STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Park Place	2401 East Eighth Street , Des Moines, Iowa, 50316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Correction date: 1/02/2026 The following deficiencies resulted from the facility's annual recertification survey and investigation of complaints #2625141-C, #2671743-C, and #2678226-C conducted December 1, 2025 through December 4, 2025 Deficiencies were cited for the regulatory categories of Complaint #2671743-C and #2678226-C No deficiency was cited for the regulatory category for Complaint 262141-C. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is	F0605		

OK/CP

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 reverse for further 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
	Administrator	12.24.25

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F0605 SS = D	Continued from page 1 not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive	F0605		

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F0605 SS = D	Continued from page 2 assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, staff interview and policy review, the facility failed to limit a as needed (PRN) psychotropic drug (drugs that affect a person's mental state) to 14 days for 1 of 5 residents reviewed (Resident #21). The facility reported a census of 51 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 9/4/25 Resident #21 scored a 12 on the Brief Interview for Mental Status, indicating moderate cognitive impairment. The resident had diagnoses to	F0605		

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F0605 SS = D	Continued from page 3 include debility, cardiorespiratory conditions, renal insufficiency, diabetes mellitus, anxiety disorder and depression. The MDS indicated the resident was not taking an antianxiety medication in the look back period. Review of the Electronic Health Record (EHR) for Resident #21 revealed an order for Lorazepam (medication to treat anxiety disorders) oral tablet 0.5 mg/ml, give 0.5 ml by mouth every 12 hours as needed for anxiety and SOB (shortness of breath), with an order date of 8/29/25 and a discontinue date of 12/3/25. Review of the Medication Administration Record (MAR) for Resident #21 for the months of August, September, October, November and December (up to the 3rd of December) revealed this medication was not administered. The EHR for Resident #21 included Pharmacist Medication Regimen Reviews (MRRs) dated 10/14/25 and 11/13/25. The recommendation on 10/14/25 documented CMS requires a 14 day stop on all PRN psychotropic medications unless the prescriber documents clinical rationale for continued use and provides a new duration for use on the continued order and further recommended to discontinue the PRN Lorazepam order due to non-use. The recommendation on 11/13/25 was the same as the recommendation on 10/14/25. The EHR lacked a response by the facility to both MRRs. During an interview 12/4/2025 at 12:00 PM, the Director of Nursing (DON) acknowledged the PRN order for Lorazepam exceeded the 14 days without a rationale or an end date for Resident #21 and acknowledged the facility did not respond to the pharmacy recommendations in October and November to discontinue the order. The DON stated an expectation PRN orders for psychotropic medications have a rationale to go past the 14 days and an end date. Review of the facility policy Psychotropic Medication Use, dated July 2022, documented psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. PRN orders for psychotropic medications are limited to 14 days. For psychotropic medications that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order.	F0605		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the	F0644		

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F0644 SS = D	Continued from page 4 pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, staff interview and facility policy review, the facility failed to refer a resident (Res #3) for a Level II PASRR evaluation following a newly diagnosed mental disorder for one of four residents reviewed for PASRR (Pre Admission Screening and Resident Review). The facility reported a census of 51 residents. Findings include: The Quarterly Minimum Data Set (MDS) assessment of Resident #3 dated 9/17/25 documented an admission date to the facility of 2/2/2023. The MDS documented diagnoses that included depression and psychotic disorder. The Care Plan of Resident #3 identified a (resolved) Focus Area of Antipsychotic Medications for behavior management with revision date of 10/01/25. The Encounter Note dated 12/17/24 from the facility physician documented the chief complaint for this visit was due to increased delusional behavior with hallucinations. The note additionally documented orders to add a new diagnosis of Delusional disorders, along with orders to begin an antipsychotic medication. Per review of the resident electronic health record performed on 12/4/25, nearly one year after the new diagnosis, the only PASRR located was dated 7/13/22 and did not include the diagnoses of depression, delusional disorder or the use of any psychotropic medications.	F0644		

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F0644 SS = D	Continued from page 5 On the afternoon of 12/2/25, the Chief Operating Officer of the long term care corporation stated the facility had self identified several PASRR being outdated or incomplete during an audit the day prior. She stated the facility Social Services Director had received education regarding this and a list of residents who needed PASRR updated. On 12/02/2025 at 3:55 pm, the Social Services Director confirmed he had received education and the list of residents. The Social Services Director shared the list of residents needing updated PASRR and confirmed Resident #3 was not included on the list, and was noted as her PASRR was accurate. The Social Services Director acknowledged no PASRR had been completed for Resident #3 since her admission to the facility. He explained the nursing staff is responsible to inform him when any new diagnoses or medications which could potentially affect the PASRR process are documented. He stated he did not recall ever being told about the diagnosis or medications for Resident #3. He added the facility had recently changed the process to include providing copies of visit notes and orders to him. The facility policy titled Admission Criteria, revision date March 2019 documented the following: All new admissions and readmissions are screened for mental disorders, intellectual disabilities or related disorders per the Medicaid Pre-Admission Screening and Resident Review process. The policy failed to reflect the need for updated screenings based on a resident change of condition.	F0644		
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,	F0645		

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F0645 SS = D	Continued from page 6 (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental	F0645		

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F0645 SS = D	Continued from page 7 disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, staff interview and policy review, the facility failed to fully submit a Level 1 Preadmission Screening and Resident Review (PASRR) evaluation to the appropriate state-designated authority prior to admission or within 30 days for 1 of 4 residents reviewed (Resident #50). The facility reported a census of 51 residents. Findings include: The Annual Minimum Data Set (MDS) dated 11/23/25 documented Resident #50 had a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. The resident had diagnoses to include medically complex conditions, cerebral palsy, anxiety disorder and depression. The MDS documented the original admission date for Resident#50 as 3/3/25. Review of the Electronic Health Record (EHR) for Resident #50 lacked documentation of a Level I PASRR submitted prior to admission or within 30 days of admission. Resident #50 admitted to the facility on 3/3/25. During an interview 12/2/25 at 11:30 AM, Staff F, Social Services Director (SSD), stated he just submitted a Level I PASRR last week for Resident #50 which had a determination of Level II, time limited approval. The determination date was 11/28/25. Staff F acknowledged the resident admitted to the facility in March of 2025. Clinical record review of the PASRR report for Resident #50, dated 11/28/25, had a determination of Level II approval, time limited, ending on 5/28/26. The PASRR report documented on 3/15/25 a Level I screen was submitted by the facility for consideration of nursing facility level of care, the screen was cancelled because the submitter did not submit requested documentation. On 11/8/25 a Level I screen was submitted by the facility for consideration of ongoing nursing facility level of care due to not having a PASRR approval prior to nursing facility admission. A full PASRR Level II assessment was completed and identified services and supports are identified. During an interview 12/2/25 at 12:40 PM, Staff F, SSD stated they were the one who submitted the PASRR in March for Resident #50 and did not realize it	F0645		

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F0645 SS = D	Continued from page 8 was cancelled due to not having the required documentation. Staff F acknowledged he did not go back in and check the resident's PASRR status and did not submit another PASRR until November which resulted in a Level II with identified specialized services for the resident. During an interview 12/2/25 at 1:39 PM, the Administrator stated an expectation a PASRR screening should have been fully completed in March when Resident #50 was admitted to the facility, and the requested documentation should have been submitted upon request in March of 2025 to completed the PASRR screening. The Administrator acknowledged the gap of time from March to November of 2025 with PASRR not completed for the resident. Review of facility policy Admission Criteria, revision date of March 2019, documented all new admissions are screened for mental disorder, intellectual disabilities or related disorders per the Medicaid Pre-Admission Screening and Resident Review (PASRR) process. The facility conducts a Level I PASRR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria.	F0645		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, staff interview, and contracted Registered Dietitian interview, the facility failed to implement dietary interventions in a timely manner for a resident who was experiencing significant weight loss (Res # 44). The facility reported a census of 51 residents. Findings include: The Minimum Data Set (MDS) Assessment of Resident #44 dated 11/12/25 reflected a height of 72 inches and a weight of 122 pounds. The MDS documented the resident had experienced a weight loss of 5% or more in the last month or 10% or more in the last 6 months, and that the resident was not on a physician-prescribed weight-loss regimen.	F0658		

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F0658 SS = D	Continued from page 9 The Care Plan of Resident #44 identified a Care Area of Inability to Maintain Nutrition, dated 12/19/24. The Care Plan directed staff to provide and serve supplements are ordered. The Weights section of Resident #44 Electronic Health Record (EHR) documented a weight of 138.5 pounds on 5/5/25. The EHR documented a weight of 122 pounds on 11/6/25, a 11.91% loss. The Orders section of the EHR documented an order for a nutritional supplement was placed on 11/24/2023. The Weight Change Note, authored by the facility Registered Dietitian (RD), dated 10/9/25 noted a weight of 125 pounds, which triggered a significant weight loss in the prior 90 days. The note documented the current interventions in place and recommended increasing his house supplement to 240 milliliters at 10:00 am and maintaining the order for 120 milliliters in the afternoon/evening. The Episodic Dietary Note, authored by the RD, dated 11/25/25 noted a weight of 122 pounds. The note stated the resident was again triggering for a significant weight loss, with the weight being stable over the last month. The note documented the RD was still recommending increasing the house supplement to 240 milliliters at 10:00 am and maintaining the order for 120 milliliters in the afternoon/evening. On 12/3/25 at 12:40 pm, the RD stated Resident #44 had always been thin and it had been a battle for years. She stated the resident likes to hide things in his coat pockets and it was implemented to make sure and weigh him with his coat off for accurate weights. She included in nicer weather, the resident likes to be outside smoking during breakfast hours so she implemented bringing him a breakfast sandwich outside so he could still eat breakfast. She stated he had been on supplements for long term in addition to other interventions such as finger foods and offering substitute meals. On 12/3/25 at 2:38 pm, the Chief Operating Officer (COO) of the facility corporation stated the Director of Nursing (DON) is to follow through on the recommendations made by the RD.	F0658		

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F0658 SS = D	Continued from page 10 On 12/3/25 at 3:40 pm, the DON stated when the RD made the recommendations, it had been faxed to the provider. She stated the provider never replied so she had called the provider that day and updated the order. On 12/3/25 at 4:30 pm, the COO stated there are other forms of communication and if the provider did not respond to a fax, the facility staff should have either called the provider or spoke to the provider in person when they are in the building. She stated the Nurse Practitioner is in the building weekly.	F0658		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, staff interview and facility policy review, the facility failed to perform pre and post dialysis assessments for one of one resident reviewed for dialysis (Res #6). The facility reported a census of 51. Findings include: The Minimum Data Set (MDS) Assessment of Resident #6 dated 11/12/25 documented diagnoses that included renal (kidney) failure. The MDS documented the resident received hemodialysis during the last 14 days of the look back period. The MDS documented that the resident scored a 14 out 15 for the brief interview for mental status, indicating intact cognitive skills. The Care Plan documented a Focus Area of Dialysis, dated 11/7/25. The Care Plan documented the resident attending dialysis on Monday, Wednesdays and Fridays, dated 11/7/25. The Care Plan failed to direct staff to perform pre and post dialysis assessments. The Evaluation section of the Electronic Health Record revealed pre and post dialysis assessment were logged for a total of 10 times between 11/7/25 and 12/3/25. The Treatment Administration Record (TAR) for November of 2025 reflected an order dated 11/6/25 to complete	F0698		

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F0698 SS = D	Continued from page 11 pre/post vital signs and weight, as well as completing a pre/post evaluation, twice a day, every Monday, Wednesday, and Friday. On 12/2/25 at 10:48 am, the Director of Nursing stated she would look into the resident's pre and post dialysis assessments. On 12/2/25 at 11:42 am, the DON stated she was unable to find any further information on the assessments and provided the facility policy. On 12/03/2025 at 9:38 am, Staff G, Registered Nurse (RN) stated he assesses what the resident ate for breakfast, vital signs, and assesses the dialysis site for pre-evaluation. He stated when the resident returns, he offers food, and assesses vital signs and the dialysis site again. He stated there is a form for pre and post dialysis that is to be filled out. The facility policy End-Stage Renal Disease, Care of a Resident with, revision date September 2010 documented the following: Point 2: Education and training of staff includes, specifically:a. the nature and clinical management of ESRD (including infection prevention and nutritional needs); b. the type of assessment data that is to be gathered about the resident’s condition on a daily or per shift basis; c. signs and symptoms of worsening condition and/or complications of ESRD;	F0698		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during	F0756		

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F0756 SS = D	Continued from page 12 this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, staff interview and policy review, the facility failed to follow through and act on recommendations of Pharmacy drug regimen reviews to complete an Abnormal Involuntary Movement Scale (AIMS) assessment for 1 of 5 residents reviewed (Resident #21). The facility reported a census of 51 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 9/4/25, Resident #21 scored a 12 on the Brief Interview for Mental Status, indicating moderate cognitive impairment. The resident had diagnoses to include debility, cardiorespiratory conditions, renal insufficiency, diabetes mellitus, respiratory failure, anxiety disorder and depression. The MDS indicated the resident was taking high-risk drug classes to include an antipsychotic in the look back period. The Care Plan for Resident #21, with an initiation date of 9/4/25, included a focus area the resident is on a antipsychotic medication with a goal the resident will be/remain free of psychotropic drug related complications, including movement disorder. Review of the Electronic Health Record (EHR) revealed Resident #21 had an order and was receiving the medication Haloperidol (antipsychotic) oral tablet 5 MG, give 0.5 tablet by mouth two times a day related to Major	F0756		

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F0756 SS = D	Continued from page 13 Depressive Disorder, with a start date of 8/29/25, the date of admission to the facility. The EHR for Resident #21 included Pharmacy Medication Regimen Reviews (MRRs), dated 9/28/25, 10/14/25 and 11/13/25. The findings and recommendations for each review were the same, which documented the resident is taking the antipsychotic medication Haloperidol, monitoring for movement disorders with an Abnormal Involuntary Movement Scale (AIMS) is recommended upon initiation of the medication, during dosage changes and then at least every 6 months. Complete an AIMS assessment now. The 11/13/25 MRR included the statement initial AIMS not found in the EHR. The EHR lacked a response by the facility to the MRR recommendations. The EHR for Resident #21 included one AIMS evaluation, completed on 12/1/25. During an interview 12/04/2025 at 8:45 AM, the Director of Nursing (DON) acknowledged an AIMS assessment was not completed until the 1st of December and should have been completed upon admission given Resident #21 was on an antipsychotic. These should be done upon admission and quarterly, or as needed. Review of the facility policy Medication Regimen Reviews, with a revision date of May 2019, documented the goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication.	F0756		
F0803 SS = E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically;	F0803		

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F0803 SS = E	Continued from page 14 §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, staff interviews and policy review, the facility failed to ensure residents on a therapeutic diet to include pureed food (Residents #24, #38, #40 and #42) were served the correct amount and serving size. The facility reported a census of 51 residents. Findings include: During an observation 12/3/25 at 10:30 AM, Staff E, cook, prepared the pureed lunch food items following a specific recipe for each food item. The recipe was followed accurately and provided the serving scoop size for each food item. Staff E advised there were 3 residents on a full pureed diet (Residents #24, #40 and #42) and one resident on a pureed meat diet (Resident #38). The food items pureed were frosted chocolate cake, beef stew, steamed vegetables and biscuit. Review of the Electronic Health Record (EHR) for Resident #24 revealed a diet order with a start date of 2/4/25 for a general diet, pureed texture (smooth, creamy and lump-free) and thin consistency. Review of the EHR for Resident #40 revealed a diet order with a start date of 10/29/25 for a general diet, pureed texture, nectar consistency. Review of the EHR for Resident #42 revealed a diet order with a start date of 2/5/24 for a general diet, pureed texture, thin consistency. Review of the EHR for Resident #38 revealed a diet order with a start date of 9/21/20 and a revision date of 5/24/22 for a general diet, mechanical soft texture, thin consistency and pureed meats. During a continuous observation 12/3/25 beginning at 12:00 PM, Staff E, Cook began preparation for lunch service in the main dining room and placed serving scoops into the pureed food items on the steam table. Staff E used the red handled scoop, which is a #16 scoop size (2 ounces), for the pureed beef stew, the pureed vegetables, and the pureed biscuit. Staff E used the grey handled scoop for the pureed dessert of frosted chocolate cake, which is a #8 scoop size (4 ounces). Review of the Sysco Dining Manager recipe sheets for the pureed food	F0803		

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F0803 SS = E	Continued from page 15 prepared and served for lunch revealed the residents on the pureed diet for the dessert should have received a scoop size #10 (3.76 ounces), for the vegetables it should have been a scoop size #12 (2.67 to 3.3 ounces), for the beef stew it should have been 2 servings of the scoop size #8 (4 ounces in each scoop) and for the biscuit it should have been a #12 scoop size. The residents received a smaller serving of the vegetables, beef stew and biscuit than what they should have received and a larger serving of the dessert. During an interview 12/3/25 at 1:30 PM, the Certified Dietary Manager (CDM) stated that staff are expected to use the appropriate size serving scoop for residents to ensure each resident is served the appropriate amount of food. The CDM acknowledged the residents on a pureed diet did not receive the appropriate amount of food, and were served less than what they should have been served for each food item other than the dessert, which was a larger portion than what they should have been served. Review of the facility policy Food and Nutrition Services, with a revision date of October 2017, documented each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Meals and/or nutritional supplements will be provided per order or per resident request.	F0803		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve	F0812		

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F0812 SS = E	Continued from page 16 food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interview and policy review, the facility failed to ensure staff used proper food handling procedures, failed to ensure hair was covered by staff while in the kitchen area, failed to maintain a clean kitchen area where food was served to residents, failed to ensure all food was covered on room trays and failed to ensure staff used proper hand placement on glassware used to serve residents. The facility failed to prevent possible contamination of food. The facility reported a census of 51 residents. Findings include: During a continuous observation 12/1/25, beginning at 12:00 PM, Staff D, Dietary Aide, placed his hand directly on the rim of a coffee cup while serving residents drinks during lunch service for four separate residents. Staff D carried two separate room trays out of the dining room down hallways with the dessert (cake) not covered. The remainder of the room trays served to residents who ate their meal in their room were placed on carts and delivered to residents with the dessert partially covered by a plastic lid. During an observation 12/3/25 at 10:30 AM, Staff D, Dietary Aide, was observed performing meal preparation tasks in the main kitchen without a beard net, Staff D had a beard. During a continuous observation 12/3/25, beginning at 11:50 AM, Staff D, Dietary Aide, stacked the water/juice plastic cups and delivered residents cups from this stack of cups, with his hand on the rim of the cups. During an observation 12/3/25 at 12:00 PM, food was brought from the main kitchen in the basement to the kitchenette in the main dining room for lunch service. Observed the swinging door into the kitchenette to have splattered fluid and food on the inside of the door, pink and brown in color, with a pick substance pooled on the bottom of the rim of the door. Observed food/fluid splattered on the walls by the door and door frame area. The walls by the utility sink in the kitchenette had a brown substance splattered on the two walls. The insulated food cart used to bring up food from the kitchen in the basement to the kitchenette in the dining room had food/fluid splattered on the outside of the cart. During a continuous observation 12/3/25, beginning at 12:05 PM, Staff E, Cook, began preparations for lunch service from the kitchenette. Lunch served on this date was beef stew, a tossed green salad with shredded cheese	F0812		

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F0812 SS = E	Continued from page 17 and dressing, a biscuit and frosted chocolate cake. Staff E placed hot food in the steam table and placed a plastic container of shredded cheese and two separate plastic containers of shredded and torn salad greens on a cart next to the steam table. Staff E put a glove on her right hand, then placed plates out on the surface of the steam table with her right hand and began plating food, using her right hand to scoop hot food onto the plate and into bowls. Staff E put her right hand directly into the lettuce containers to place lettuce onto the plates and then put her right hand directly into the cheese container and put the cheese on top of the lettuce on the plates. Staff E continued this process of plating food for residents. In between placing the lettuce and cheese onto the plates, Staff E used this same gloved hand to touch plates, paper tickets, utensils and surfaces. Staff E used this same gloved hand to put the lettuce and the cheese onto several plates without changing the glove. Staff E did change the glove after touching fish sticks and then placed her gloved hand into the lettuce and then into the cheese for several more plates without changing gloves and touched surfaces, plates and utensils, and paper tickets in between. At the end of lunch service, with approximately 10 room trays left to plate, Staff E then used tongs to put the lettuce and the cheese onto the plates. The room trays had the dessert on a plate, the plate was covered with just a plastic lid, it did not cover the entire dessert, which was a piece of cake. During an interview 12/3/25 at 1:30 PM, the Certified Dietary Manager (CDM) stated an expectation staff do not place their hands on the rim of the cups or glasses to serve residents and do not stack the plastic cups while placing cups at each resident's table. The CDM stated an expectation all food is covered completely on room trays before they leave the dining room. The CDM stated an expectation staff change gloves each time before putting the gloved hand into a container of food and touching the food directly, the CDM stated an expectation staff use tongs or a utensil to touch food items and not their hands, and not use the same gloved hand after touching surfaces to stop the potential for cross contamination and for infection control purposes. The CDM stated an expectation the kitchenette area be clean and staff with beards wear a beard net while in the kitchen. The CDM acknowledged male staff in the kitchen, two staff, have a beard and have not worn beard nets, he stated the facility does not have beard nets available and they will need to be ordered. During an observation 12/3/25 at 1:50 PM, observed two male staff in the main kitchen, both cleaning the lunch service dishes, neither of them had a beard net and both had beards. Review of the facility policy Food Preparation and Service, with a revision	F0812		

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F0812 SS = E	Continued from page 18 date of April 2019, documented food and nutrition services employees prepare and serve food in a manner that complies with safe food handling practices and food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks. Disposable gloves are single-use items and are discarded after each use. Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food. Review of the facility policy Sanitization, with a revision date of November 2022, documented the food service area is maintained in a clean and sanitary manner, all kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects.	F0812		
F0865 SS = E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and	F0865		

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F0865 SS = E	Continued from page 19 §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;	F0865		

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F0865 SS = E	Continued from page 20 §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is NOT MET as evidenced by: Based on review of the facility's Quality Assurance Performance Improvement (QAPI) plan, the facilities past 3 surveys, and staff interview, the facility failed to correct their own deficiencies for 1 of 1 areas of concern. The facility reported a census of 51 residents. Findings include: The facility had the following concern identified at the current recertification survey that had also been cited at the previous 2 recertification surveys and at a recent complaint survey at a harm level: a. Food Procurement,Store/Prepare/Serve-Sanitary The facility policy Quality Assurance and Performance Improvement (QAPI) Program, dated 2001, documented this facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and	F0865		

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F0865 SS = E	Continued from page 21 quality of life for our residents. The objectives of the QAPI program are to:provide a means to measure current and potential indicators for outcomes of care and quality of life.provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators.reinforce and build upon effective systems and processes related to the delivery of quality care and services.establish systems through which to monitor and evaluate corrective actions. The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include:tracking and measuring performance;establishing goals and thresholds for performance measurement;identifying and prioritizing quality deficiencies;systematically analyzing underlying causes of systemic quality deficiencies;developing and implementing corrective action or performance improvement activities; andmonitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed. During an interview 12/04/2025 at 1:15 PM, the Administrator acknowledged F812 was cited on the current survey, the previous 2 surveys and a recent complaint survey.	F0865		
F0883 SS = E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:	F0883		

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F0883 SS = E	Continued from page 22 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, staff interview, guidance from the Centers for Disease Control (CDC) and facility policy review, the facility failed to offer the recommended pneumococcal and Influenza vaccines to eligible residents for 4 of 5 residents reviewed for vaccines (Resident #14, Resident #33, Resident #41 and Resident #50). The facility reported a census of 51 residents. Findings include: 1.The Admission Minimum Data Set (MDS) of Resident #14	F0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Park Place	**2401 East Eighth Street , Des Moines, Iowa, 50316**

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F0883 SS = E	Continued from page 23 dated 10/22/25 documented an admission date to the facility of 10/16/25 and a date of birth of 9/4/1957. The MDS documented that the resident had diagnoses including chronic respiratory disease, heart disease, peripheral vascular disease, and diabetes. The MDS indicated that the resident had oxygen therapy. It also indicated that he was not given the influenza vaccination as it was not offered. Observation 12/03/25 at 7:28AM revealed the residents room had an oxygen concentrator, and a Continuous Positive Airway Pressure (CPAP) machine in the room at the bedside. The Electronic Health Record (EHR) indicated that Resident #14 received the influenza vaccination on 12/3/25 at 12:00 AM and no education was provided. The EHR lacked documentation of offering, educating or declination of vaccination prior to this time and date. The progress notes indicated that the vaccination time was actually 7:15 PM on 12/3/25. 2. The MDS of Resident #33 dated 11/5/25 documented an admission date to the facility of 12/12/24 and a date of birth of 10/27/1961. It also indicated that she was not up to date with her pneumococcal vaccination as it was not offered. The Electronic Health Record (EHR) indicated that Resident #33 received the pneumococcal vaccination on 12/4/25 at 12:00 AM and no education was provided. The EHR lacked documentation of offering, educating or declination of vaccination prior to this time and date. The progress notes indicated that the vaccination time was actually 7:15 AM on 12/4/25. 3. The MDS of Resident #41 dated 10/8/25 documented an admission date to the facility of 6/16/20 and a date of birth of 11/4/1950. It also indicated that he was not given the Influenza vaccination and none of the above reasons was indicated as why not. The Electronic Health Record (EHR) indicated that Resident #41 received the influenza vaccination on 12/3/25 at 12:00 AM and no education was provided. The EHR lacked documentation of offering, educating or declination of vaccination prior to this time and date. The progress notes indicated that the vaccination time was actually 7:18 AM on 12/4/25. 4. The MDS of Resident #50 dated 11/23/25 documented an admission date to the facility of 11/20/25 and a date of birth of 11/24/1975. It also indicated that she was not up to date with her pneumococcal vaccination as it	F0883		

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F0883 SS = E	Continued from page 24 was not offered. The Electronic Health Record (EHR) indicated that Resident #50 received the pneumococcal vaccination on 12/4/25 at 12:00 AM and no education was provided. The EHR lacked documentation of offering, educating or declination of vaccination prior to this time and date. The progress notes indicated that the vaccination time was actually 7:02 AM on 12/4/25. On 12/03/2025 a list of missing vaccinations for 4 residents was provided to Staff A, Infection Preventionist. Resident #14 missing Influenza and COVID-19, Resident #33 missing pneumovax, Resident #41 missing Influenza and COVID-19 and Resident #50 missing COVID1-19 and pneumovax. Requested documentation of offering and refusing or vaccination given. Stated she would look into it. In an interview on 12/4/25 at 10:15 AM Staff A, Infection Preventionist (IP) stated that her process for ensuring residents are offered vaccinations is to look on the Immunization Registry Information (IRIS) database (database which tracks vaccination records), ask residents on admission and offer yearly required vaccinations. She has an immunization tracker that she follows. When asked about how 4 out of 5 residents reviewed were missing vaccinations. She stated that she must have just missed them and she takes responsibility. She stated that since being aware of the missing vaccinations she has now received orders and has given them. In a policy titled Azria Influenza, Prevention and Control of Seasonal revised August of 2020, it indicated that the IP organizes and oversees an annual influenza vaccine campaign and all residents and staff are offered the vaccine prior to the onset of the influenza season. In a policy titled Azria Pneumococcal Vaccine updated September 2020, it indicated all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. It also indicated that prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within 30 days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. The CDC document titled Adult Immunization Schedule Notes, dated 10/7/25 documented the following concerning pneumococcal and influenza vaccinations and	F0883		

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F0883 SS = E	Continued from page 25 can be found at https://www.cdc.gov/vaccines/hcp/imz-schedules/adult-notes.html#note-pneumo: Pneumococcal Vaccine age 50 years or older who have: Not previously received a dose of PCV13, PCV15, PCV20, or PCV21 or whose previous vaccination history is unknown: 1 dose PCV15 or 1 dose PCV20 or 1 dose PCV21. If PCV15 is used, administer 1 dose PPSV23 at least 1 year after the PCV15 dose (may use minimum interval of 8 weeks for adults with an immunocompromising condition,* cochlear implant, or cerebrospinal fluid leak). Previously received only PCV7: follow the recommendation above. Previously received only PCV13: 1 dose PCV20 or 1 dose PCV21 at least 1 year after the last PCV13 dose. Previously received only PPSV23: 1 dose PCV15 or 1 dose PCV20 or 1 dose PCV21 at least 1 year after the last PPSV23 dose. If PCV15 is used, no additional PPSV23 doses are recommended. Previously received both PCV13 and PPSV23 but NO PPSV23 was received at age 65 years or older: 1 dose PCV20 or 1 dose PCV21 at least 5 years after the last pneumococcal vaccine dose. Previously received both PCV13 and PPSV23, AND PPSV23 was received at age 65 years or older: Based on shared clinical decision–making, 1 dose of PCV20 or 1 dose of PCV21 at least 5 years after the last pneumococcal vaccine dose. Influenza vaccine age 19 years or older: 1 dose any influenza vaccine appropriate for age and health status annually. Solid organ transplant recipients aged 19 through 64 years receiving immunosuppressive medications: HD-IIV3 and aIIV3 are acceptable options. No preference over other age–appropriate IIV3 or RIV3. Age 65 years or older: Any one of HD-IIV3, RIV3, or aIIV3 is preferred. If none of these three vaccines is available, then any other age–appropriate influenza vaccine should be used.	F0883		
F0887 SS = D	COVID-19 Immunization	F0887		

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F0887 SS = D	Continued from page 26 CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:	F0887		

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F0887 SS = D	Continued from page 27 (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, staff interview, guidance from the Centers for Disease Control (CDC) and facility policy review, the facility failed to offer the recommended COVID-19 vaccine to eligible residents for 3 of 5 residents reviewed for vaccines (Resident #14, Resident #41 and Resident #50). The facility reported a census of 51 residents. Findings include: 1.The Minimum Data Set (MDS) of Resident #14 dated 10/22/25 documented an admission date to the facility of 10/16/25 and a date of birth of 9/4/1957. It also indicated that he was not up to date with his COVID-19 vaccination. The Electronic Health Record (EHR) indicated that Resident #14 received the COVID-19 vaccination on 12/4/25 at 12:00 AM and no education was provided. The EHR lacked documentation of offering, educating or declination of vaccination prior to this time and date. The progress notes indicated that the vaccination time was actually 8:14 AM on 12/4/25. 2.The MDS of Resident #41 dated 10/8/25 documented an admission date to the facility of 6/16/1920 and a date of birth of 11/4/1950 It also indicated that he was not up to date with his COVID-19 vaccination. The EHR indicated that Resident #41 received the COVID-19 vaccination on 12/4/25 at 12:00 AM and no education was provided. The EHR lacked documentation of offering, educating or declination of vaccination prior to this time and date. The progress notes indicated that the vaccination time was actually 8:20 AM on 12/4/25 3.The MDS of Resident #50 dated 11/23/25 documented an	F0887		

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F0887 SS = D	Continued from page 28 admission date to the facility of 11/20/25 and a date of birth of 11/24/1975. It also indicated that she was not up to date with her COVID-19 vaccination. The EHR indicated that Resident #50 received consent and an order to give COVID-19 on 12/3/25 at 6:33 PM but lacked documentation of the vaccination being given prior to the surveyors exiting. The EHR also lacked documentation of offering, educating or declination of vaccination prior to this time and date. On 12/03/2025 a list of missing vaccinations for 4 residents was provided to Staff A, Infection Preventionist. Resident #14 missing Influenza and COVID-19, Resident #33 missing pneumovax, Resident #41 missing Influenza and COVID-19 and Resident #50 missing COVID1-19 and pneumovax. Requested documentation of offering and refusing or vaccination given. Stated she would look into it. In an interview on 12/4/25 at 10:15 AM Staff A, Infection Preventionist (IP) stated that her process for ensuring residents are offered vaccinations is to look in IRIS, ask residents on admission and offer yearly required vaccinations. She has an immunization tracker that she follows. When asked about how 4 out of 5 residents reviewed were missing vaccinations. She stated that she must have just missed them and she takes responsibility. She stated that since being aware of the missing vaccinations she has now received orders and has given them. In a policy titled Azria Coronavirus Disease (COVID-19) – Infection Prevention and Control Measures revised October 2022, it indicated that the facility follows infection prevention and control practices recommended by the CDC to prevent the transmission of COVID-19 within the facility. The CDC document titled Staying Up to Date with COVID-19 Vaccines, dated 11/19/25 documented the following concerning COVID-19 vaccination and can be found at https://www.cdc.gov/covid/vaccines/stay-up-to-date.html : Importance of staying up to date Getting the 2025–2026 COVID-19 vaccine is important because: Protection from the COVID-19 vaccine decreases with time.	F0887		

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F0887 SS = D	Continued from page 29 Immunity after COVID-19 infection decreases with time. COVID-19 vaccines are updated to give you the best protection from the currently circulating strains. Getting the 2025–2026 COVID-19 vaccine is especially important if you: Never received a COVID-19 vaccine Are ages 65 years and older Are at high risk for severe COVID-19 Are living in a long-term care facility Are pregnant, breastfeeding, trying to get pregnant, or might become pregnant in the future. Want to lower your risk of getting Long COVID	F0887		

Allegation statement Date of Compliance 1 2 2026

F 605

1. Resident #21s prn medication was reviewed and updated

2. All residents with prn psychotropic medications have the potential to be affected. Facility reviewed all residents with psychotropic medications to ensure the appropriate stop date or provider rationale for not having the stop date.

3. RNC completed education with applicable IDT members in r/t prn psychotropic requirements.

4. The DON/Designee will complete audits of prn psychotropics weekly x 4 weeks and monthly x 3 months to ensure appropriate stop date or physician rational is provided for all psychotropic. DON/Designee will audit pharmacy recommendations on monthly basis x 3 months. The DON will report findings to the QAPI committee monthly for 3 months to ensure compliance and further analysis.

F644

1. Resident #3 was referred for possible level 2 PASRR to include the newly diagnosed mental disorder on 12/4/25.

2. All residents have the potential to be affected. Facility reviewed and updated as needed all residents PASRRs to ensure accuracy and the inclusion of all diagnosed mental disorders.

3. Regional Social Service Director completed education with Social worker on 12/2 in r/t PASRR process and compliance.

4. The Administrator /Designee will complete random PASRR audits weekly x 4 weeks and monthly x 3 months to ensure they contain accurate active Diagnoses. The Administrator will report findings to the QAPI committee monthly for 3 months to ensure compliance and further analysis.

F 645

1. Resident #50 Level 2-time limited PASRR completed on 11/28/25 remains current.

2. All residents have the potential to be affected. Facility reviewed and or updated as needed all newly admitted residents PASRRs.

3. Regional Social Service Director completed education with Social workers on 12/2 in r/t PASRR process and compliance.

4. The Administrator /Designee will complete random PASRR audits weekly x 4 weeks and monthly x 3 months to ensure PASRR is present or requested on Admission. The Administrator will report findings to the QAPI committee monthly for 3 months to ensure compliance and further analysis.

F 658

1. Resident #44s supplement order recommended by the RD was obtained on 12/4/25.

2. All residents have the potential to be affected. Facility reviewed and ensured appropriate follow up on all RD recommendations in last 60 days.

3. RNC completed education with RD, DON, and Nurse Manager on timely response to RD recommendations on 12/3/2025.

4. The Administrator /Designee will complete audits weekly x 4 weeks and monthly x 3 months to ensure appropriate follow-up for all RD recommendations. The DON will report findings to the QAPI committee monthly for 3 months to ensure compliance and further analysis.

F 698

1. Resident #6 no longer resides in the facility.

2. All residents on Dialysis have the potential to be affected. Facility reviewed Residents on Dialysis to assess and ensure completion of pre/post dialysis evaluation.

3. DON initiated education with licensed nurses on completion of the pre/post dialysis evaluations on 12/3.

4. The DON/Designee will complete audits weekly x 4 weeks and monthly x 3 months to ensure appropriate follow-up for all RD recommendations. The DON will report findings to the QAPI committee monthly for 3 months to ensure compliance and further analysis.

F 756

1. Resident #21s AIMS assessment was completed on 12/1/2025.

2. All residents have the potential to be affected. Facility reviewed October and November 2025 Pharmacy Recommendations to ensure all were acted on including those indicating the need for AIMS assessments

3. RNC provided education on 12/4 and 12/23/25 to DON /Nurse Management on monthly DRR review and timely follow up.

4. The Administrator/Designee will complete audits monthly x 3 months to ensure appropriate follow-ups for all DRR. The Administrator will report findings to the QAPI committee monthly for 3 months to ensure compliance and further analysis.

F 803

1. There were no adverse occurrences associated with residents # 24, 38,40 and 42.

2. All Residents have the potential to be affected. CDM educated Staff E, Cook on Meal service and scoop sizes, therapeutic diets and pureed food on 12/3/25.

3. CDM educated Dietary Staff Cooks and any other Dietary staff associated with serving meals (including therapeutic diet and pureed meals) and scoop sizes.

4. The Admin/Designee will complete audits weekly x 4 weeks and monthly x 3 months to ensure appropriate scoop sizes are used for meal service. The Administrator will report findings to the QAPI committee monthly for 3 months to ensure compliance and further analysis.

F 812

1. There were no adverse occurrences associated with alleged deficient Kitchen sanitation practices.

2. All residents have the potential to be affected. CDM educated Dietary Staff on Kitchen sanitation practices to include the use of hair and beard nets, proper handling of plates and glasses during meal service, food being covered when being taken out of the dining area, utilization of tongs vs. gloved hands, and general cleanliness of kitchen areas, walls, carts etc.

3. CDM educated Dietary Staff on Kitchen sanitation practices to include the use of hair and beard nets, proper handling of plates and glasses during meal service, food being covered when being taken out of the dining area, utilization of tongs vs. gloved hands, and general cleanliness of kitchen areas, walls, carts etc.

4. The Admin/Designee will complete audits weekly x 4 weeks and monthly x 3 months to ensure the use of hair and beard nets, proper handling of plates and glasses during meal service, food being covered when being taken out of the dining area, utilization of tongs vs. gloved hands, as well as general kitchen cleanliness. The Administrator will report findings to the QAPI committee monthly for 3 months to ensure compliance and further analysis.

F 865

1. There were no adverse occurrences associated with the alleged deficient practice associated with Food Procurement Store, Prepare/Serve- Sanitary (Kitchen Sanitation)

2. All residents have the potential to be affected. Administrator educated facility staff on Kitchen Sanitation and associated practices and Regulation.

3. Administrator educated facility staff on Kitchen Sanitation and associated practices and Regulation. An active process improvement plan (PIP) r/t Kitchen Sanitation was put into place as part of facilities routine QAPI process to maintain continued focus.

4. Regional Staff will complete audits monthly x 3 months of QAPI minutes including specifically the Kitchen Sanitation PIP and review of other survey related items.

F 883

1. Facility offered and administered if applicable pneumonia and influenza vaccines to residents # 14, 33, 41, and 50.

2. All residents have the potential to be affected. Facility reviewed current residents to ensure pneumonia and influenza vaccines offered and administered as applicable.

3. RNC educated DON and Nurse Manager on Vaccine polices and associated requirements on 12/4/25. Going forward, new admissions including vaccination status will be reviewed routinely at clinical start up to ensure residents are offered or are current with vaccinations. Immunization status will be reviewed monthly by DON/Nurse Manager.

4. The DON/Designee will complete audits weekly x 4 weeks and monthly x 3 months to ensure appropriate follow-up for all RD recommendations. The DON will report findings to the QAPI committee monthly for 3 months to ensure compliance and further analysis.

F 887

1. Facility offered and administered if applicable the updated covid 19 vaccine to residents # 14, 41 and 50.

2. All residents have the potential to be affected. Facility reviewed current residents to ensure COVID 19 2025 /2026 vaccines were offered and administered as applicable.

3. RNC educated DON and Nurse Manager on Vaccine polices and associated requirements on 12/4/25. Going forward, new admissions including vaccination status will be reviewed routinely at clinical start up to ensure residents are offered or are current with vaccinations. Immunization status will be reviewed monthly by DON/Nurse Manager.

4. The DON/Designee will complete audits weekly x 4 weeks and monthly x 3 months to ensure appropriate follow-up for all RD recommendations. The DON will report findings to the QAPI committee monthly for 3 months to ensure compliance and further analysis.