 240 = 2 Units; 241 - 300 = 3 Units; 301 - 350 = 4 Units; 351 - 400 = 5 Units; 401+ = 0 Units Notify Physician for Instructions, subcutaneously before meals and at bedtime for Diabetes. On 7/30/25 at 12:14 PM, Staff B, Licensed Practical Nurse (LPN) prepared supplies to check the resident's blood sugar. Resident #36 observed at a table in the dining room, and already had foods consumed off of his plate at the table. Staff B took the resident's blood sugar resulting in reading of 200. Staff B then administered 2 units of the resident's Lispro Kwikpen 100 Unit/ml (milliliter). 2. Review of the MDS assessment for Resident #33 dated 4/24/25 revealed the resident scored 14 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Per this assessment, the resident was always incontinent of bowel and bladder. Review of the Physician Order dated 8/22/24 revealed the resident ordered Ferrous Sulfate Oral Tablet 325 MG with directions to take one tablet by mouth two times a day for anemia. On 7/31/25 at 8:13 AM, Staff H, Certified Medication Aide (CMA) administered Resident #33 one tablet of Ferrous Sulfate 324 mg (milligram) EC (enteric coated). 3. Review of the MDS assessment for Resident #36 dated 5/22/25 revealed the resident scored 15 out of 15 on a BIMS exam, which indicated intact cognition. Review of the Physician Order dated 12/6/24 revealed, Polyethylene Glycol Powder (Polyethylene Glycol 1450) with directions to give 17 grams by mouth one time a day for constipation (Mix in 408 oz (ounces) fluid of choice). On 7/31/25 at 8:08 AM, Staff H, Certified Medication Aide (CMA) administered Clearlax 3350 to the resident instead of Polyethylene Glycol 1450. On 7/31/25 at 5:05 PM, the facility's Director of Nursing (DON) queried as to process if difference in order versus what in the cart, the DON responded to call for clarification. Review of the Facility Policy titled Administering Medications dated 2001, revised 4/2019, reveled the following: Medications are administered in a safe and timely manner, and as prescribed. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility Administering Medications Policy dated 6/2022 revealed: a. Medications are administered in accordance with prescriber orders, including any required time frame. b. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure Warfarin and Apixaban, anticoagulant medications, sliding scale insulin, and narcotic pain medication were administered per physician order for four of four residents reviewed for significant medication errors (Resident #20, Resident #36, Resident #55 and #62). The facility reported a census of 53 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Per this assessment, the resident took anticoagulant medication. Review of Resident #20's Physician Order dated 6/13/25, discontinued on 6/17/25, revealed the following: Warfarin, also known as Coumadin) Sodium Oral Tablet 4 mg (milligram) with directions to give 1 tablet by mouth one time a day every Monday, Tuesday, Wednesday, Friday, and Saturday for anticoagulant therapy. Review of the resident's Medication Error Form dated 6/17/25 at 4:30 PM revealed, Nurse reported to this nurse manager that she had started med pass prior to med aide arriving and had given res (resident) afternoon medications and was unable to sign out the Coumadin when med aide arrived and on the cart she took over and noted it wasn't given and gave it again. Res was to receive 4mg (milligram) and was administered a total of 8mg. Review of Resident #20's Medication Administration Record (MAR) dated June 2025 revealed Warfarin Sodium 4mg was signed out on 6/17/25 at 4:42 PM by Staff E, Certified Medication Aide (CMA). Review of the Late Entry Nurses Note dated 6/17/25 at 11:03 PM revealed, gave resident 4 mg of coumadin, MAR was yellow however did not have a way to mark off that i gave the medication, another resident returned to hospital and got him in his room, when leaving room saw med aide giving medication to resident. dr (doctor) and new orders obtained by [name redacted] LPN (Licensed Practical Nurse). hold on 6-18-25 and recheck INR (International Normalized Ratio-lab used for blood clotting) on 6-19-25. On 7/30/25 at 4:51 PM, Staff D, Registered Nurse (RN) queried what it meant if a medication was yellow in system, and she responded meant was something to give them (resident). On 7/31/25 at 5:16 PM, the Director of Nursing (DON) explained the following about the situation: the second shift nurse had come on duty, nurse had a fall and an admit at that time, and were having med aides come in to help or med aide came in from another hall to help. She gave the coumadin, didn't mark on the EMAR (electronic medication administratration record), and when med aide came she then gave the meds which included the coumadin. Per the DON, resident got an extra dose that night. 2. Review of the MDS assessment dated [DATE] revealed Resident #36 scored 15 out of 15 on a BIMS exam, which indicated intact cognition. The MDS list of diagnoses for Resident #36 included diabetes mellitus. Per this assessment, the resident took insulin for four of the last seven days. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Order dated 7/1/25 revealed, Insulin Lispro Inject as per sliding scale: if 0 - 60 = 0 Units Follow Hypoglycemia Protocol; 61 - 140 = 0 Units; 141 - 180 = 1 Unit; 181 - 240 = 2 Units; 241 - 300 = 3 Units; 301 - 350 = 4 Units; 351 - 400 = 5 Units; 401+ = 0 Units Notify Physician for Instructions, subcutaneously before meals and at bedtime for Diabetes. On 7/30/25 at 12:14 PM, Staff B, Licensed Practical Nurse (LPN) prepared supplies to check the resident's blood sugar. Resident #36 observed at a table in the dining room, and already had foods consumed off of his plate at the table. Staff B took the resident's blood sugar resulting in reading of 200. Staff B then administered 2 units of the resident's Lispro Kwikpen 100 Unit/ml (milliliter). Review of the resident's Blood Sugar Summary revealed an entry on 7/30/25 at 12:19 PM for resident blood sugar 200.0 mg/dL (milligram/deciliter). Per Resident #36's Treatment Administration Record (TAR) dated July 2025, 2 units of insulin were administered to the resident on 7/30/25, scheduled per the Treatment Administration Record (TAR) at 11:30 AM. On 7/31/5 at 5:04 PM, the facility's Director of Nursing (DON) explained usually 30 minutes before meal would try to start the sliding scale. 2. The MDS assessment dated [DATE] revealed Resident #55 scored a 15 out of 15 on the BIMS exam, which indicated cognition intact. The MDS revealed the resident received scheduled and as needed medication. The MDS indicated Resident #55 received an opioid medication. Review of the Care Plan revealed a Focus area dated 5/14/23 to address Resident has increased risks for alteration in comfort due to aging and decreased mobility. The Interventions dated 5/14/23 included, in part: Provide me my pain medication as ordered, document and evaluate the effectiveness of my pain medication. Coordinate with NP (Nurse Practitioner) to manage pain medication for optimum pain control. Review of the electronic health record (EHR) revealed a Physician Order for oxyCODONE HCl oral tablet 5 mg…give 5 mg by mouth every 8 hours for chronic pain. Start date: 12/16/24. Review of an Incident Report #1296 for Medication Error dated 6/25/25 at 9:30 PM revealed the following: Incident Description section: a. Nursing Description: Licensed Practical Nurse (LPN) [name redacted] called this DON stating that a medication error had been made. LPN gave 5 mg Oxy (oxycodone) and CMA (Certified Nurse Aide) went to cart to assist LPN with Med Pass and another 5 mg oxy was given. Immediate Action Taken section: a. Description: LPN notified PCP (primary care provider) and order received to monitor vitals for 24 hours. No adverse side effects noted. Review of a Nurse's Note entered at 6/25/25 at 9:48 PM, revealed med error occurred. Resident was given 2 5 mg oxycodones. PCP notified about med error told to get vs (vitals) q (every) 15 min for 2 hrs (hours), q 30min for 1 hour and q 4hrs for 24 hours. VSS (vitals signs stable) when checked. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/5/25 at 11:36 AM, Staff Q, LPN stated he went and gave Resident #55 his medications and then a resident’s bed deflated and he went and helped them. Staff Q stated he forgot to click off the medications given to Resident #55 before Staff M, QMA (Qualified Medication Aide) came over to his hall to help Staff Q with the remaining medication pass. Staff M and Staff Q counted narcotics and Staff Q handed Staff M the keys to the cart. Staff Q stated when he found out Staff M gave Resident #55 another dose of oxycodone he immediately called the DON and the provider and they started vitals on Resident #55. During an interview on 8/6/25 at 11:10 AM, Staff M, QMA stated she remembered the medication error with Resident #55. Staff M stated she went over to help Staff Q because he was drowning and logged him out of the computer and then she logged into the medication cart computer. Staff M stated when she clicked on the medication administration record (MAR), Resident #55 still needed clicked off so Staff Q took Resident #55 his medications. Staff M stated she freaked out when Staff Q asked her if she gave Resident #55 a dose of oxycodone because Staff M never made a medication error before. Staff M stated Staff Q took blame and stated Staff Q should of clicked the medication off the MAR. Staff M stated Staff Q signed the narcotic out in the narcotic book, just not off the MAR. During an interview on 8/6/25 at 3:02 PM, the DON stated Staff Q, LPN had an admission and a fall that night and gave Resident #55 his medications and walked away without clicking them off. The DON stated they did competencies after that and told Staff Q to not leave the cart again without clicking off his medications. 3. Review of the MDS assessment dated [DATE] revealed Resident # 62 scored 15 out of 15 on a BIMS exam, which indicated intact cognition. Per this assessment, the resident is prescribed an anticoagulant medication. Review of the hospital discharge progress notes dated 4/29/25 for Resident #62 revealed the resident is diagnosed with severe pulmonary hypertension. Continue Eliquis (Apixaban) 10 mg twice daily for 6 more doses. Needs lifelong anticoagulation Eliquis 5 mg BID (two times per day). Review of Resident # 62 Hospital Discharge Medication List. Active Medication Orders Prior to Transfer: Apixaban-Take 2 tabs twice daily for 6 more doses then followed by 1, 5 mg tab twice daily thereafter for maintenance. The Physician Order dated 4/30/25 entered by the facility revealed the order was incorrectly entered as Eliquis 5 MG tablet. Take 1 tablet by mouth twice daily. Start date of 5/1/25 and end of 5/3/25. Review of the May 2025 MAR revealed Apixaban Oral Tablet 5 MG. (Apixaban) Give 2 tablet by mouth two times a day for Venous Insufficiency for 2 days Order Date 4/30/25. The MAR reflected Resident #62 was given 2 doses of Apixaban on both 5/1/25 and 5/2/25. During an interview on 8/4/25 at 2:10 PM, the DON queried regarding Resident #62’s medication and in particular anticoagulant Apixaban (Eliquis) 5 mg tab which was listed on the resident’s active Medication Orders Prior to Transfer. The DON stated she had just started at the facility at that time and the hospital discharge order was entered by the Assistant Director of Nursing and the Regional Director of nursing. The facility became aware of the medication error after the resident was discharged . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165220	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Prairie Ridge	608 Prairie Street Mediapolis, IA 52637

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/5/25 at 1:51 PM, the Regional Director of Nursing (RDN) stated that both she and the Assistant Director of Nursing (ADON) entered and reviewed the order. She believes there was a transcription error from when the order was entered. The RDN stated she printed off the packet used for admission. There were five directions for Apixaban from the active medication list from the hospital when the resident was discharged . The physician’s order that should have been entered was entered incorrectly. The RDN explained they did not realize the error until after the resident was discharged . The resident’s primary provider contacted the facility and wanted to know about the medications and this is how the error was discovered. During an interview on 08/05/2025 2:02 PM, the ADON queried about the medication and advised the order had been entered incorrectly, and she stated the facility had problems in the past regarding discharge paperwork from this medical center. The ADON explained in the past they have contacted this medical center for clarification on physician orders and they have had difficulty getting any information or resolution. In this instance the discharging medical center was not contacted for clarification. During an interview on 8/6/25 at 10:40 AM, the facility if the information entered doesn’t match the order from the hospital that is an error on the facility. If there is some discrepancy or something is not clear it is her expectation that the facility nurse entering the order follow up with the hospital or the medical group for clarification. Review of the facility policy titled Administering Medications dated 2001, revised 4/2019, revealed a Policy heading which declared: Medications are administered in a safe and timely manner, and as prescribed. The Policy Interpretation and Implementation section of the policy directed, in part: 4. Medications are administered in accordance with prescriber orders, including any required time frame. 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 10. The individual administering the medication checks the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165220	A. Building B. Wing	08/06/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, facility policy review, and staff interviews, the facility failed to store, prepare and handle food in a sanitary manner in an effort to prevent cross contamination and food borne illness during 2 of 2 kitchen observations. The facility reported a census of 53 residents. Findings include: During the initial tour of the kitchen on 7/28/25 at 1:15 PM, a metal basin observed to contain raw hamburger thawed on an upper shelf of rack. Meal trays with lidded plates rested on the shelf underneath. During an observation on 7/30/25 at 10:03 AM, bags of frozen chicken breasts in a stainless steel basin were placed on the second shelf of the refrigerator. Fruits in the plastic containers with plastic lids sat under the meat on the bottom shelf. Staff N, [NAME] noticed the meat on the second shelf and moved it to the bottom shelf. During an interview on 7/30/25 at 10:04 AM, Staff N, [NAME] stated she kept telling staff to put the meat on the bottom shelf so it didn't drip everywhere. During a continuous observation during the lunch meal service on 7/30/25 at 12:06 PM, Staff N used tongs to take a bun out of the package and then used her gloved hands to open the bun. Staff N did not change her gloves. At 12:07 PM, Staff N took another bun out of the package and opened with gloved hands and then proceeded to move the meal tickets down the line and picked up utensils. At 12:23 PM, Staff N removed the bun from the package using tongs, used the tongs and her gloved hands to open the bun. Staff N didn't remove or change gloves. At 12:24 PM used her gloved hand to put the top of the bun on the hamburger patty on the plate, then moved the hamburger bun to the side of the plate to fit a bowl of cream of mushroom soup on it, and did not remove gloves. At 12:33 PM, Staff O, Dietary Aide scooped ice from an ice container on a cart and left the scoop in the container. The scoop handle continued to laid in the container and then Staff O picked up the handle with her gloved hands, Staff O did not remove gloves and continued to use the scoop. Staff O did not try to keep the handle of the ice scoop out of the ice container. At 12:39 PM, Staff O scooped ice from container, let the ice scoop handle fall into the container. At 12:45 PM the ice scoop remained in the ice container. During an interview on 7/30/25 at 1:09 PM, Staff O, Dietary Aid queried if the ice scoop could stay in the container, and she stated the scoop could stay in the ice container but the handle should not go into the basin because she touched other things with her hands. Staff O asked what she did when gloves were contaminated and she stated take them off and wash your hands and put new gloves on. During an interview 7/30/2025 at 1:21 PM, Staff N, [NAME] queried who took the meat out of the freezer, and she stated the night cook did and confirmed the meat needed thawed on the bottom shelf. Staff N asked about the ice scoop and Staff N stated the handle should not fall in the ice container because of cross contamination. Staff N asked about touching the hamburger buns with her gloved hands and Staff N acknowledged she touched the buns and stated she should of changed her gloves due to cross contamination. During an interview on 7/30/25 at 1:32 PM, Staff P, [NAME] queried where meat needed placed when thawing in the refrigerator, and she stated on the very bottom shelf. Staff P stated she witnessed other people putting it on different shelves. Staff P stated she put the chicken on the very bottom shelf. Staff P stated nothing should be under raw meat. During an interview on 7/30/25 at 3:23 PM, the Administrator confirmed meat needed thawed on the bottom shelf and the handle of the ice scoop should never touch ice. The Administrator stated the cook should had used tongs and if she used her gloved hands, the cook should of changed her gloves.Review of the facility policy titled, Food Preparation and Service Policy dated April 2019 revealed: a. Appropriate measures are used to prevent cross contamination. These include: 1. storing raw meat separately and in drip-proof containers, and in a manner that prevents cross-contamination from other foods in the refrigeratorb. Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness.c. Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks. Disposable gloves are single-use items and are discarded after each use.