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	06/11/2026

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Records (EHR) review and staff interviews the facility failed to provide written notice, including the reason for the change, before the resident's room at the facility was changed for 3 of 3 residents reviewed (Resident #1, #7 and #8). The facility reported a census of 74 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] revealed Resident #1 had a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment. Review of Resident #1's EHR titled, Assessment documented Social Services Roommate Change Notification on [DATE] and no documentation of Social Services Relocation Notification.Review of Resident #1's EHR titled, Progress Notes documented room change on [DATE] and [DATE].Review of Resident #1's EHR documented no other notification of room change.2. The MDS dated [DATE] revealed Resident #7 was rarely/never understood. Review of EHR titled, Progress Notes documented Resident #7 expired on [DATE].Review of EHR titled, Census documented Resident #7 changed rooms on [DATE], [DATE], [DATE], [DATE] and [DATE].Review of EHR titled, Assessment documented Social Services Room Relocation on [DATE] the day after the survey team requested documentation of room change.Review of Resident #7's EHR documented no other notification of room change.3. The MDS dated [DATE] revealed Resident #8 did not have a BIMS score completed because Resident #18 returned from the hospital [DATE] after a stroke which expired on [DATE]. Review of EHR titled, Census documented Resident #8 changed rooms on [DATE] and [DATE].Review of Resident #8's EHR titled, Assessment documented no Social Services Roommate Change Notification. Review of Resident #8's EHR documented no other notification of room change.On [DATE] at 10:49 AM Staff A, Social Service Director stated she would call the family before a room change occurred but, if it was medically necessary the facility would change rooms and then try to call the family. Staff A said sometimes families are not the best to answer the phone. Staff A stated she would try to get a hold of the family before moving the resident. Staff A stated when she was by herself in the office she did not do the room change family notification very well but, she really tried to get a hold of the family first. Staff A explained when called the family she would put the documentation of the room change in the Room Location Assessment. Staff A reported the room Resident #7 was in the facility turned into the Director of Nurse's (DON) office. Staff A revealed the room number was 320 and Resident #7 changed rooms on [DATE]. Staff A stated she did not see the assessment completed with the room change for Resident #7 at all. Staff A acknowledged neither Resident #7 or Resident #7's Power of Attorney (POA) for care and financial were notified appropriately of the room change notification completed. Staff A stated for quite a while Resident #1 did not have any POA. Staff A explained if the resident did not have a POA they told the resident of the upcoming room change and there would be an assessment completed. Staff A stated there was a Room Location Assessment completed on [DATE] but it was when she got a new roommate. Staff A stated Resident #1 was in room [ROOM NUMBER] until [DATE]. Staff A stated she could not find any notification for the POA when the room change occurred on [DATE]. Staff A explained Resident #1 was spoken to and she was ready to move and would move today was documented in the EHR titled, (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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress Notes. Staff A stated if the resident was able to make their own decisions then there was no reason to notify the POA. Staff A stated Resident #8's family was at the bedside when he returned and they were aware of the room change. Staff A stated Resident #8 was changed to hospice that day with daughter and son present when the hospice papers were signed. Staff A acknowledged there was no formal documentation to the POA of that room change. Staff A stated the son was called on [DATE] returned and was moved upstairs in an EHR titled, Progress Notes by the nurse that did the return assessment. Staff A stated she had never presented a resident with written notice of room change but did enter the room change in the EHR titled, Assessments when it occurred.On [DATE] at 10:49 AM Staff B, Social Service stated when she had a resident that was going to have a room change she always tried to notify the family. Staff B stated there were 2 assessments completed for Resident #1 one for getting a new roommate and one for when they are getting moved. Staff B explained the assessments were entered in the EHR titled, Assessments and were titled Social Service relocation notification and Social Service roommate change notification. Staff B explained Resident #1 had a room change notification on [DATE] with notification to POA because Resident #1 was getting a new roommate. On [DATE] at 10:38 AM the Administrator stated the facility does not have a policy for resident room change notice. The Administrator stated she would expect the room change assessment form to be utilized and filled out at least 2 days prior to room change and for staff to notify family or POA if the resident's BIMS is less than 15.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, Electronics Health Record (EHR) review and policy review the facility failed to ensure residents received required direct supervision during meals and failed to implement specific care-planned interventions during meals with 2 of 2 residents reviewed (Resident #5 and #6). The facility reported a census of 74 residents. Findings Include:1. The Minimum Data Set (MDS) dated [DATE] for Resident #5 did not document a Brief Interview for Mental Status (BIMS) score. The MDS documented Resident #5 had severely impaired daily decision making skills.Review of Resident #5 Electronic Health Record (EHR) titled, Care Plan documented an intervention for eating that Resident #5 required supervision during meals, was at high risk for aspiration, tried to eat quickly and required cues to slow down. On 6/9/26 at 8:49 AM a continuous observation revealed Resident #5 unsupervised feeding himself for 16 minutes. On 6/9/26 at 9:51 AM Staff F, Certified Nurse Assistant (CNA) stated Resident #5 needs assistance but he eats on his own. Staff explains Resident #5 should not be unattended and that she did not watch him eating breakfast this morning.2. The MDS dated [DATE] for Resident #6 documented a BIMS score of 10 indicated moderate cognitive impairment.Review of Resident #6 EHR titled, Care Plan documented an intervention for eating that Resident #6 required supervision.On 6/9/26 a continuous observation revealed from 9:30 AM till 9:42 AM Resident #6 feeding herself unsupervised in the dining room.On 6/9/26 at 9:33 AM an observation revealed no CNA's present in the dining room with 6 residents eating breakfast.On 6/10/26 at 2:49 PM Staff G, Certified Nurse Assistant (CNA) stated when she worked with Resident #6 she would assist the resident with meals. On 6/11/26 at 10:38 AM the Administrator stated she expected the staff to follow the current care plan and physician orders for supervision with eating needed for each resident.Review of facility provided policy titled, Azria Therapeutic Diets dated 2017 documented therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, Electronic Health Record (EHR) review and policy review the facility failed to provide food at a palatable temperature to 2 of 2 residents (Resident #6 and Resident #9) reviewed. The facility reported a census of 74 residents. Findings Include:The Minimum Data Set (MDS) dated [DATE] for Resident #6 documented a Brief Interview For Mental Status (BIMS) score of 10 indicated moderate cognitive impairment.On 6/9/26 at 9:26 AM a continuous observation revealed Staff D, Certified Nurse Assistant/Certified Medication Assistant (CNA/CMA) escorted Resident #6 into the dining room and retrieved her tray from the kitchen serving window. Staff D was requested by the survey team to return the tray to the kitchen for Staff C, Certified Dietary Manager (CDM) to obtain the temperature of the food items. Staff C obtained the temperature of eggs at 121 degrees Fahrenheit and cream of wheat at 109 degrees Fahrenheit. Observation revealed Staff C placed the food in the microwave and stated he would warm it up. Staff C removed the food from the microwave with failure to obtain new temperature of eggs or cream of wheat, applied cover and handed it to staff D to serve the tray to Resident #6.On 6/9/26 at 9:42 AM, Staff C stated he did not measure the temperature of Resident #6's breakfast after microwaving it, as he observed steam and believed the food was sufficiently hot. Staff C acknowledged that he would expect the food temperature to exceed 135 degrees Fahrenheit after reheating.Review of facility provided document dated 6/8/26 titled, Daily Census documented Resident #9 resided in room [ROOM NUMBER] (304) at the facility.Observation on 6/9/26 at 9:42 AM revealed Staff brought a tray down at 9:12 AM for resident in room [ROOM NUMBER]. At 9:21 AM the breakfast tray remained sitting on the bedside table outside the room for Resident in room [ROOM NUMBER] yogurt sitting unopened, cereal covered with a lid and plate also covered with a lid. At 9:39 AM breakfast tray was taken into the residents room. Staff stated it was her intentions to have the resident from room [ROOM NUMBER] eat the food. Stated she was going to take the resident down to the dining room to eat the food. At 9:42 AM resident and tray brought to the dining room. The survey team requested a temperature for the tray of food. Staff C retrieved the meal tray from staff and placed it on the counter. Staff C did not perform hand hygiene, cleansed the thermometer, inserted the probe into a hard-boiled egg while stabilizing the egg with an ungloved hand, and recorded a temperature of 107 degrees Fahrenheit. Without cleansing the thermometer, Staff C inserted it into a cup of yogurt and recorded a temperature of 72 degrees Fahrenheit. Staff C cleansed the thermometer, inserted it into a bowl of oatmeal, and recorded a temperature of 95 degrees Fahrenheit. Staff C discarded the hard-boiled egg and the yogurt. Staff C retrieved a fresh hard-boiled egg from the refrigerator, placed it on the plate, did not cleanse the thermometer and recorded a temperature of 36 degrees Fahrenheit. Staff C heated the oatmeal in the microwave, verified an internal temperature of 149 degrees Fahrenheit, returned the items to the tray, and handed the tray to the CNA for service and performed hand hygiene.On 6/10/26 at 2:49PM Staff E, Licensed Practical Nurse (LPN) stated that residents frequently complain the food was cold. Staff E stated nursing staff will warm the food up in the microwave. Review of facility provided policy titled, Azria Food Preparation Service revised 2019 documented previously cooked food is reheated to an internal temperature of 165 F for at least 15 seconds. Ready to eat foods that require reheating are taken directly from the sealed container or intact package from the food processing source and cooked to at least 135 F. Mechanically altered hot foods prepared for a modified consistency diet remain above 135 F during preparation or they are reheated to 165 F for at least 15 seconds. Proper hot and cold temperatures are maintained during food service. Foods that are held in the temperature danger zone are discarded after 4 hours.The document further revealed the longer foods remain in the danger zone the greater the risk for growth of harmful pathogens. Therefore, PHF must be maintained below 41 F or above 135 F.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, family interview and policy review the facility failed to store, prepare, and serve food in accordance with professional standards. The facility did not label and date open food items, follow best-by dates, discard expired food items, perform hand hygiene prior to or during food services, complete hand hygiene when obtaining temperatures on food items and did not reheat food in a microwave to an appropriate internal temperature. The facility reported a census of 74 residents.Findings include:1.The Minimum Data Set (MDS) dated [DATE] for Resident #1 documented a Brief Interview for Mental Status (BIMS) score of 9 indicated cognitive impairment.On 6/8/26 at 10:43 AM the POA (Power of Attorney) of Resident #1 stated while visiting the resident she assisted her with her morning apple juice and upon removing the lid to the cup the POA found what she believed to be mold inside the cup. The POA explained it was a dark, fuzzy and a circular film on top of the fluids. The POA reported the incident to a nurse and the dietary manager at the time. The POA stated the nursing staff returned with a new cup of apple juice for Resident #1.2. The MDS dated [DATE] for Resident #6 documented a BIMS score of 10 indicated moderate cognitive impairment.Observation on 6/9/26 at 9:26 AM revealed Staff C, Certified Dietary Manager (CDM) obtained the temperature of food items on Resident #6's meal tray. Staff C retrieved the tray from the staff and placed it onto the counter, grabbed the thermometer from the shelf without proper cover noted, did not cleanse the thermometer tip, did not perform hand hygiene, stabilized egg with an ungloved hand and inserted the probe into the egg on the tray. Staff C removed the thermometer from the egg and placed the thermometer into the bowl of cream of wheat and did not cleanse the tip of the thermometer in between the food items. Staff C obtained the temperature of eggs at 121 degrees Fahrenheit and cream of wheat at 109 degrees Fahrenheit. Staff C placed the food in the microwave and stated he would warm it up. Staff C removed the food from the microwave, did not obtain new temperature of eggs or cream of wheat, applied cover and handed the tray to staff D to serve the tray to Resident #6 and did not perform hand hygiene.On 6/9/26 at 9:42 AM Staff C stated that he failed to obtain a temperature on Resident #6's room tray after removing from the microwave and stated he believed it was warm enough because the food was steaming. Staff C explained the temperature of food items after being re-heated in the microwave should not be below 135 degrees Fahrenheit after reheating. Review of facility provided document dated 6/8/26 titled, Daily Census documented Resident #9 resided in room [ROOM NUMBER] (304) at the facility.Observation on 6/9/26 at 9:12 AM revealed staff brought a tray down at 9:12 AM for resident in room [ROOM NUMBER]. At 9:21 AM the breakfast tray remained sitting on the bedside table outside the room for Resident in room [ROOM NUMBER] yogurt sitting unopened, cereal covered with a lid and plate also covered with a lid. At 9:39 AM the breakfast tray was taken into the residents room. Staff stated it was her intentions to have the resident from room [ROOM NUMBER] eat the food. Stated she was going to take the resident down to the dining room to eat the food. At 9:42 AM Staff C retrieved a meal tray from staff and placed it on the counter. Staff C did not perform hand hygiene, cleansed the thermometer, inserted the probe into a hard-boiled egg while stabilizing the egg with an ungloved hand, and recorded a temperature of 107 degrees Fahrenheit. Without cleansing the thermometer, Staff C inserted it into a cup of yogurt and recorded a temperature of 72 degrees Fahrenheit. Staff C cleansed the thermometer, inserted it into a bowl of oatmeal, and recorded a temperature of 95 degrees Fahrenheit. Staff C discarded the hard-boiled egg and the yogurt. Staff C retrieved a fresh hard-boiled egg from the refrigerator, placed it on the plate, did not cleanse the thermometer and recorded a temperature of 36 degrees Fahrenheit. Staff C heated the oatmeal in the microwave, verified an internal temperature of 149 degrees Fahrenheit, returned the items to the tray, and handed the tray to the CNA for service and performed hand hygiene.Observation on 6/8/26 at 2:00 PM revealed in the refrigerator pureed (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	peaches dated 5/31, pureed pears dated 6/5 and thickened apple juice with an open date of 5/29. The facility prepared lemonade, orange juice, apple juice and tomato juice in individual cups without the preparation dates and a one gallon of white milk without an open date located in the stand up refrigerator.On 6/8/26 at 2:20 PM Staff C, Certified Dietary Manager (CDM) stated the facility made lemonade, tea, orange juice and tomato juice normally do not last more than a day and he was unable to answer how long those liquids are maintained in the refrigerator before discarding and stated they are as good as the open date dated on the item. Stated the liquids that are in their original container are good in the refrigerator until the expiration date labeled on the container from the manufacturer or at least up to one week after being opened. Staff C explained he believed the pureed peaches and pears were acceptable to serve because it was just fruit. Staff C stated he thought items in the refrigerator should be removed 3 days after the open date and stated that he normally will throw items away after he feels they do not look good anymore and believes they can be in the refrigerator for over a week. Review of the facility provided document titled, Azria Food Preparation and Service revised 2019 documented staff to clean and sanitize food preparation areas and all food-contact equipment between uses. Policy documented food thermometers to be cleaned, sanitized, and calibrated for accuracy according to food code guidelines. To prevent foodborne illness, the policy directs staff to adhere to strict hygiene and sanitation practices. It requires Potentially Hazardous Foods (PHF) to be maintained below 41 F or above 135 F to limit pathogen growth within the danger zone. Furthermore, the policy prohibits bare-hand contact with food, requires the use of single-use gloves during direct food handling, and mandates glove changes between tasks. The policy requires food, nutrition, and nursing services staff to perform hand hygiene before serving residents and after collecting soiled plates or food waste. Previously cooked food is reheated to an internal temperature of 165 F for at least 15 seconds. Reheated foods that are not consumed within 2 hours are discarded.