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	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Longview	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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility investigative file review, staff and pharmacist interviews and facility policy review, the facility failed to ensure 4 of 4 residents (Resident #1, #2, #3 and #5) was free from exploitation. The facility reported a census of 80 residents.Findings include: 1) According to the admission Minimum Data Set (MDS) assessment tool with a reference date of [DATE], Resident #1 had a Brief Interview of Mental Status (BIMS) score of 14. A BIMS score of 14 suggested no cognitive impairment. The MDS documented he received scheduled pain medications and an as needed (PRN) medication or was offered and declined. At the time of the assessment the resident voiced almost constant pain in the last 5 days that effected his sleep, interfered with therapy activities, and his day-to-day activities. Resident #1 rated his pain a 7 out of 10 with zero being no pain and ten being the worst pain imaged. The MDS documented he received an opioid during the 7-day review period. The following diagnoses were listed for Resident #1: fusion of the lumbosacral region, seizure disorder, anxiety, depression, pseudarthrosis after fusion or arthrodesis, chronic myeloid leukemia, low back pain, right shoulder osteoarthritis, and rheumatoid arthritis.The Care Plan Focus Area with an initiation date of [DATE] documented Resident #1 was on pain medication therapy. The care plan directed staff to monitor, document and report PRN adverse reactions to analgesic therapy. Staff were also directed to review for pain medication efficacy: assess whether pain intensity is acceptable to resident, no treatment regimen or change in regimen required; controlled adequately by therapeutic regimen no treatment regimen or change in regimen required but continue to monitor closely; controlled when therapeutic regimen followed, but not always followed as ordered; therapeutic regimen followed, but pain control not adequate, changes required. A second Care Plan Focus Area with an initiation date of [DATE] documented Resident #1 had acute and chronic pain related to spinal fusion, fracture to his sacrum, arthrodesis and chronic myeloid leukemia. The care plan directed staff to administer his analgesics as ordered and to give 1/2 hour before treatments or care. Staff were also directed to identify and record previous pain history and management of that pain and impact on function, identify previous response to analgesia including pain relief, side effects and impact on function.The following progress note was documented for Resident #1:-[DATE] at 1:34 PM he was admitted to the facility following an acute hospital stay with a primary diagnosis of fusion of the spine in the lumbosacral region, with a surgical date of [DATE].Review of Resident #1's [DATE] Medication Administration Record (MAR) revealed he had the following order: oxycodone (opioid painkiller), give 10 milligrams (mg) by mouth every 6 hours as needed (PRN) for severe pain, with a maximum daily intake of 40mg. The order had a start date of [DATE] and discontinued date of [DATE]. The medication was signed out as being given 25 times from [DATE] through [DATE].Review of Resident #1's [DATE] MAR revealed he had the following orders:-oxycodone, give 10mg by mouth every 6 hours PRN for severe pain, with a maximum daily intake of 40mg. The order had a start date of [DATE] and discontinued date of [DATE]. The medication was signed out as being given 27 times from [DATE] through [DATE],-oxycodone, give 10mg by mouth STAT (right now) for pain and will give new orders. The order was dated [DATE],-oxycodone, give 10mg by mouth every 12 hours PRN for severe pain. The order had a start date of [DATE]. The medication was (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	signed out as being given 27 times from [DATE] through [DATE].Review of Resident #1's September MAR revealed Staff G Certified Medication Aide (CMA) administered the resident's oxycodone 10mg every 12 hours PRN order on [DATE] at 6:54 PM for pain rating of 6 out of 10. Staff D documented she administered the same medication on [DATE] at 7:06 AM for a pain rating of 6 out of 10.Review of Resident #1's individual narcotic record for his oxycodone 10mg order revealed the following:-on [DATE] at 6:55 PM Staff G signed out he administered one pill with 9 pills remaining-on [DATE] at 6:00 AM Staff A completed a count of the pills remaining, documenting 9 remained.Review of Resident #1's pain rating documentation revealed the following:-on [DATE] at 10:08 PM he rated his pain at a 0 out of 10-on [DATE] at 2:19 AM he rated his pain at a 0 out of 10; documented by [NAME] Licensed Practical Nurse-on [DATE] at 2:29 AM he rated his pain at a 6 out of 10; documented by [NAME] Licensed Practical NurseAn attempt was made to contact Resident #1 on the phone number listed in his Electronic Health Record (EHR) on [DATE] at 9:33 AM. There was no answer but a message was left to return the call. Resident #1 did not return the phone at the conclusion of the investigation.The facility investigative file included the following summary:-On [DATE] the facility was notified by Staff B Pharmacist of a possible narcotic diversion from the med bank, the facility emergency supply of medications. The cubie containing oxycodone 5mg was returned the pharmacy on [DATE] and it was relayed to the facility on [DATE] that the cubie appeared to be tampered with and the cubie contained the packaging for 12 individually wrapped oxycodone 5mg with 11 carvedilol (treatment of high blood pressure, heart failure) 6.25mg inside, 1 package was empty.-Staff B, the [NAME] President of Clinical Service Lines and the Senior [NAME] President of Clinical Services joined a call to review details of the pharmacy's findings. It was reported the oxycodone 5mg cubie containing 16 tablets was delivered by the pharmacy on [DATE] was received by Staff C Licensed Practical Nurse (LPN) and was stocked on [DATE] in the med bank by Staff H LPN. The cubie was destocked on [DATE] by Staff I Pharmacy Consultant. Staff B provided the specific individuals who were logged to access this medication unit in the cubie: Staff J Registered Nurse (RN) witnessed by Staff K Certified Medication Aide (CMA); Staff A LPN witnessed by Staff C LPN and Staff L LPN completed a skip transaction.-The facility immediately initiated an investigation. On [DATE] Staff E LPN reported to the [NAME] President of Clinical Service Lines, he was attempting to retrieve oxycodone 5mg form the med bank and the cubie would not open. Upon observation of the cubie, it appeared to have medications to pull but the cubie would not open. There were scratch marks on top of the cubie but no apparent tampering was noted. The [NAME] President of Clinical Service Lines sent email to the pharmacy team on [DATE] at 7:58 AM that they oxycodone cubie would not open.-Staff B sent the facility a log of the med bank transactions for narcotics and the facility began interviewing the staff provided above.-On [DATE] at 5:40 PM [NAME] President of Clinical Service Lines and the Administrator interviewed Staff C. Staff C stated she recalls receiving a cubie on [DATE] and put it in the medication room. Staff C stated she recalls Staff A pulling 2 oxycodone 5mg tablets on [DATE] at 2:43 AM. She physically validated there were only 2 tablets pulled, the count was correct and she observed the remaining tablets that were in the cubie did not appear tampered with, and the cubie opened and closed effectively. Staff C reported she is unaware of what Staff A did with the oxycodone after they left the med bank. Staff J and Staff K accessed the 5mg oxycodone cubie in the med bank on [DATE] with no concerns noted. Both Staff J and Staff K stated the count was correct and no tampering was noted. It was determined the transaction for Staff L skip transaction was in error and Staff B validated Staff L did not access any of the cubies on [DATE].-A further investigation into the oxycodone pulled by Staff A was started. On [DATE] this medication was pulled for resident #1 who had an order for oxycodone 10mg every 12 hours PRN. Per the MAR Resident #1 received a dose on [DATE] at 6:54 PM, so would not be due for the next dose until [DATE] at 6:54 AM. Upon review of the narcotic record, it was noted on [DATE] there 9 oxycodone 10mg tablets available in the narcotic drawer of the medications cart available to administer to Resident #1. Upon further review, the facility is unable to locate any documentation the oxycodone (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pulled from the med bank was administered to Resident #1.-The facility was unable to interview Resident #1 as he was discharged from the facility on [DATE]. The facility was able to validate no dosages of the resident's oxycodone was missed or misappropriated.-Upon further review of Staff A's access into the med bank for dates of [DATE] into [DATE]. Staff A accessed the med bank drawer number 3 on [DATE] at 2:43 AM to obtain two oxycodone 5mg tablets with 12 remaining which was witnessed by Staff C. Staff A accessed the fridge key located in drawer number 3 on [DATE] to stock the lorazepam concentrate that was delivered on [DATE], this was unwitnessed. Staff A accessed the fridge key located in drawer number 3 on [DATE] at 4:23 AM with no medication linked and no witness noted. The facility attempted to contact Staff A on [DATE] via phone to obtain an interview with no response.-Upon the identification of multiple unwitnessed accesses to the fridge key in the med bank that is also located in drawer 3, the same as the oxycodone 5mg was located, the facility suspended Staff A pending further investigation.-Pain interviews were completed with cognitive residents with no concerns identified. Re-education was started with nurses and medication aides regarding the facility's abuse policy. A complete audit of the narcotics, including a cycle count of the medication bank, revealed no concerns.-Staff A contacted the facility on [DATE] at 1:25 PM via phone; an interview was completed by [NAME] President of Clinical Service Lines and the Administrator. Staff A reported she recalls pulling the oxycodone 5mg, two tablets on [DATE] with Staff C as a witness. Staff A reported the count being accurate with no tampering noted. When Staff A was asked why the oxycodone was not signed out as given on either the narcotic count log or the MAR, she stated Staff C told her she did not have to sign out medications that were pulled from the med bank. When asked why she pulled the oxycodone when there was oxycodone available in the cart, Staff A stated she didn't realize there was oxycodone available in the cart until she went to sign it out. When clarified her previous statement of her not signing it out, she stated she was told she did not have to sign it out on the narcotic log only on the MAR. When asked why she pulled the oxycodone out at 2:43 AM when the resident was not due for his next dose until approximately 7:00 AM, Staff A stated she again did not realize that until she went to sign it out and placed the 2 oxycodone's in a cup in the narcotic drawer for the medication aide to use in the morning. Staff A denied witnessing anyone having any unusual behavior. She was asked to come in for a drug screen; Staff A stated she was unable to come in for a drug screen today but would be available tomorrow. Staff A later stated she was able to come in to do a drug screen on [DATE]. Upon arrival to the facility, Staff A would not allow staff to be present during the drug screening but agreed to complete it. After reviewing the results of the drug screen, there were concerns of tampering. Staff A was requested to complete a second drug screen in which she agreed. A drug screen was set up at a drug and alcohol testing center on [DATE]. Upon Staff A arriving at the clinic, she refused to do the drug screen at 10:32 AM because someone had to be present in the room with her. Staff A called the executive assistant asking why someone had to be present and said she would go back to the clinic. The clinic called the executive assistant and stated Staff A never went back to the clinic to complete the drug screen. At approximately 11:00 AM Staff A called the executive assistant and informed her she will resign from her position.-On [DATE] at 8:30 AM an interview was completed with Staff D by [NAME] President of Clinical Service Lines and the Administrator. Staff D was the medication aide assigned to the specific hall on [DATE], who stated that there were no narcotics left in a cup in the narcotic box inside that medication cart.The facility provided a document titled Controlled Substance Transactions: [DATE]-[DATE]. The log documented Staff A accessed the med back on:-on [DATE] at 2:43 AM: removed two 5mg tablets of oxycodone for Resident #1The facility provided a document that showed when Staff A accessed the med bank. The document showed:-on [DATE] at 2:43 AM two oxycodone 5mg tablets were removed for Resident #1. Staff C was a witness to Staff A dispensing this medication-[DATE] at 10:18 PM Staff A obtained the fridge key, no witness documented-[DATE] at 4:22 AM Staff A obtained the fridge key, no witness documented-[DATE] at 4:22 AM Staff A stocked lorazepam concentrate, no witness documented-[DATE] at 4:23 AM Staff A obtained the fridge key, (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	no witness documentedThe facility provided a document titled Controlled Substance by cabinet, bin and by time documented:-on [DATE] at 12:41 PM two 5mg tablets of oxycodone was removed by Staff J and witnessed by Staff K. The medication was signed out for Resident #1. The count before the medication was removed was 16 tablets with 14 remaining after dispensing two tablets. The medication was located in cabinet #1 and bin #03, 00.-on [DATE] at 2:43 AM two 5mg tablets of oxycodone was removed by Staff A and witnessed by Staff C. The medication was signed out for Resident #1. The count before the medication was removed was 14 tablets with 12 remaining after dispensing two tablets. The medication was located in cabinet #1 and bin #03, 00.Review of Staff A's timecard from [DATE] through [DATE] revealed she worked the following shifts: a) Sunday [DATE] at 6:01 PM- Monday [DATE] at 6:23 AM b) Monday [DATE] at 5:56 PM-Tuesday [DATE] at 6:14 AM c) Tuesday [DATE] at 5:56 PM-Wednesday [DATE] at 6:29 AM d) Sunday [DATE] at 5:43 PM-Monday [DATE] at 6:16 PM e) Monday [DATE] at 5:58 PM-Tuesday [DATE] at 6:10 PM f) Tuesday [DATE] at 5:55 PM-Wednesday [DATE] at 6:24 PM (last shift worked).The facility provided photos of the cubie and medications that were tampered with. The photo of the cubie is of a rectangle shaped box. There is a clear top with a medication label that read: oxycodone 5mg tablets, maximum count of 16 tablets with an issued date of [DATE] and expired date of [DATE]. In the box there are white pills in packets. One label on a packet is visible and reads oxycodone table. Below the clear top is a black rectangle cover that is labeled Pyxis Cubie. In the center of the black cover the border does not appear to be straight, it looks ragged. To the left of the black cover were 3 clear drops of what appears to be clear glue. To the right of the black cover were 3 more clear drops of what appears to be clear glue.The facility provided photos of the medication packets that were removed from the tampered cubie. There were 13 pill packets in the photo. The white backing on the packets appeared to have been wrinkled with some corners separated from the pill packets. The label on the packets read oxycodone 5mg tablets. When looking at the front of the pill packets, 1 packet was empty and 12 packets had white pills in them. While looking at the packets with the pill showing, from the center of the packet it appears the aluminum backing had been pealed back to the each of the packet.On [DATE] at 11:55 AM Staff E LPN stated on [DATE] Staff D Certified Medication Aide (CMA) needed to pull an oxycodone from the med bank which required a second person to do so. They went through the process to obtained the medication but cubie would not open. He could hear the motor working but nothing flipped up. They kept trying but it would not open. They could pin point which one it was; it was the bin the stored the oxycodone that would not open. He tried to use his fingers to open the black square piece but he could tell it was beaten up. Someone had definitely tinkered with it. Him and Staff D went to the [NAME] President of Clinical Service Lines right away. It was just fishy because it looked like it someone had tampered with it. There is a black square piece towards the bottom of the bin and there's enough space, like a battery backing on a remote, to pop it open. But it looked like someone was prying on it. Instead of the black piece being flat it was pulled up and dented as if something was put in there and started to pry at it. Staff E was asked to walk through the process of removing a medication in the med bank. Two people are needed to co-sign as a witness. You would type in the resident's name and medication needing to be administered. You type in your credentials, use your fingerprint and the drawer will open that contains the medication that was selected for the resident. Both staff members count the medications to see how many are present before removing what is needed. Then the staff will count what is left after removing the ordered amount, then close the drawer. If a second person is not present the med bank will not open to get the medication out. Staff E acknowledged the fridge key is in the med bank in a cubie like the medications are. Once you are done with the key you return it. He added you do not need a witness to obtain that key. He denied noticing medications in a cup in the medication cart. Staff A did not report any concerns with the bins not opening in the med bank.On [DATE] at 12:15 PM Staff D CMA stated she remembered the situation of concern. On [DATE], she was on East Court and came down to get a medication for a resident. She asked Staff E LPN. They put in the required information in the med bank but the bin (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	because she always makes sure it closes before walking away from tit. The pills were in pre packed individual packets; you tear of an aluminum like backing to get to the pill to administer it. She did not witness Staff A remove the medication from the packet just from the med bank. When asked if she verified the order with Staff A present, Staff C stated when at the med bank you put in her your name, click the order you want and the drawer with the specific medication will pop open. She was not aware of Resident #1's order or that the medication Staff A was going to administer was not within the ordered timeframe. She denied observing Staff A administering the medication as she went back to work on her tasks. Staff C was asked to talk through the documentation process after a medication is pulled from the med bank. Staff C stated you always document in the resident's EHR, make a note like pulled medication from cubie and administered to the resident. At least that's what she does. Then you would sign out the medication on the resident's MAR and you could do a progress note to note where the medication was pulled from. Staff C was asked if it was appropriate to remove medications from the med bank if the medication is available in the medication cart. She indicated she always checks to see if the resident had medications cards in the cart before pulling them from the med bank. If the resident has a medication card in the cart, then she would use the medications in the cart first. If the resident did not have medications in the cart, then she would go to the med bank for the medication. She would check the order if it was a PRN to see when it was last given and if she was able to give the medication. When asked if she ever noticed any staff members acting suspicious or paranoid, she stated months ago there were two staff that seemed off but they do not work here anymore. She stated Staff A did not seem off but she had nervous picking habits that did not seem super odd to her. Staff C stated she did not see her that often because their working days were different, it was random when they worked together. She heard of Staff A taking longer breaks and disappearing but a lot of people do that.On [DATE] at 9:14 AM Staff B stated they provide emergency medications to long term facilities via a med bank. A med bank is a tower of compartments with drawers (cubie) that dispense medications after signing in to the med bank. On [DATE] they were contacted by the facility about one of the cubies having issues with opening to get the medication out. They contacted med bank support and they were unable to find a solution to open the cubie. When they removed the cubie from the med bank to inspect it further two things were noted: the cubie was tampered with or broken and the medication packets had been tampered with as well. He looped in the other pharmacy staff on what was found and they made the decision to break the cubie to see what was inside. Once it was opened, the medication packets were labeled as 5mg oxycodone but the packaging had been tampered with. The oxycodone pills had been removed and replaced with Carvedilol pills; there were 13 packets: 1 packet was empty and 12 packets had been replaced with Carvedilol. Staff B called the facility to inform them what he had found and he started to dig in and narrow down a timeframe on who had accessed this specific cubie. The facility also started their own investigation. When asked why they thought the cubie had been tampered with, Staff B stated there is a little black rectangle piece on top of the cubie. He stated there were pry marks on it and once they opened it, they noticed there was adhesive on the lid to reseal it to close it. Both of these things indicate the cubie was broken or tampered with. When asked how they were able to determine the oxycodone pills had been replaced in the pill packets. The back of the packets has a while cover label and some had corners that were pulled back. Once the packets were flipped over you can see the backing had pulled open and that's when they noticed the markings on the pills and used those markings to identified the replaced pills. The pills that were used to replace the oxycodone pills looked just like oxycodone pills, small white round pills. The only difference were the markings. When staff need to get a medication from the med bank they would log in, select the resident that needs the medication, select the medication that is to be administered. After the medication is selected the cubie (drawer) that [TRUNCATE

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	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Longview	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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on the previous Centers for Medicare and Medicaid Services (CMS) form 2567 review, staff interviews and facility policy review the facility failed to ensure they provided a comprehensive, effective Quality Assessment and Performance Improvement (QAPI) program. The facility reported a census of 80 residents.Findings include:A review of the Department of Inspections, Appeals, and Licensing website revealed the facility had repeat deficient practices identified during the annual survey and complaint investigations from 2/27/2024 through 10/1/2025. The repeat deficiencies cited include:-6/12/2025 during an annual survey and complaint investigation: 865 QAPI plan.-10/1/2025 during a complaint investigation: 602 exploitation.On 11/25/2025 at 12:17 PM the Administrator stated after deficiencies have been identified they educate all staff on the process change prior to their next working shift. They will bring the same information to the huddle meetings to ensure staff understand. When asked how they ensure the issue has been resolved she stated they will complete audits for about three months or until they are in compliance. When asked about the repeated 602 deficiency from the 10/1/2025 and current surveys, she indicated she felt both issues were ethical issues with staff. She felt their processes were in place and worked successfully but staff involved too advantage of the situation.The facility provided a document titled Quality Assurance and Performance Improvement (QAPI) Program, with a revision date of February 2020. The policy statement included: this facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents.The objectives of the QAPI program are to:1. provide a means to measure current and potential indicators for outcomes of care and quality of life.2. provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators.3. reinforce and build upon effective systems and processes related to the delivery of quality care and services.4. establish systems through which to monitor and evaluate corrective actions.Implementation:1. The QAPI committee oversees implementation of our QAPI plan, which is the written component describing the specifics of the QAPI program, how the facility will conduct its QAPI functions, and the activities of the QAPI committee.2. The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include: a. tracking and measuring performance; b. establishing goals and thresholds for performance measurement; c. identifying and prioritizing quality deficiencies; d. systematically analyzing underlying causes of systemic quality deficiencies; e. developing and implementing corrective action or performance improvement activities; and f. monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed.3. The committee meets monthly to review reports, evaluate data, and monitor QAPI-related activities and makes adjustments to the plan.