STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165373	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Longview	1010 Longview Road Missouri Valley, IA 51555

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. According to the Minimum Data Set (MDS) dated [DATE], Resident #136 was independent with self-care and mobile with the use of a wheel chair. His diagnoses included heart failure, renal insufficiency, diabetes mellitus, anxiety disorder and respiratory failure. The following was found in the nursing progress notes for Resident #136: a. On 1/30/25 at 3:35 PM, mental status upon admission oriented x 3 communicated verbally, speech clear, is able to understand and be understood when speaking. Mood was pleasant no unwanted behaviors witnessed. Arrived by private transportation, reported shortness of breath, b. On 1/30/25 at 4:20 PM, he was admitted to the facility from the hospital at 3:00 PM. He had difficulty ambulating and shortness of breath. The resident required 3-4 liters of supplemental oxygen, stated that he wanted physical therapy to evaluate him in the morning. c. On 1/31/25 at 10:00 AM, Resident #136 wanted to leave Against Medical Advice (AMA) and he signed the required paperwork. He said he was leaving because he wasn't able to stay at the facility. The discharge paperwork from the hospital to the facility, dated 1/30/25 at 2:32 PM, showed that his evening medications included the following: a. Albuterol inhalation 2 puffs 2 times a day the next dose to be given on 1/30 evening dose. b. Chlorhexidine, oral rinse, 15 milliliters, rinse and spit twice daily, the next dose to given on 1/30 evening dose. c. Furosemide, 20 milligrams (mg) one tab, 2 times a day, the next dose to be given on 1/30, evening dose. d. Hydroxychloroquine, 200 mg 2 times a day, the next dose to be given on 1/30, evening dose. A review of the Medication Administration Record (MAR) showed that Resident #136 did not get any of the above medications on 1/30/25. The chart lacked documentation that the doctor had been notified of the omission. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/25 at 8:27 AM, a Family Member (FM) for Resident #136 said that he signed himself out of the facility the day after admission because he wasn't getting good care. The family member said that he wasn't getting his medications and his oxygen tank ran out and no one came to replace the tank until he called the FM, and she had to call the facility to let them know the oxygen tank was empty. The FM said that he called her again later that night, around 9:00 PM and told her that he didn't get his night medications. On 6/11/25 at 10:00 AM, a representative for the pharmacy said that most of the medications for Resident #136 were delivered on 1/31/25 at 2:58 AM. Another delivery went out at 8:01 PM on 1/31/25. The representative said that the fax they received for the medication order was sent on 1/30/25 at 9:38 PM and they sent a driver out to deliver them at 1:20 AM. On 6/11/25 at 2:30 PM, the Director of Nursing (DON) said that as soon as they get medication orders for a new admission, they fax those over to the pharmacy as soon as possible. She said that they have had some glitches with the pharmacy service especially if the admission is later in the day. She said that she would expect a nurse to let the doctor know if a resident had missed his evening medications. On 6/12/25 at 4:00 PM, Staff D, Nurse Consultant, said that she remembered the situation with Resident #136 and from the moment that he came into the facility, he was telling staff that he was going to leave AMA that was why they didn't get the medications ordered from the pharmacy until later that evening. She said she would expect that this would be documented in the nursing notes. A facility policy titled: admission Criteria, dated 2019, showed that prior to an admission the residents attending physician provided the facility with information needed for the immediate care of the resident, including orders covering at least: medication orders, and medical condition associated with each medication. Based on observations, clinical record review, resident interview, pharmacy interview, staff interviews and policy review, the facility failed to follow physician's orders for 2 of 4 residents (Resident #38 and #136). The facility failed to follow physician orders for wound care for Resident #38 resulting in increased edema and detioration of the wound. Resident #136 was admitted to the facility in the afternoon of 1/30/25 and the medication orders were not faxed to the pharmacy until later that evening. The resident missed his night medications and the physician was not notified. The facility reported a censes of 86 residents. Findings include 1. Review of Resident #38's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11/15 indicating moderate cognitive impairment. The document revealed diagnoses of coronary artery disease, heart failure, and peripheral vascular disease. Resident #38's Care Plan dated 5/27/25 revealed a Focus Area for potential for pressure ulcer development with a revision on 4/2/25 for non pressure chronic vascular ulcer right lower leg. Interventions for staff included administration of treatments as ordered and monitor for effectiveness, monitor/document/report any changes as needed (PRN). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observed on 6/9/25 at 12:37 PM Resident #38 wore compression stockings on bilateral lower extremities (BLE). Observed on 6/10/25 at 9:00 AM the resident had compression stockings on BLE. Observed on 6/10/25 at 3:11 PM the resident had compression stockings on BLE. Observed on 6/12/25 at 8:30 AM Staff U, Licensed Practical Nurse (LPN) with Staff P, Assistant Director of Nursing (ADON) present. Staff U removed the resident's right lower extremity (RLE) compression stocking to complete the dressing change. Upon removal of the stocking there was no dressing observed on the outside RLE. On 6/9/25 at 11:25 AM Staff V, Registered Nurse (RN) with Southwest (SW) Iowa Program of All-inclusive Care for the Elderly (PACE) stated Resident #38 was admitted to the facility with a wound to the RLE outer calf. The staff stated the facility had been inconsistent with following the wound care orders as written by the PACE provider. The staff stated when the resident had an order for Kerlix and Coban the staff would only apply at the wound site, instead of wrapping the RLE to minimize edema (swelling). The staff stated when they were present the Kerlix/Coban would be at the wound site causing significant edema above and below the wound. Staff V stated the resident developed cellulitis and was provided antibiotics (Cephalexin 500 mg 4 times/day until 6/6/25). On 6/9/25 at 11:45 AM Staff T, Licensed Practical Nurse (LPN), stated the resident did not have a facility acquired wound. The staff stated they had not received any specific training/education on the resident's wound care. Staff T stated the resident utilized Vaseline gauze for the wound and it was changed every 3 days. On 6/11/25 at 3:54 PM Staff W, Advanced Registered Nurse Practitioner (ARNP)/SW Iowa PACE, stated she did have concerns with the treatments being provided by the facility as they were not following the orders for quite awhile. The staff stated she had been notified by other staff from SW Iowa PACE of the facility not following orders. The staff stated she had witnessed the resident not wearing compression stockings as ordered. On 6/12/25 at 6:30 AM Staff X, RN, stated she had not completed the wound dressing for the overnight as she did not have the time to do so. The staff further acknowledged that a treatment had not been completed on a different date due to time constraints. On 6/12/25 at 8:30 AM Staff U stated Resident #38 only had a Xeroform dressing in place on 6/12/25 when getting up as the resident stated the foam dressing had fallen off. The staff stated they did not replace the foam dressing as the resident would be having a dressing change observation, and left the Xeroform dressing as was with putting compression stockings over it and it was present at the time of the dressing change. On 6/12/25 at 10:00 AM, Staff Y, LPN/SW Iowa PACE, stated she had observed incorrect dressings applied by the facility involving Kerlix and Coban. The staff stated with the incorrect dressing application the resident had increased edema above and below the wound. On 6/12/25 at 10:49 AM Staff T stated the resident had not refused to wear compression stockings. The staff stated dressing supplies were available. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 11:00 AM the Director of Nursing (DON) stated she had conversations with SW Iowa PACE staff regarding the resident not having the correct dressings on per orders. The staff stated she had corrected the orders on the Treatment Administration Record (TAR). The DON stated she expected Xeroform to be covered with an additional dressing unless immediately stepping out of the room to obtain additional supplies. The DON was unaware of supplies not being available. On 6/12/25 at 11:25 AM the Administrator stated she had knowledge of missed treatments due to needs within the facility. The Administrator stated the nurse should have asked for assistance from another nurse on duty to complete the treatment rather than not complete per orders. On 6/12/25 at 12:47 PM Staff W, ARNP, stated the facility not consistently completing treatments as ordered, did not promote healing of the wound and did not benefit the resident's wound healing. The Medication Administration Record (MAR)/TAR for 6/10/25 revealed no documentation for the left ischium treatment. The document disclosed an order for applying edema wear to the left leg in the morning and off at night every shift related to localized edema with a start date of 4/4/25. The document provided each shift marking off the use of edema wear to the left lower extremity. The SW Iowa PACE Health and Physical note dated 3/4/25 revealed the resident was concerned her wound care was not completed as needed. The document further revealed the resident was not wearing compression stockings as ordered. The wound care order dated 3/25/25 provided: Cleanse with Vashe, pat dry, apply skin prep to surrounding intact skin. Vaseline gauze to wound base in double layer, cover with Mepilex border dressing 4x4. Change Q3 days and PRN. The SW Iowa PACE Clinic Progress Note dated 4/1/25 revealed Resident #38's right lateral above ankle site with ankle irregular border shallow oval wound bed with yellowish exudate, surrounding area is red/inflamed - more intense under adhesive area. Lower legs were tight but not pitting per se, not wearing compression stockings. The resident's cellulitis was resolved and the inflammation was from dressing adhesive. The wound care order dated 4/1/25 provided: cleanse with normal saline/Vashe if available, pat dry. Apply Vaseline gauze to the wound bed in a double layer. Cover with foam dressing, no border. Secure with compression dressing such as Kerlix wrap then Coban wrap. Change Q 3 days and PRN. Continue edema ware to the left lower extremity (LLE). The SW Iowa PACE Progress Note dated 4/3/25 revealed new orders provided to the facility with education. The document revealed a statement by an unidentified facility staff stating the Kerlix/Coban order may not be completed as ordered. The SW Iowa PACE Treatment-Wound Care document dated 4/3/25 revealed a blister with an area of 1.5 cm (-63% - decreased), length 1.46 cm (-57%), width 1.32 cm (-38%). The SW Iowa PACE Progress Note dated 4/7/25 revealed an unidentified facility nurse stated the facility did not have Alleveyn, Coban, or Kerlix and inquired if SW Iowa PACE could provide. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SW Iowa PACE Progress Note dated 4/14/25 noted the treatment was provided with Staff T in attendance. The note indicated the dressing changed from what was applied from previous treatment by SW Iowa PACE nurse. The document revealed the facility was not following wound care orders as noted to not have Xeroform applied and the use of a border dressing, noted redness to peri-wound bed from border dressing. The SW Iowa PACE Treatment-Wound Care document dated 4/14/25 revealed the area 1.62 cm (+19% - increased), length 1.42 cm (+25%), width (-8%), and depth - (-100%). The SW Iowa PACE Treatment-Wound Care document dated 4/21/25 revealed the area 2.15 cm (+43%), 1. 57 cm (+8%), weight 1.76 cm (+33%), and depth 0.19 cm (+100%). The wound care order dated 4/21/25 provided: right lower leg, venous stasis ulcer. 1. Cleanse with normal saline/Vashe if available, pat dry. 2. Apply Vaseline gauze to the wound bed in a double layer. 3. Cover with foam dressing. 4. Change every 3 days and as needed if soiled. Facility to complete. 5. Cont to encourage to elevate LEs to level of heart BID to decrease peripheral edema. The SW Iowa PACE Progress Note dated 5/1/25 revealed old treatment being provided and current orders were not being followed. The document further revealed the DON was made aware of current orders not being followed. The SW Iowa PACE PCP Progress Note dated 5/5/25 revealed Resident #38's right lateral leg wound was wrapped in Coban and the bandage was dated 5/2/25. The document further revealed the resident was not wearing compression stockings and had stated if she didn't ask for them to be put on the staff didn't do it. The SW Iowa PACE Progress Note dated 5/8/25 revealed the resident did not have the appropriate dressing as noted in the current orders with the facility continuing to utilize Coban and the resident was not wearing compression stockings. The document further revealed contact made with the DON who voiced she was on her way to orientation so she would have to check about his at a later time. The SW Iowa PACE Progress Note-Facility Collaboration document dated 5/15/25 revealed treatment provided with the DON in attendance. The SW Iowa PACE Treatment-Wound Care document dated 5/13/25 revealed the area 2.95 cm (+25%), 1. 99 cm (+14%), width 2.08 cm (+14%), and depth - (+100%). The SW Iowa Progress Note dated 5/23/25 revealed the resident had incorrect dressing on the RLE with Kerlix, Telfa, and Xeroform. The document indicated education will continue regarding the correct wound care orders, and the DON was notified. The SW Iowa PACE Treatment-Wound Care document dated 5/23/25 revealed the area 2.4 cm (-19%), 1.83 cm (-8%), width 1.94 cm (-7%). The SW Iowa PACE Progress Note dated 5/29/25 revealed possible infection, wound care was incorrect with Kerlix utilized instead of Allevyn per order. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SW Iowa PACE Treatment-Wound Care document dated 5/29/25 revealed the area 2.08 cm (-13%), 1. 95 cm (+6%), width 1.38 cm (-29%). The document revealed the resident had intermittent pain 5/10, the periwound temperature was hot (localized heat), progress stalled, and suspected infection. The SW Iowa PACE PCP Progress Note dated 6/2/25 revealed the resident's chronic wound on the RLE was managed with difficulty due to the facility challenges in maintaining dressing regimens. The facility compliance with donning compression socks was inconsistent and the resident was currently on antibiotic treatment for suspected cellulitis. The document included the plan for the chronic right lower leg wound was complicated by nursing facility issues with compliance. The SW Iowa PACE Progress Note dated 6/5/25 revealed the wrong wound dressing was in place with border gauze dressing in place instead of Allevyn dressing. The note included the PACE staff meeting with the DON and reconciling the current order with the TAR was correct. The document noted the DON would continue to provide ongoing education to staff regarding the correct dressing. The facility Medication and Treatment Order Practice Level III Policy, dated 11/14) revealed physician orders shall be followed and if unable to follow the DON/designee and physician shall be notified.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. The Minimum Data Set (MDS) dated [DATE] for Resident #39 documented a Brief Interview for Mental Status (BIMS) score of 13 indicating no cognitive impairment. The MDS documented diagnoses of acute and chronic respiratory failure with hypercapnia. Review of Resident #39's EHR titled, Orders documented a physicians order for albuterol sulfate inhalation aerosol solution 2 puffs inhaled orally every 4 hours as needed as needed for 2-4 puffs may keep at bedside. Review of Resident #39's EHR titled, Assessments revealed no medication self administration assessment completed. Review of Resident #39's EHR titled, Care Plan documented no medication self administration plan in place. On 6/9/25 at 1:18 PM an observation in Resident #39's room revealed an albuterol inhaler present on the bed side table next to the resident's bed. On 6/9/25 at 1:18 PM Resident #39 stated she self administered the albuterol when she needed it. On 6/10/25 at 3:10 PM the DON stated Resident #39 recently requested to self administer her own medications. The DON explained to Resident #39 she would have to have a self administration assessment completed. The DON stated Resident #39 had not had an assessment completed and did not know how Resident #39 had the medication. The DON stated medications should not be left in the room for the resident to self administer without a self administration assessment. The DON explained Resident #39 should not have medications left in her room and should have the self administration assessment completed. 3. The MDS dated [DATE] for Resident #77 documented a BIMS score of 15 indicating no cognitive impairment. The MDS documented diagnoses of severe persistent asthma with (acute) exacerbation and morbid (severe) obesity due to excess calories. Review of Resident #77's EHR titled, Orders documented a physicians order for Nystatin external powder 100000 unit/GM applied to abdominal fold and groin topically one time a day for open areas and redness and an order for albuterol sulfate inhalation aerosol solution 2 puffs inhale orally every 4 hours as needed for wheezing. Review of Resident #77's EHR titled, Assessments revealed no medication self administration assessment completed. Review of Resident #77's EHR titled, Care Plan documented no medication self administration plan in place. On 6/10/25 at 8:23 AM an observation in Resident #77's room revealed an inhaler and powder next to the bed on the bed side table. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 6/10/25 at 8:23 AM Resident #77 stated the powder was for under his abdomen and was left in the room by the overnight nurse. Resident #77 stated he liked to apply the powder himself. Resident #77 stated he has had his inhaler in his room since he first entered the facility. Resident #77 stated he administered it when he needed it. On 6/10/25 at 8:24 AM Staff L, Assistant Administrator / CNA stated she did not know what the powder was. Staff L stated it should not have been left in Resident #77's room. On 6/10/25 at 3:33 PM the DON acknowledged Resident #77 did not have a self administration assessment completed and should not have medication left in his room. The DON stated Resident #77 should have had a self administration assessment completed. The DON explained Resident #77 would not be happy without the Albuterol inhaler in his room. The DON stated a self-administration assessment should have been completed. Review of policy revised 2/21 titled, Self-Administration of Medications documented that residents had the right to self-administer medications if the interdisciplinary team had determined that it was clinically appropriate and safe for the resident to do so. If it was deemed safe and appropriate for a resident to self-administer medications, this was documented in the medical record and the care plan. The decision that a resident could safely self-administer medications should be re-assessed periodically based on changes in the resident's medical and/or decision-making status. Based on observations, interviews of residents, family and staff, Electronic Health Record (EHR) reviews, and review of policies the facility failed to provide the needed services in accordance with professional standards by not completing assessments for 3 of 26 residents (Resident #14, Resident #39 and Resident #77). The facility failed to complete thorough assessments for a resident following a fall with a subsequent fracture, and completion of self administration of medication assessments for 2 residents. The facility reported a census of 86 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #14 scored 2/15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The document revealed diagnoses of cerebrovascular accident/transient ischemic attack/stroke, hemiplegia or hemiparesis, and anxiety disorder. The assessment disclosed the resident required substantial/maximal assistance for rolling, sitting to/from lying, sit to stand, and transfers, and partial/moderate assistance for walking up to 50' with 2 turns. The document indicated the resident utilized a manual wheelchair with substantial/maximal assistance. The MDS documented the resident had fallen since admission/entry or reentry. The Care Plan dated 6/5/25 revealed a focus area related to Activities of Daily Living (ADLs). The interventions provided for staff use included: provide staff 1 assist -partial revised on 8/13/24, and toileting with 1 staff assist - partial revision on 8/13/24. A Falls Focus Area provided staff interventions of assistance of 2 staff members for transfers and ambulation initiated on 5/12/25. The EHR Witnessed Fall Without Injury dated 5/9/25 revealed the Resident #14 was lowered to the floor when the resident's legs got weak and gave out. The document disclosed the resident ambulated with assistance with a walker and had a gait imbalance. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The EHR Fall Risk Evaluation completed on 5/9/25 revealed a score of 12 indicating At Risk. The document identified the resident had sustained 1-2 falls in the past 3 months, and was ambulatory and incontinent. The EHR Unwitnessed Fall with Injury dated 5/28/25 revealed Resident #14 was found lying on her left side by the bedside table, a blanket wrapped around her legs, and the lift recliner was all the way up. The resident had a skin tear on the left side. The resident range of motion (ROM) was within normal limits (WNL). The document did not identify any pain. The EHR Fall Risk Evaluation completed 5/28/25 revealed a score of 22 indicating At Risk. The document identified the resident had 3 or more falls in the past 3 months and was ambulatory/incontinent. The document further revealed the resident had balance problems while standing and walking, decreased muscular coordination, and required use of assistive devices. The 5/25 Medication Administration Record (MAR)/Treatment Administration Record (TAR) revealed documentation for Pain Evaluation for 2 shifts daily initiated 7/1/24. The document revealed the Resident #14 had 0/10 pain from 5/1 to 5/30/25 during both shifts. On 5/30 the first shift identified pain at 3/5 and the second shift 5/10. On 5/31 the document indicated the resident had pain 4/10 during the first shift. The document further revealed Resident #14 had an order for as needed (PRN) Tylenol Extra Strength 500 mg (Acetaminophen). Give 1 tablet by mouth every 6 hours as needed for mild pain or fever initiated 8/17/22. The resident required the PRN on 5/3, 5/28, and 5/29/25. The 6/25 MAR/TAR revealed the resident required the PRN Tylenol Extra Strength 500 mg (Acetaminophen) on 6/1/25. The EHR Progress Notes provided the following: -On 5/28/25 at 6:30 PM Resident #14 sustained a fall with the physician notified. -On 5/29/25 at 1:09 PM the eINTERACT SBAR summary for providers revealed a change in condition with functional decline. The document indicated the resident required more assistance with ADLS, general weakness and decreased mobility, and the resident had pain. The document revealed awaiting response from the provider. -On 5/29/25 at 5:17 PM the resident has pain in wound when ambulating. -On 5/30/25 at 3:00 PM the resident will be admitted to hospice on 6/2/25. -On 6/1/25 at 3:54 PM the resident complained of pain in the left hip in the morning and the physician contacted. X-rays were ordered and completed approximately 3:45 PM. -On 6/2/25 at 3:46 AM X-ray findings returned with notifications completed. A fax dated 5/30/25 to the physician revealed Resident #14 had a decline. The document revealed the resident had increased pain with ambulation and generalized overall weakness. The document contained a time stamp of 6/2/25 2:01 PM with a statement of hospice consult? by the physician. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Trident Care Radiology Report dated 6/1/25 revealed Resident #14 had a left intertrochanteric (hip) fracture with minimal callus and modest displacement. The joint shows no dislocation. Pubic rami were intact. On 6/10/25 at 8:52 AM the resident's family member stated the resident had complained of pain during visits on 5/29 and 6/1/25. On 6/11/25 at 8:54 AM Staff N, Certified Nurses Aide (CNA) stated upon finding Resident #14 on her left side on the floor she had complaints of pain, but when repositioned with the nurse onto her back the resident had no further complaints of pain. The staff stated the resident continued to transfer with the use of a gait belt and walker during the rest of the shift. The staff stated on the next shift worked 5/31/25 the resident had increased complaints of pain and was using an EZ Stand (weight bearing lift) for all transfers. Staff N stated the resident had more bruising on the right side of her body; the opposite side from the original injury of the fall. The staff stated she reported the increase in pain and bruising to the nurse on duty who stated the resident had bruising all over. On 6/11/24 at 9:40 AM Staff O, Social Services Designee/PRSC, and the Administrator stated the resident had no complaints of pain at the time of the fall on 5/28/25. The staff acknowledged there was a change in condition on 5/29/25 where the resident was more lethargic and a fax communication was sent to the provider. When asked if a call to the physician should have been made to the physician for further assessment, the Administrator acknowledged a call should have been made. On 6/11/25 at 11:00 AM Staff Q, Licensed Practical Nurse (LPN), stated on 5/28/25 Resident #14 stated her left hip hurt upon initial contact following the fall. However when the resident was repositioned on her back the resident had no further complaints of pain. The staff stated the only injury was the skin tear on the left elbow. The staff stated PRN Tylenol was provided for the resident's complaint of pain in her back. The staff stated the resident required assistance of 2 staff for ambulation with a gait belt and walker to and from the bathroom. On 6/11/25 at 11:35 AM the Medical Director (MD) stated he was notified of the resident's fall on 5/28/25 while he was at the facility. The MD stated he did not see the resident as she was not on his schedule. The MD stated he left instructions with the notifying nurse to obtain an x-ray if it was thought one was needed. On 6/11/25 at 11:56 AM Staff R, Physical Therapist, stated the Resident #14 was receiving physical therapy services twice weekly. The staff stated the resident was transferring with assistance of staff with the use of a walker, and the resident was not using an EZ Stand consistently. On 6/11/25 at 1:25 PM Staff Q acknowledged the physician had stated the resident could have an X-ray if needed. The staff stated she did not think the resident required one at that time. The staff confirmed she verbally notified the next shift of the doctor's statement, but did not put it into the written exchange document. On 6/11/25 at 2:44 PM Staff S, CNA, stated Resident #14 had complaints of pain during repositioning and transfers during her shifts on 5/28 and 5/29/25. The staff stated she notified the nurses that were on duty. The staff stated she did not use an EZ Stand with the resident before or after the fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165373	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Longview	1010 Longview Road Missouri Valley, IA 51555

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 6/12/25 at 10:30 AM Staff T, LPN, stated he was not aware of the physician statement to obtain an X-ray if one was needed. The staff stated he would look in the written shift exchange nursing documentation for information on residents. The staff stated he was notified by the prior shift nurse that the Resident #14 was using the EZ Stand for all transfers at the time of the scheduled shift on 5/29/25. Staff T acknowledged there was more bruising on the resident on 5/29, but did not document the additional bruises since a skin assessment had been completed after the fall. On 6/12/25 at 10:53 AM the Director of Nursing (DON), stated if the physician indicated to obtain an X-ray if needed, it should have been documented on the nurses written shift exchange for all nurses to know. The DON acknowledged if there had been a change in pain level as indicated on the MAR-TAR a call should have been made to the physician for further assessment of the resident's pain. The staff stated the increase in bruising should have had a root cause analysis initiated as to the cause, especially if it was not noted on the skin assessment after the fall. The DON stated with the resident having plans for transitioning to hospice services on 6/2/25 the facility was trying to navigate the gray area. The staff did acknowledge that the plan for transition to hospice services should not change how a resident was treated. On 6/12/25 at 11:37 AM the Administrator stated a skin assessment should be performed when there is new bruising noted and try to find the cause of it. The facility Assessing Falls and Their Causes Policy, dated 3/18, revealed assessments and documentation should continue for approximately 72 hours after the fall for changes in mobility, pain, swelling and bruising. The document indicated relevant risk factors including underlying medical conditions and overall functional decline must be addressed promptly.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interviews, Electronic Health Record (EHR) review and policy review the facility failed to provide timely and adequate treatment and interventions to prevent the worsening of pressure ulcers for 1 of 4 residents reviewed (Resident #61.) The facility failed to request or apply any treatment or dressing to Resident #61's right heel for 8 days until seen by the visiting wound care nurse, to prevent the worsening of the wound. The facility reported a census of 86 residents. Findings include: The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry,black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. The MDS dated [DATE] documented Resident #61 admitted to the facility on [DATE]. The MDS documented the resident required partial to moderate assistance with chair transfers, required substantial/maximum assistance with toilet transfers, bed mobility and walking 10 feet. Walking more than 10 feet not attempted. On 6/10/25 at 8:56 AM Resident #61 stated he had an open area on his right heel. Resident #61 stated the facility completed a treatment daily. Resident #61 stated he was not sure what the area looked like. Resident #61 stated he did not know if the area was getting better. (continued on next page)

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	165373	A. Building B. Wing	06/12/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EHR dated 5/20/25 and titled, Fax, documented Resident #61 had an open area on the right heel. Wound started as a bruise soft with a dark center. Can we have the visiting wound care nurse practitioner see the resident? Provider responded, yes on 5/20/25. Review of the document dated 6/9/25 titled, Resident Matrix identified Resident #61 had a Stage II pressure ulcer that was facility acquired. On 6/11/25 at 8:18 AM an observation of Resident #61's pressure ulcer on the right foot revealed a white wound bed present with some depth. Pressure ulcer was the size of the entire right heel with slough present on the surrounding areas. Moderate amount of drainage was noted on previous dressing. Review of Resident #61's EHR titled, Care Plan documented on 5/20/25 pressure to the right heel was added. EHR also documented to float the right heel initiated on 3/22/25 and to remove foot board from bed per wound provider recommendations. Review of Resident #61's EHR titled, Orders documented minimal weight bearing to right foot started 5/29/25, no submersion baths, showers only, keep wound covered with waterproof barrier during showers started 5/30/25, right foot heel wound cleans with wound cleanser of choice use to irrigate and scrub wound bed apply Santyl to wound base cover with bordered gauze daily and PRN started 6/11/25, Prevalon boot at all times except transfers minimal weight bearing to right foot started 5/29/25, heel protector boots on bilateral feet at all times in bed, wheelchair and recliner. May remove for short amount of time at the residents request for transfers and or cleaning, and a discontinued order of right foot heel wound cleanse with wound cleanser of choice used to irrigate and scrub wound bed apply calcium alginate to wound base (cut to fit) and cover with border gauze and kerlix every other day and PRN started 5/29/25. Review of EHR titled, Assessments dated 4/29/25 documented the first discovery of the wound on the right heel. Right heel described as bruising that measured 5 cm x 2 cm. The wound was also described as purple discoloration. Interventions were pressure reducing device mattress, incontinence management, moisture barrier, encouraging small, frequent position changes, providing assistance as needed and no new additional interventions implemented. Review of EHR titled, Assessments dated 5/9/25 documented right heel described as bruising that measured 5 cm x 2 cm. The wound was also described as purple discoloration fading. Assessment further described a bruise related to resident hangs leg over the side of the bed and hits foot on the foot board/rail of bed. Interventions were pressure reducing device mattress, incontinence management, moisture barrier, encouraging small, frequent position changes, providing assistance as needed and no new additional interventions implemented. Review of EHR titled, Assessments dated 5/16/25 documented right heel described as bruising that measured 5 cm x 2 cm. The wound was also described as purple discoloration fading. Interventions were pressure reducing device mattress, incontinence management, moisture barrier, encouraging small, frequent position changes, providing assistance as needed and other was checked for new additional interventions implemented. Area charted as, Other Specified documented to increase frequency of peri care. (continued on next page)

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	165373	A. Building B. Wing	06/12/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of EHR titled, Assessments dated 5/20/25 documented change in right heel described right heel identified initially as a bruise. The heel had changed in condition and the provider was aware. The wound was described as a new issue. The wound was also described as a stage 2 pressure ulcer that measured 7 cm x 4.5 cm. Wound bed described as purple, brown (necrosis) with 40% of wound covered. The wound was also described as edges regular and well defined without odors. Other relevant information described the area as a bruise from trauma from hitting the heel on the bed frame. Interventions were pressure reducing device mattress, incontinence management, moisture barrier, encouraging small, frequent position changes, providing assistance as needed and areas for new additional interventions implemented were heel suspension / protection device and will add a low loss air mattress. Review of EHR titled, Assessments dated 5/29/25 documented right heel identified pressure ulcer/injury. The wound was also described as an unstageable pressure ulcer that measured 3/4cm length x 4.9cm width x 0. 1 depth. Wound bed was described as beefy red (granulation tissue), yellow slough, brown (necrosis) with 20% of wound covered with granulation 60% covered with slough and 20% covered with necrosis. The wound was also described with edges that were regular and well defined without odors. The wounds exudate was serosanguinous (thin, watery, pale and red/pink). Dressing described as heavy saturation with odor. Assessment stated Staff AA, Nurse Practitioner (NP) from visiting wound care service was present at the bedside and agreed with measurements. New wound care orders given at that time. Other relevant information described the area as a bruise from trauma from hitting the heel on the bed frame. Interventions were pressure reducing device mattress, incontinence management, moisture barrier, encouraging small, frequent position changes and providing assistance as needed. That was the first treatment order for the pressure area on Resident #61's right heel and the first time the wound nurse made an observation of the wound on Resident #61's right heel. (continued on next page)

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	165373	A. Building B. Wing	06/12/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #61's EHR dated 5/28/25 titled, Progress Note from visiting wound care service completed by Staff AA, NP from visiting wound care service documented Resident #61 was observed for initial assessment/admission to services in his room in bed. Initial report and dates of wounds obtained from DON and rounded w/ bedside nurse, Staff L, Assistant Administrator. Resident #61 had 2 pressure injuries - 1 on his buttocks, full thickness with slough obscuring base and very tender to patient and - 1 on his R heel. The heel was noted to be dressing w/ a bordered gauze, completely saturated, and the heel was resting on the baseboard of his bed without a Prevalon boot on - Prevalon boot present on L foot, however. It would be advisable to remove the baseboard, if possible, unless this causes patient unsafe positioning in bed. The wound was tender, though not acutely as he does have notable neuropathy - did not feel any of the monofilament testing today. There is necrotic tissue in the wound base, debrided away today, will most likely need weekly debridement's. He is diabetic with neuropathy so this is a multifactorial wound, though do believe that pressure was the primary cause of the wound as observed today to have a point of pressure directly over the wound. D/t large amount of drainage, apply calcium alginate only over open wound bed not in periwound, and change EOD. This will allow moisture control while still facilitating autolytic debridement of wound face. He also has uncontrolled 2-3+ edema in his BLE w/ no compression - start ACE wraps apply daily from toe to knee bilaterally. His coccyx was too tender to be debrided today, ordered topical Lidocaine to be applied prior to my next visit, to allow him to tolerate a sharp debridement - see orders tab. For now, order TRIAD (see orders tab), to protect and facilitate autolytic debridement in the meantime. See specific application instructions in the specific wound orders. Ensure offloading measures are in place - regular turns to offload the coccyx, floating his heels, keeping the R foot in Prevalon boot at all times. He should bear weight on this foot as little as possible, and should be assisted while up to accomplish this. Continue to follow weekly - anticipate debridement's on both wounds next week. Document described pressure ulcer as unstageable due to slough and/or eschar obscuring the base of the wound. Review of Resident #61's EHR dated 6/9/25 titled, Progress Note from visiting wound care service completed by Staff AA, NP from visiting wound care service documented Resident #61 was observed in bed that day, rounded with the ADON. Resident #61 denied pain at either wound site that day. Resident #61's bilateral lower extremities were appropriately in Prevalon boots. Resident #61's right heel wound was noted to be too dry throughout last week, so ADON reached out to me and I gave her OK to use Hydrogel as Santyl was not in yet. That day the wound remained too dry with only a small amount of serious drainage on the dressing. The wound was nearly completely covered with dry, unstable eschar and nearly dry slough. It is ringed with epithelial tissue and some minimal granular tissue can be noted peppered throughout the wound bed. The wound was effectively debrided, removing all slough & eschar, revealing underlying adipose tissue, though no other underlying structures are identified post debridement. As such, we can diagnose this as a stage three pressure ulcer. Santyl was present today, so this was applied to the wound and it was properly dressed and replaced in a Prevalon boot. Ordered arterial ultrasound studies with ABI's as Resident #61 had multiple risk factors for arterial disease, a very slow healing ulcer that remains full of necrotic tissue week to week, and has need for compression. Need to identify the level of arterial disease, if any, before deciding on the appropriate level of compression. He has tolerated Ace wraps OK so will order edema wear stockings to be applied for this week as the lightest level of compression until arterial studies are complete. He only has 1+ edema in the right foot as of today. He does remain on a specialty offloading mattress. Continue to follow weekly. Anticipate continued weekly debridement's. Hopefully Staff AA could get away from those soon with use of daily Santyl, though this can sometimes take a week or 2 to see improvement. (continued on next page)

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	165373	A. Building B. Wing	06/12/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 8:04 AM the DON acknowledged she completed numerous wound assessments for Resident #61's right heel since the area was noticed. The DON stated when it was first identified she looked at the area it was purple and looked like a bruise. The DON stated Resident #61's mattress was off to the side a little and the frame of the bed was exposed and when he got out he would flop his legs over. The DON stated Resident #61 likely hit the right heel on the rail of the bed. The DON stated Resident #61 stated he really could not recall what had happened. The DON stated the area was not open at that time. The DON explained on 5/20/25 it was reported to her that there was a change in the wound on Resident #61's right heel. The DON stated at that time there was a blister over it with a crack and the nurse reported a little blood on the sock. The DON stated an assessment was completed and physician was notified at that time. The DON explained that was when the order was obtained for the visiting wound care nurse to come see the heel. The DON stated the visiting wound care nurse came on Mondays but she came on Wednesday that next week because of the holiday. The DON stated the fax was sent with description of wound and request for wound care plus. The DON stated there were no new orders for the open area on the right heel. The DON stated the visiting wound care nurse, Staff AA, NP arrived on 5/29/25 and orders were started at that time. The DON acknowledged the facility probably should have had a dressing in place at the time when the area opened on 5/20/25. The DON explained a request for a treatment to the right foot should have been sent to the physician because the area was at that time a stage 2 pressure ulcer. The DON acknowledged the wound on Resident #61's right foot was staged as a stage 2 on 5/20/25 because there was a crack and a blister with drainage. On 6/12/25 at 9:09 AM Staff Z, Nurse Practitioner (NP) stated she did not know Resident #61 had a stage 3 pressure ulcer on his right foot. Staff Z stated she had last seen Resident #61 on 5/16/25. Staff Z stated she clarified with the nursing home for her to receive all notifications for Resident #61. Staff Z stated the facility had been going back and forth between her and Staff BB, the facility's Medical Director. Staff Z stated she had seen Resident #61 on 5/16/25 and was not informed of the bruise on his right heel at that time. Staff Z stated when she saw Resident #61 on 5/16/25 the facility was in the process of determining that Staff Z was supposed to be Resident #61's primary provider. Staff Z stated if she would have known the resident had a wound on his right heel she would have come to assess the wound. Staff Z stated her concern was primarily in communication because if Resident #61 wanted a specific provider then the provider should be getting all the information. On 6/12/25 at 9:38 AM Staff BB, the facility's Medical Director stated Resident #61 kind of picks and chooses who he wants to see between Staff Z and Staff BB. Staff BB acknowledged he had not seen Resident #61 in a while. Staff BB explained the fax was signed by another physician in the office that was not Staff Z or Staff BB. Staff BB stated he had not seen the wound on Resident #61's right heel Staff BB stated he could say that it came to the top of his mind that Resident #61 had a wound. Staff BB stated Resident #61 wanted to see Staff Z as a patient preference. Staff BB stated he would expect that Resident #61 would have any plan or wound care treatment in place for the pressure ulcer / wound. Staff BB stated any wound care would have been appropriate until seen by outside wound care service. (continued on next page)

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	165373	A. Building B. Wing	06/12/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 10:03 AM Staff K, Licensed Practical Nurse (LPN) stated she had worked at the facility for about 10 years. Staff K stated she did not measure the wound for Resident #61 but she did complete the wound treatment. Staff K stated when Resident #61's wound on his right heel was first noticed; it was described as a bruise and one day the bottom of the heel was bleeding. Staff K stated management did look at the area. Staff K stated she spoke with Staff L, Assistant Administrator about the area. Staff K stated she told Staff L that Staff G, Certified Medication Aide told her that Resident #61's right foot was bleeding. Staff L stated she told Staff L the wound was definitely not a bruise. Staff K stated the area on Resident #61's right foot was purple on the heel area and towards the middle of the area it had a light layer of skin peeling and was stuck to the sock that he was wearing and it looked like a popped blister. Staff K stated the area on Resident #61's right foot was bleeding. Staff K stated she applied the Prevalon boot. Staff K stated the boot was on as to release the pressure on the heel. Staff K stated there was no treatment until Staff AA came to the facility to assess the area. On 6/12/25 at 11:37 AM the DON stated she believed Resident #61's physician was Staff Z, NP. The DON acknowledged a dressing should have been requested from the physician and / or applied from 5/20/25 through 5-29-25 before the visiting wound nurse (Staff AA) came to the facility. The DON stated Resident #61's primary physician should have been notified and a request for treatment should have been completed. The DON acknowledged she could not find documentation of notification of the wound to primary physician or request for treatment in Resident #61's EHR. On 6/12/25 at 12:38 PM Staff AA, NP stated she was familiar with Resident #61. Staff AA acknowledged she worked for the visiting wound care service. Staff AA explained when she first came the wound on Resident #61's right heel was mostly eschar covered. Staff AA described the wound at that time as Deep Tissue Injury (DTI). Staff AA stated the wound was surrounded by slough and draining out of the wound edges. Staff AA stated it had concerned her that the facility did not start a treatment or a dressing until she arrived. Staff AA stated it was dressed and the facility should have got orders from the primary in the meantime. Staff AA stated it was staged at a stage 3 the last visit and was unstageable when first time she arrived. Staff AA stated once the necrotic tissue was removed it was staged as a stage 3. Staff AA stated the wound was possible of mixed etiology. Staff AA stated when she came in the first time Resident #61 was resting his right foot on the top of the baseboard of his bed. Staff AA stated that day Resident #61 was supposed to have boots on both feet but did not have any on his right foot. Review of policy revised 2/14 titled, Resident Examination and Assessment documented to notify the physician of any abnormalities such as wounds. Report other information in accordance with facility policy and professional standards of practice. Review of policy revised 10/10 titled, Wound Care documented the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. Verify that there was a physician's order for the procedure.

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	165373	A. Building B. Wing	06/12/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, call light log review, Electronic Health Record (EHR) review, policy review, resident interview, and staff interview the facility failed to provide nursing staff to assure residents safety by not responding to call lights in a timely manner for 4 of 24 residents reviewed (Resident #25, #29, #39 and #54). The facility reported a census of 86 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #39 documented a Brief Interview for Mental Status (BIMS) score of 13 indicating no cognitive impairment. The MDS documented diagnoses of type 2 diabetes mellitus with diabetic chronic kidney disease, dependence on renal dialysis, end stage renal disease, vascular dementia, unspecified severity, with anxiety and flaccid neuropathic bladder. Review of the EHR for Resident #39 revealed the resident resided in room [ROOM NUMBER]-B. On 6/9/25 at 12:55 PM Resident #39 stated at least 3 times a week it takes longer than 15 minutes to answer the call light and stated it had happened this weekend. Resident #39 stated she asked to be put to bed and the staff told her they did not have time to put her to bed. Review of document titled, Past Calls 6/6/25-6/9/25 for room [ROOM NUMBER] documented call light response longer than 15 minutes on: 6/6/25 at 5:38 PM 18 minutes 41 seconds. 6/6/25 at 9:11 PM 16 minutes 45 seconds. 6/7/25 at 5:04 AM 21 minutes 43 seconds. 6/7/25 at 6:36 AM 26 minutes 33 seconds. 6/7/25 at 7:20 AM 31 minutes 49 seconds. 6/7/25 at 1:33 PM 19 minutes 29 seconds. 6/7/25 at 5:39 PM 21 minutes 50 seconds. 6/8/25 at 7:11 AM 29 minutes 26 seconds. 6/8/25 at 8:05 AM 23 minutes 15 seconds. 6/8/25 at 1:37 PM 45 minutes 35 seconds. 6/9/25 at 4:31 AM 35 minutes 40 seconds. 6/9/25 at 11:28 PM 16 minutes 1 second. (continued on next page)

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	165373	A. Building B. Wing	06/12/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The MDS dated [DATE] for Resident #54 documented a BIMS of 15 indicating no cognitive impairment. The MDS also documented diagnoses of hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting an unspecified side, anxiety disorder, unspecified, need for assistance with personal care and generalized muscle weakness. Review of the EHR for Resident #54 revealed the resident resided in room [ROOM NUMBER]-B. A continuous observation on 6/9/25 at 1:49 PM revealed the call light on in room [ROOM NUMBER]. On 6/9/25 at 1:55 PM Staff M, Regional Director of Operations entered the room and shut off the call light. Staff M left the room and spoke to Staff G about the need for Resident #54 to use the toilet. On 6/9/25 at 2:05 PM Resident #54 stated she wanted to be taken to the toilet that is why she had the call light on. Resident #54 stated staff entered the room asked her and her roommate if and what they needed and Resident #54 told the staff that she wanted to use the toilet. Resident #54 stated the staff told her that they would be right in to take her to the toilet. Resident #54 stated it frequently took longer than 15 minutes to answer her call light. Resident #54 stated it took longer than 15 minutes this morning 6/9/25. Resident #54 stated she had her light on and it was shut off but she turned the call light on longer than 15 minutes ago right now. On 6/9/25 at 2:13 PM Staff G, Certified Medication Aide explained that Staff M had told him that Resident #54 needed to use the bathroom. Staff G stated he had spoken to another staff member to let them know Resident #54 needed to use the bathroom. Staff G stated he did not remember which staff he told Resident #54 needed to use the bathroom. Staff G stated he thought the call light would have been left on but Staff G must have shut it off. Staff G stated the facility's expectation was a call light should be answered in less than 15 minutes. Staff G stated usually the staff get to Resident #54 pretty quickly. Staff G acknowledged it was longer than 15 minutes that Resident #54 had been waiting to go to the bathroom. On 6/9/25 at 2:15 PM Staff G told Staff K, Licensed Practical Nurse that Resident #54 needed to use the toilet. An observation on 6/9/25 at 2:21 PM revealed staff entered Resident #54 room and offer to take her to the bathroom. Review of document titled, Past Calls 6/6/25-6/9/25 for room [ROOM NUMBER] documented call light response longer than 15 minutes on: 6/6/25 at 11:53 AM 23 minutes 46 seconds. 6/7/25 at 7:32 AM 21 minutes 11 seconds. 6/8/25 at 9:37 AM 17 minutes 16 seconds. 6/8/25 at 11:25 AM 42 minutes 50 seconds. 6/8/25 at 1:20 PM 30 minutes 1 seconds. 6/8/25 at 4:10 PM 20 minutes 17 seconds. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165373	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Longview	1010 Longview Road Missouri Valley, IA 51555

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/9/25 at 11:17 AM 20 minutes 59 seconds. 6/9/25 at 6:55 PM 24 minutes 45 seconds. On 6/11/25 at 1:01 PM the DON stated depending on what she sees with the staff on the floor at times she will answer call lights. The DON stated if the staff are busy she will answer the call lights. The DON acknowledged call light reports are available for the east wing. The DON stated there have been grievances about call lights. The DON stated if she could not provide the care she would leave the call light on and then talk to a staff member about what is needed by that resident. The DON stated if she could provide the care at that time she just did. The DON stated the facility's expectation was that call lights would be answered in 15 minutes or less. The DON stated if the staff are unable to provide care, the expectation was that the call light would be left on and explain why the help could not be provided at that time to the resident. On 6/11/25 at 3:36 PM the Administrator stated she expected if anyone was able to answer the call light at that time then the call light would be answered. The Administrator stated she would like to see call lights answered as soon as possible. 3. Review of Resident #25's MDS revealed a BIMS score of 15 indicating intact cognition. Interview 6/9/25 at 1:45 PM with Resident #25 revealed at shift change he had to sit on the toilet for 45 minutes. Resident #25 further revealed call lights are constantly taking 15 minutes or longer. 4. Review of Resident #29's MDS revealed a BIMS score of 14 indicating intact cognition. Interview 6/9/25 at 12:40 PM with Resident #29 revealed that call lights can take over 15 minutes to be answered. Review of a facility provided policy titled, Answering the Call Light with a revision date of 9/2022 revealed: a. Staff are to answer the call light system in a timely manner.