

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/16/2025
NAME OF PROVIDER OR SUPPLIER  Azria Health Longview		STREET ADDRESS, CITY, STATE, ZIP CODE  1010 Longview Road Missouri Valley, IA 51555	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observations, record review, staff interviews and facility policy review the facility failed to ensure fall interventions were in place after 1 of 3 residents (Resident #8) sustained a fall. Resident #8 had a fall on 6/30/2025 that resulted in a hematoma on the right side of his head. Staff updated his care plan to include the placement of non-skid strips in front of his bed. A work order was developed to have the non-skid strip placed but the work order documented the wrong bed number. Resident #8 did not have non-skid strips placed when he sustained a fall on 7/14/2025 and suffered multiple facial fractures and had to be hospitalized . When the survey ended on 7/16/2025, Resident #8 was still in the hospital. The facility reported a census of 82 residents. Findings include:According to the 5-day admission Minimum Data Set (MDS) with a reference date of 6/13/2025, Resident #8 had a Brief Interview of Mental Status (MDS) score of 7. A BIMS score of 7 suggested mild cognitive impairment. Resident #8 utilized a walker for mobility and had an impairment on one side of his upper extremity. He required partial/moderate assistance for lying to sitting on the side of his bed, was dependent on staff to go from a sitting to standing position, chair/bed to chair transfer, toilet transfers, walking 10 feet and walking 50 feet with two turns. The MDS documented he was frequently incontinent of urine and always incontinent of bowel. The MDS documented he did not have any falls since admission/entry or reentry or the prior assessment whichever is more recent. The MDS listed the following diagnoses for Resident #8: metabolic encephalopathy, hypertension, renal failure, Alzheimer's disease, anxiety disorder, constipation, and rhabdomyolysis.The Care Plan Focus Area with an initiation date of 6/11/2025 and revision date of 6/30/2025 documented the resident was at risk for falls related to deconditioning, gait/balance problems, psychoactive drug use and falls at home. Resident #8 sustained a fall on 6/30/2025 that resulted in a hematoma to his forehead. The Care Plan documented on 6/30/2025 non-skid strips are to be placed in front of his bed and place a scoop mattress for edge identification. The Care Plan Focus Area with an initiation date of 6/18/2025 documented Resident #8 had an Activities of Daily Living (ADLs) self-care performance deficit related to activity intolerance, Alzheimer's, limited mobility, and pain. The Care Plan documented he required the assistance of one staff member for positioning in bed, toileting hygiene and incontinence management. He required the assistance of one staff and a gait belt for transfers. Staff were directed to encourage him to use his call light for assistance.Fall Risk Evaluations were completed on 6/10/2025 and 6/19/2025 and Resident #8 was determined to be at risk for falls.Record review revealed the following Progress Notes:a) On 6/10/2025 at 3:00 PM Resident #8 was admitted to the facility following a hospitalization.b) On 6/13/2025 at 11:22 PM the nurse noted the resident was getting more confused, hypoxic, audible gurgles sound, rhonchi, feeling very congested, feverish and had thrown up. Resident #8 was sent to the emergency room (ER) for evaluation.c) On 6/19/2025 at 3:00 PM Resident #8 returned from the hospital.d) On 6/22/2025 at 4:19 PM the resident had a change in condition: unresponsiveness, required more assistance with ADLs, general weakness and decreased mobility. He was admitted for observation.e) On 6/23/2025 at 3:47 PM Resident #8 was admitted back to the facility.f) On 6/24/2025 at 4:24 PM Resident #8 refused to leave his oxygen on and kept throwing his call light on the floor. Staff had gone in several times to replace the call light and apply his oxygen.g) On 6/25/2025 at 8:37 PM Resident #8 continued to remove his oxygen and call light from reach by throwing them on the floor, staff replaced call light within reach and oxygen in place several times.h) On 6/30/2025 at 12:46 AM a Certified Nursing Assistant (CNA) reported to the nurse that he was on the floor, after the CNA went in to answer his call light. Resident was observed to be sitting on his bottom with his back against the bed; resident had non-skid socks on his feet and was continent. His oxygen machine is to the left of him and oxygen was not on, bedside tray was in front of him and slight to the left. Resident stated he woke up and was confused where he was and was trying to figure it out. He denied pain at that time, had a hematoma to the right side of his forehead; 5.5-centimeter (cm) x 3cm; no other injuries related to fall were observed at that time.i) On 6/30/2025 at 6:02 PM Resident #8 was on fall follow-up with a new intervention to have a nightlight on during the night; appears to have been effective through this shift.j) On 7/1/2025 at 10:38 AM Resident #8 had a fall on 6/30/2025. Resident woke up confused as to where he was at and tried to get up to find out where he was. Resident was not wearing his oxygen as he tends to remove it. Intervention is frequent rounding to monitor oxygen and call light placement. Non-skid strips placed on floor next to bed.k) On 7/14/2025 at 10:00 PM Resident #8 had a fall at 9:40 PM that was not witnessed. Fall occurred in the resident's room and was attempting to self-toilet at time of the fall and tripped over oxygen tubing. He stated he tripped on a rope and</p>		