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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, Electronic Health Record (EHR) review, resident interviews, staff interviews and policy review, the facility failed to provide dignity and respect to 1 of 3 residents reviewed (Resident #54). The facility reported a census of 86 residents. Finding include: The Minimum Data Set (MDS) dated [DATE] for Resident #54 documented a Brief Interview for Mental Status (BIMS) score 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 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. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/09/25 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 offered to take her to the bathroom. On 6/11/25 at 12:24 PM Resident #54 acknowledged that she waited longer than 20 minutes on 6/9/25 at 1:49 PM. Resident #54 stated she waited about a 1/2 hour for staff to help her with toileting. Resident #54 stated she was incontinent on 6/9/25 as a result of waiting for staff to assist her with toilet use. Resident #54 stated when this happens she is very embarrassed. Resident #54 stated she was incontinent at times. Resident #54 stated she could tell when she had to urinate though. Resident #54 stated when she was incontinent after having to wait an extended period of time she felt like she was not being provided dignity. Resident #54 stated she felt ashamed, sad, and upset that staff did not assist her in a timely manner and she ended up having an accident. On 6/11/25 at 1:45 PM the DON stated she could understand a resident's embarrassment with incontinence when the resident's call light was not answered in a timely manner. Review of policy revised 2/21 titled, Dignity documented Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example promptly responding to a resident's request for toileting assistance.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical document review, staff interview, and policy review the facility failed to provide a comprehensive care plan related to high risk medications for residents with an order for diuretics for 1 of 5 residents (Resident# 12) reviewed. The facility reported a census of 86 residents. Findings include: Review of Resident #12's Minimum Data Set (MDS) dated [DATE] revealed diagnoses of cancer, diabetes mellitus, and hyperlipidemia. The MDS further revealed that during the look back period Resident #12 received diuretic medication daily. Review of the Electronic Healthcare Record (EHR) page titled, Physician's Orders revealed an order for Furosemide 20 mg 1 tablet daily. Review of Resident #12's Care Plan with a revision date of 5/21/25 revealed no documentation of diuretic medications usage. Interview on 6/11/25 at 8:07 AM with the Director of Nursing (DON) revealed that diuretics should be in the Care Plan for Resident #12. Review of a facility provided policy titled, Care plans, Comprehensive Person-Centered with a revision date of 3/2022 revealed: a. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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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)

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

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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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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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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)

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
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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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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 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 clinical record review, observation, staff interview, and policy review the facility failed to assess a resident for safety while smoking for 1 of 2 residents reviewed (Resident #16). The facility reported a census of 86 residents. Findings include: Review of Resident #16's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS further revealed that Resident #16 uses tobacco products. The MDS then revealed an admission date of 3/6/25 from a skilled nursing facility. The MDS revealed diagnoses of hypertension, peripheral vascular disease, renal failure, respiratory failure, and acquired absence of left leg above the knee. Review of Resident #16's Electronic Healthcare Record (EHR) page titled, Progress Notes revealed an entry 5/9/25 at 1:45 PM documenting Resident #16 requested to have his cigarettes and a lighter to take with him to his appointment. The Administrator advised Resident #16 these items would be given to the driver for appropriate smoking times while out. The Director of Nursing (DON), and Administrator re-reviewed the smoking policy with Resident #16. Review of Resident #16's Care Plan revealed no information of Resident #16 smoking. Review of Resident #16's EHR page titled, Assessments revealed no smoking assessment was completed. During continuous observation 6/10/25 at 3:45 PM until 3:54 PM Staff G, Certified Medication Aide (CMA), brought cigarettes and lighters out for the residents. Staff H Certified Nurses Aide (CNA), then gave Resident #16 a cigarette and lit it. At 3:48 PM Staff H then disposed of Resident #16's cigarette and lit another cigarette for Resident #16 at Resident #16's request. When Resident #16 was done with the second cigarette Staff H disposed of Resident #16's cigarette. Interview 6/11/25 at 8:11 AM with the Director of Nursing (DON) revealed that a smoking assessment should have been completed for Resident #16. The DON further revealed that all residents who smoke should have a smoking assessment completed, and that it should be in their care plans. Interview 6/11/25 at 8:23 AM with the Administrator revealed that Resident #16 should have had an assessment prior to smoking to make sure that the resident was safe when doing so. Review of facility provided policy titled, Smoking Policy-Residents with a revision date of 8/2022 revealed: a. Resident smoking status is evaluated on admission. b. A resident's ability to smoke safely is re-evaluated routinely.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Records (EHR) review, resident interview, policy review and staff interviews the facility failed to provide dialysis services consistent with professional standards by not completing a post dialysis assessment to 1 of 1 residents reviewed (Resident #39). The facility reported a census of 86 residents. Finding include: 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, and end stage renal disease. On 6/9/25 at 1:00 PM Resident #36 stated she goes to dialysis appointments every Monday, Wednesday and Friday. Review of Resident #39's EHR titled, Orders documented an order for a complete pre/post vital signs, weight and evaluation. The EHR titled, Orders also revealed an order for dialysis schedule 3 times a week on Monday, Wednesday and Friday. Review of Resident #39's EHR titled, Assessments Pre/Post Evaluation Complete for the last 60 days documented post dialysis assessments were not completed on 4/11/25, 4/18/25, 4/21/25, 4/23/25, 4/28/25, 5/2/25, 5/5/25, 5/7/25, 5/14/25, 5/16/25 and 6/6/25. On 6/11/25 at 10:48 PM Staff I, Licensed Practical Nurse (LPN) stated she was familiar with Resident #39. Staff I stated Resident #39 had dialysis every Monday, Wednesday and Friday. Staff I stated pre and post dialysis assessments are completed every day Resident #39 had dialysis. Staff I stated the post assessment would be completed by nurses on the am shift. On 6/12/25 at 8:34 AM Staff J, Registered Nurse (RN) stated dialysis assessments were supposed to be completed before and after dialysis going to dialysis treatments. 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. She stated there should be a pre and post dialysis assessment completed on the days Resident #39 attends dialysis. Staff K stated she did not remember missing any post dialysis assessments for Resident #39. On 6/12/25 at 8:20 AM the DON stated her expectation was that dialysis assessments would be completed prior and after each dialysis. The DON stated the assessments were charted in the assessment tab. The DON stated some of the assessment was documented in the TAR. The DON explained she would have expected the post assessments would have been completed on all dialysis days. The DON acknowledged the days identified did not have a post assessment completed. The DON explained the post dialysis assessments should have been completed on those days. (continued on next page)

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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy revised 9/10 titled, End-Stage Renal Disease, Care of a Resident with documented that education and training of staff includes, specifically the type of assessment data that was to be gathered about the resident ' s condition on a daily or per shift basis.

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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)

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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.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to serve residents their therapeutic menu as ordered, for 3 of 22 residents (Residents #31, #69 and #6) with mechanically altered diets. The dietary staff ran out of the scheduled vegetable of the day and served corn to residents that required a mechanical soft diet. The facility reported a census of 86 residents. Findings include: According to the Diet Spreadsheet for week 4, the mechanical soft menu on 6/10/25 included; ground sweet and sour chicken with sauce, soft steamed rice w/gravy, soft and chopped steamed broccoli and chopped fruit fluff. 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #31 had a Brief Interview for Mental Status (BIMS) score of 2 (severe cognitive deficits) and he required partial assistance with eating. The Care Plan for Resident #31, updated on 1/25/24, showed that he was at risk for nutritional deficits related to dysphagia, and had diet texture modifications; with a mechanical soft diet. An order dated 4/14/25 at 1:25 PM, show that Resident #31 had a regular diet, mechanical soft texture. 2) The MDS dated [DATE] for Resident #69, showed that she had a BIMS of 8 (moderate cognitive deficits) She required supervision with eating and was on a therapeutic diet. The Care Plan updated on 2/11/25 showed that the resident was at risk for weight loss due to a diagnosis of Alzheimer's disease. The resident was able to feed herself. An order dated 5/27/25 at 10:19 AM, showed that she was on a general diet with pureed texture. The order was changed to mechanical soft texture on 6/11/25 at 8:45 PM. 3) The MDS dated [DATE], showed that Resident #6 had a BIMS score of 10 (moderate cognitive ability). She required supervision with eating and was on a mechanically altered diet. The Care Plan last updated on 10/11/24, showed that Resident #6 required assistance with eating and had swallowing problems related to coughing or choking during meals. An order dated 12/26/24 at 3:07 PM, indicated that Resident #6 was on a regular diet mechanical soft texture. She required assist with eating due to difficulty swallowing. In an observation of the lunch service on 6/10/25, Staff C, Dietary Aide/Cook served the meals and at 12:40 PM, he said that he ran out of broccoli so he would need to serve the remaining meals corn as a replacement. Staff C served corn to Resident #31, #69 and #6. (continued on next page)

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

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Azria Health Longview	1010 Longview Road Missouri Valley, IA 51555

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/25 at 1:30 PM, the Dietician said that she would not recommend corn on a mechanical soft diet. She said that creamed corn would be acceptable. On 6/10/25 at 1:16 PM, Staff C said that he does occasionally run out of vegetables and will need to use a substitute. He said that he wasn't aware that regular corn is not a good option for mechanically soft therapeutic diets. On 6/11/25 at 3:17 PM, the Director of Nursing (DON) said that there was a communication from Speech Therapy to nursing that the diet orders for Resident #69 had changed from pureed to mechanical soft, but the orders had not been transcribed in a timely manner. The facility policy titled: Therapeutic Diets dated 2010, showed that a therapeutic diet must be prescribed by the resident attending physician. If the mechanically altered diet was ordered, the provider would specify the texture modification.

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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 86 residents. Findings include: A review of the Department of Inspections Appeals and Licensing website revealed that the facility had repeat deficient practices identified during the annual surveys and complaint investigations from 1/16/25 and 7/18/24. The repeat deficiencies cited include: 686 Treatment/Services to Prevent/Heal Pressure Ulcers 880 Infection Control On 6/12/25 at 12:58 PM the Administrator said that they had not reviewed or addressed Enhanced Barrier Precautions (EBP) in the Quality Assurance meetings. She acknowledged that prevention and treatment of pressure ulcers has been an on-going challenge. According to the facility policy titled: Quality Assurance and Performance Improvement (QAPI) Program, revised in February of 2020, the facility would develop, implement and maintain an ongoing facility wide data-driven QAPI program that was focused on indicators of the outcomes of care and quality of life for the residents. The committee would meet monthly to review reports and make adjustments to the plan.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and policy review the facility failed to use universal infection control measures and Enhanced Barrier Precautions (EBP) during cares for 4 of 5 residents reviewed for infection control (Residents #38, #57, #61, and #189). The Facility reported a census of 86 residents. Findings include: 1. Review of Resident #61's Minimum Data Set (MDS) dated [DATE] revealed diagnoses of renal insufficiency, Multidrug-Resistant Organism (MDR), and stroke. Review of Resident #61's Electronic Healthcare Record (EHR) page titled, Physician's Orders revealed treatments to a wound on Resident #61's coccyx as well as a treatment to Resident #61's right heel. Further review of the Physician Orders revealed an order for the implementation of EBP related to wounds and positive MRSA. Review of Resident #61's Care Plan with a revision date of 4/21/25 revealed Resident #12 required EBP related to a wound. The Care Plan further revealed interventions for staff to utilize proper personal protective equipment (PPE), and for staff to utilize proper hand hygiene techniques. Observation 6/11/25 at 9:52 AM Staff A Certified Nursing Aide (CNA) and Staff B Registered Nurse (RN) completed hand hygiene and donned gloves. Staff A and Staff B then prepared Resident #61 for a two person whole body mechanical lift. Staff A and Staff B then repositioned Resident #61 into bed. Staff A helped reposition Resident #61's foot with wound dressings into bed without changing gloves or hand hygiene. Staff B was then observed placing heel protector boots onto Resident #61 without changing gloves or completing hand hygiene. No gowns were observed for EBP while repositioning Resident #61. 2. Review of Resident #189's MDS dated [DATE] revealed Resident #189 utilizes the usage of an indwelling catheter. The MDS further revealed diagnoses of Urinary Tract Infection (UTI), Non-Alzheimer's dementia, and urine retention. Review of Resident #189's EHR page titled, Physician's Orders revealed orders for catheter care every shift, as well as an order for the implementation of EBP related to catheter cares. Further review of the Physician Orders revealed an order for hot charting related to positive Methicillin-resistant Staphylococcus aureus (MRSA). Observation 6/11/25 at 10:02 AM Staff A and Staff E CNA completed hand hygiene and donned gloves. Staff A and Staff E then prepared Resident #189 for transfer to the bathroom utilizing a mechanical sit to stand lift. Resident was transferred to the bathroom and then from the bathroom to Resident #189's bed. Staff A then repositioned Resident #189's feet into bed, and repositioned Resident #189's catheter bag to the side of the bed while wearing the same gloves with no hand hygiene completed. No gowns were observed during the transfers related to EBP. Interview 6/11/25 at 10:11 AM with Staff A and Staff E revealed that they should have worn gowns while transferring Resident #61, and Resident #189 as they both are on EBP precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview 6/11/25 at 10:44 AM with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) revealed their expectations would be for hand hygiene to be completed at the appropriate times and for proper PPE to be worn while completing cares. Interview 6/11/25 at 10:54 AM with the Administrator revealed that her expectation would be for proper hand hygiene at the appropriate times, and for PPE to be worn at appropriate times. 3. Review of Resident #38's MDS dated [DATE] revealed a 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 pressure chronic vascular ulcer right lower leg. The document further revealed a Focus Area for Enhanced Barrier Precautions (EBP) related to wounds initiated on 4/16/25. The Electronic Health Record (EHR) Clinical Physician Orders revealed an order started on 6/9/25 for implementation of EBP due to wounds. The 6/25 Treatment Administration Record (TAR) revealed 1. Cleanse with Normal Saline/Vashe wound wash if available, pat dry. 2. Apply Vaseline Gauze to the wound bed in Double Layer. 3. Cover with Foam Dressing such as Allevyn or Mepilex (bordered foam dressing). Change every 3 days and as needed if soiled every night shift every 3 day(s) for Right Lower Leg Wound Care-Order Date 5/23/2025. Observed on 6/9/25 at 12:37 PM a sign for EBP Resident B on the Resident #38's door. Continuous observation on 6/12/25 at 8:30 AM of Staff U, Licensed Practical Nurse (LPN), performed wound care to Resident #38's right lower extremity (RLE) lateral calf wound. Staff P, Assistant Director of Nursing (ADON) also present. A. Staff U completed hand hygiene, applied gown and gloves, and assisted the resident with application of gripper socks. B. Staff U removed gloves, and donned new gloves without hand hygiene. The staff disinfected a tote lid and applied paper towels as a barrier for placement of dressing supplies. C. Staff U changed gloves without hand hygiene, completed setup for dressing change, and changed gloves with hand hygiene completed. D. Staff U completed removal of compression garment on RLE, completed glove change with hand hygiene. E. Staff U completed saline wash followed by glove change with hand hygiene. F. Staff U utilizing scissors that had been disinfected cut through Xeroform packing to cut the appropriate size of dressing needed for the wound. The staff completed this technique twice as the Xeroform fell on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. Staff U completed glove change with hand sanitizer used. The staff dated the foam dressing and applied. The staff replaced the compression stocking and gripper sock. The staff gathered the trash, completed glove change with hand hygiene and placed the resident's wheelchair within reach. The staff completed hand hygiene at the end of the interaction. During the treatment on 6/12/25 at 8:30 AM Resident #38 stated no one but Staff U and the PACE girls wore gowns during her treatments. During an interview on 6/12/25 at 8:45 AM Staff P expected the staff utilize a chuck pad for a barrier and not paper towels. The staff stated sanitized scissors should not be used to cut through packaging of dressing. The staff expected hand hygiene with all glove changes. The staff further stated was concerning that Resident #38 stated Personal Protective Equipment (PPE) was not utilized during dressing changes or personal care. On 6/12/25 at 9:22 AM Staff V, Registered Nurse (RN)/Southwest (SW) Iowa Program of All-inclusive Care for the Elderly (PACE), stated she was not aware of an EBP sign posted on Resident #38's door until this week. The staff stated PPE had not been used prior to the current week's treatment even when the facility's staff were present. On 6/12/25 at 10:00 AM Staff Y, LPN/SW Iowa PACE, stated there was no sign on Resident #38's door regarding EBP until 6/9/25. The staff stated when she asked Staff T, LPN, about the sign, Staff T was unable to provide details as to why the resident required PPE. Staff Y stated the PPE had to be obtained from an unidentified staff member who stated PPE was only required during personal care. On 6/12/25 at 11:00 AM the Director of Nursing (DON) stated gloves were to be changed between tasks or when soiled with hand hygiene completed between gloves. The staff stated sanitized scissors should not be used to cut through packaging of dressings for wounds, and gloves should not touch packaging and dressing without changing and sanitizing. 4. Resident #57's MDS dated [DATE] revealed a BIMS score of 9/15 indicating moderate cognitive impairment. The document revealed diagnoses of cancer (with or without metastasis), anemia, and other specified polyneuropathy. The document provided the resident had 1 or more unhealed pressure ulcers/injuries with the resident having a Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle; slough or eschar may be present on some parts of the wound bed). The resident's Care Plan dated 6/10/25 revealed a Focus Area for EBP related to wounds dated 11/12/24. The document further revealed a Focus Area related to admission with a Stage 3 chronic pressure ulcer to the right buttock and Moisture Associated Skin Damage (MASD) to the left buttock initiated on 11/12/24. A revision on 2/27/25 revealed the right inner buttock deteriorated to a Stage IV on 12/12/24. Interventions provided for staff included treatment, position changes to offload pressure, diet and labs. The TAR 6/25 revealed Silvadene External Cream 1 % (Silver Sulfadiazine) Apply to Buttock topically every day shift for Wound care apply to wound bed to right inner buttock-Order Date 2/11/2025 and Triad Hydrophilic Wound Dress External Paste (Wound Dressings) Apply to peri-anal area topically every day shift for excoriation-Order Date 1/15/2025. Observed on 6/10/25 at 7:57 AM a sign on the resident's door for EBP Resident B. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continuous observation on 6/12/25 at 7:37 AM of Staff J, RN, provided wound care to Resident #57. Staff P present during observation. A. Staff J obtained supplies (treatment, gloves) before entering the resident's room. B. Upon entry Staff J began setting up treatment in the bathroom (resident was already in there). Staff P reminded Staff J to obtain a gown prior to beginning the treatment. C. Staff P reminded Staff J to complete hand hygiene prior to donning gloves. D. Staff J completed cleansing of the resident's buttocks maintaining a clean hand and dirty hand. Staff J's technique included wiping back to front. E. Staff J completed glove change with hand hygiene and wiped the area. Glove change completed without hand hygiene. F. Staff J applied Silvadine front to back using the same hand in multiple areas on the right and left buttocks. Glove change completed without hand hygiene. G. Staff J cleansed the resident's front peri area, placed cream on the back of the left glove and used the right to apply cream. H. The staff completed glove change without hand hygiene, assisted the resident with garment management, bagged trash, removed gloves and washed hands. On 8/12/25 at 8:00 AM Staff P stated her expectation for proper techniques for wound care and peri care included cleansing and ointment application from front to back techniques. The staff further expected hand hygiene to be completed between all glove changes. On 8/12/25 at 11:00 AM the DON stated peri hygiene and treatment application should be completed in a front to back technique. On 8/12/25 at 11:25 AM the Administrator stated EBP signs had been posted on resident doors, but recently been changed to include either Resident A or Resident B. The staff stated gloves should be changed after cleaning a resident, between tasks, and when changing a dressing. The Administrator expected that hand hygiene be completed between gloves. The Administrator stated hygiene should be completed in a front to back method. The facility Handwashing/Hand Hygiene Policy dated 8/19 revealed hand hygiene should be performed after removing gloves. The document further stated the use of gloves did not replace hand washing/hygiene, and gloves should be used when in contact with a resident who is on contact precautions.