DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH LONGVIEW	1010 LONGVIEW ROAD MISSOURI VALLEY, IA 51555

(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
F 000	INITIAL COMMENTS	F 000		
Ok ✓ Lg	Correction date: 1-24-25			
	The following deficiencies resulted from investigation of complaints #125113-C, # 125192-C, and # 125781-C, conducted January 14, 2025 to January 16, 2025.			
	Complaints #125113-C and #125192-C were substantiated.			
	See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.			
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		
	§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 interviews, physician interview, and policy review the facility failed to complete physician's orders for 2 of 3 residents (Resident #3 and #4) reviewed. The facility reported a census of 72 residents.			
	Findings include:			
	1. According to the Quarterly Minimum Data Set (MDS) with a reference date of 10/23/24 documented a Brief Interview of Mental Status (BIMS) score of 15. A BIMS score of 15 suggested Resident #3 had no cognitive impairment. No rejection of care was noted		✓	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelly Pattison | TITLE: Administrator | (X6) DATE: 1/31/25

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

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F 658	Continued From page 1 during the review period. The MDS listed the following diagnoses for Resident #3: Parkinson's Disease, coronary artery disease, diabetes mellitus, anxiety, depression, post traumatic stress disorder (PTSD) and insomnia. The following Progress Notes were documented for Resident #3: -On 11/20/22 at 11:33 AM the nurse practitioner (ARNP) saw Resident #3 today. Resident indicated his knee is a lot better since surgery. Resident indicated he had a sore throat, PCP ordered strep test, flu test and COVID-19 test. -On 11/22/24 at 12:03 PM strep test was collected. PCP aware. -On 11/22/24 at 5:51 PM strep test was negative, resident denied having a short throat. PCP office aware. Review of the November 2024 Medication Administration Record (MAR) documented the following order: strep test, flu test, and COVID-19 test, one time only for mild pain, until 11/20/24 at 11:59 PM. The order date was documented as 11/20/24 at 11:36 AM. The order was not signed out as being completed. Clinical record review revealed a document titled Nursing Home Visit, dated 11/25/24, resident was seen for his routine care. He did report having a sore throat and it hurting to swallow. The Assessment/Plan included strep test, flu test and COVID-19 test. In the results section the following notes were documented by the ARNP's Medical Assistant (MA): -On 11/21/24 at 11:58 AM spoke with the Medical Records Director at the facility. She stated the order for the strep test was laying by the fax machine this morning when she got to work. She	F 658		

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F 658	Continued From page 2 gave the orders to a nurse, so hopefully it will get done\today. -On 11/22/24 at 6:59 AM spoke with staff member and she stated the order is there for the strep test, but no record of it being completed. -On 11/22/24 at 12:40 PM the ARNP spoke with Staff A Licensed Practical Nurse (LPN) and Director of Nursing (DON) about getting the strep test. Monitor and if it does not appear at the lab by 2:00 PM, let the ARNP know so she can call the nursing home again. The test has not been posted as of 12:40 PM. -On 11/22/24 at 2:24 PM the ARNP documented the strep test was negative. Does the resident still have a sore throat or is he feeling ill in any way, please find out from the facility. -On 11/22/24 at 2:36 PM spoke with staff at the nursing home, resident is not having a sore throat any more and is feeling fine. Clinical record review revealed a document titled Molecular Report with a collected date and time of 11/20/24 at 2:50 PM. The report documented the following tests were negative: respiratory syncytial virus (RSV), influenza A and B, and COVID-19. 2. According to the quarterly MDS, with a reference date of 11/6/24, Resident #4 had a BIMS score of 3. A BIMS score of 3 suggested severe cognitive impairment. The MDS documented Resident #4 had no rejection of care during the review period. Resident #4 did not have a pressure ulcer or injury, but it was documented she had an open lesion on her foot. There was an order for a dressing to be applied to her foot (with or without topical medications). The following diagnoses were documented for Resident #4: dementia, renal failure, diabetes	F 658		

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F 658	Continued From page 3 mellitus, anxiety, depression and insomnia. The Care Plan focus area documented Resident #4 was at risk for impaired skin integrity due to a diagnosis of eczema and incontinence, history of picking at skin and lesions located on her back. On 11/2/24 open blister to left heel; 11/9/24 blister to left heel is cultured and grew gram negative rods, no new orders given; 11/11/24 changed to Stage II Pressure Injury; and 11/22/24-12/2/24 antibiotic treatment for wound infection due to resident being non-compliant with dressing. The Care Plan documented to complete treatments to her left heel as ordered, with an initiation date of 11/4/24. The following Progress Notes documented for Resident #4: -On 11/9/24 at 10:05 AM this writer removed opti foam dressing. Peri wound is red with white wet flaps covering peri wound. Small amount of yellow drainage noted. No pain, no odor, and small amount of yellow drainage noted. Treatment done per doctor's orders and sterile border gauze is on; -On 11/9/24 at 11:13 AM received culture results, no new orders; -On 11/12/24 at 3:48 PM antibiotic Cefdinir for infection, no signs and symptoms of reaction. Dressing changed to left heel as resident keeps taking it off to pick her heel. Encouraged resident to not pick at area or dressing; -On 11/14/24 at 2:59 PM received a facsimile (fax) from primary care provider (PCP) to contact wound care due to her picking at her wound. Wound care was faxed; -On 11/20/24 at 4:38 PM call to wound care to set up evaluation and treatment, left a voicemail; -On 11/22/24 at 6:33 PM assessment of left heel	F 658		

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F 658	Continued From page 4 wound, noting wound to be boggy, dark with slough, see comprehensive skin assessment dated today by this nurse. Call placed to PCP with notification of wound status. New orders given to culture wound, start Omnicef, wound to be monitored and measured daily, and new treatment to cleanse with house cleanser, rinse, pat dry, apply thera honey and cover with bordered gauze daily and refer to wound care clinic. Email sent to wound care clinic for referral; -On 12/4/24 at 12:39 PM PCP saw resident today, Resident was sitting at dining room table with no bandage noted to heel. If resident takes off bandage staff need to reapply bandage. PCP was wondering if wound clinic came, this nurse asked around no one was aware of this order. Reviewed notes, notes stated DON placed order for wound clinic to see this resident dated 11/22/24. Review of the November 2024 Treatment Administration Record (TAR) revealed the following orders: -Keep left heel blister covered and monitor every shift, order start date of 11/2/24 and discontinued date of 11/22/24; -culture wound on left heel, one time only to rule out infection for one day, order start date of 11/22/24; -cleanse left heel wound with house cleanser, rinse, pat, dray and apply thera honey sheet (cut to size) and cover with border gauze daily. Monitor and measure wound daily and document on the comprehensive skin assessment in the assessment tab in the Electronic Health Record (EHR), order date of 11/22/24, discontinued date of 12/2/24. The November 2024 TAR lacked the duoderm	F 658		

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F 658	Continued From page 5 order that was ordered by the ARNP on 11/6/24. The facility provided a document titled MD/Nursing Communication dated 11/6/24 at 8:23 AM. In the nursing concern section staff documented: left heel red and open, painful and is without odor or drainage. In the ARNP response it was documented: culture wound to left heel, duoderm to be changed every 3 days, and wound care consult. The document was signed by facility nursing staff as noted on 11/6/24 at 10:12 AM. Clinical record review revealed a Nursing Home Visit, dated 11/7/24, documented a nurse home visit was made on 11/6/24 as nursing staff reported the resident had a large open area on her left heel. This started out as a blister, is now sloughed off and has beef red wound underneath. The Assessment/Plan documented: return if symptoms worsen or fail to improve for recheck, wound culture, wound care consult and apply duoderm. The document contained a message dated 11/8/24 at 7:14 AM, from the ARNP to call the nursing home and found out why the wound culture has not been obtained on this resident. In the additional information section, it was documented a specimen date taken on 11/8/24 at 3:45 PM and specimen date received on 11/8/24 at 8:00 PM. On 1/14/25 at 12:52 PM the ARNP stated she saw Resident #3 on 11/20/24 and he complained of a sore throat. She ordered tests for strep, flu and COVID-19. She had asked for two days in a row why the strep test was not done as the test should have been completed the same day it was ordered. There was no adverse outcome and his symptoms resolved without treatment. She later	F 658		

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F 658	Continued From page 6	F 658		

learned that when the nurse ordered the tests she ordered a 4 plex to be done but that panel does not include the strep test. The nurse that collected the 4 plex swabs, she did not see the strep test had been ordered but not on the 4 plex panel. The ARNP stated she saw Resident #4 on 11/6/24 to assess her left heel wound. She ordered for a wound culture, wound consult and to apply a duoderm dressing to the left heel. After she completed her visit and wrote the orders, she sent them via fax to the facility. She also wrote orders on the facility forms while onsite. On 11/8/24 she called the facility and asked why the culture had not been completed yet, it was completed later that day. She received the results on the 11th and started the resident on the appropriate medications. She also noted at that time the wound consult was not yet set up and they had not initiated the duoderm dressing. She spoke with the DON about the consult still not being set up and took her orders for a dressing treatment. She followed up with the facility on 12/4/24 and the consult had still not been set up. The ARNP indicated at the time of assessment and orders, the DON was on vacation and no one followed up with the orders in her absence. She added the DON is trying to get this pattern fixed as she indicated she looked in to it, identified the problem.

On 1/15/25 at 9:17 AM Staff A stated when physicians complete in house visits, one of the nurse managers will round with them. They will give verbal orders and they are put in their system. Otherwise, the physician will do their dictation and send over the orders to the facility within 24 hours. The nurse will take the orders from the printer and put them in for the pharmacy to fill. If the orders include wound orders they will

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F 658	Continued From page 7 check the facility to see if they have the supplies, put in the order, get the supplies, do the swab and send to the hospital to be processed quicker. If the physician orders a wound consult, she would consult the nurse manager or primary care provider (PCP) to ask what was going it, then get the order to have them seen at the wound clinic. When a physician orders tests such as strep, flu and COVID they should all be done that same day as any nurse can complete the tests. On 1/15/25 at 1:28 PM the DON stated she looked at Resident #4's records and noted the wound consult that was ordered did not occur. Staff were completing the assessments to her left heel, was in communication with the physician, they were doing everything. The DON indicated she attempted to get wound care in the facility but the resident fell, broke her hip and came back to the facility on hospice. When asked about the duoderm order that was not completed she indicated that order got changed on 11/20/24 or 11/22/24. She indicated she would need to look further in to why the duoderm order did not get initiated. The wound is improving. During a follow up interview at 2:42 PM with corporate staff present, the DON stated they did miss the duoderm order and obtained a new treatment/dressing order on the 20th or 22nd. When she noticed the duoderm was not ordered she called the physician and obtained a new order for treatment. They also did another culture and ordered an antibiotic prophylactically. The DON was informed Resident #4 went to the hospital on 12/6/24 due to an injury after a fall, a month after the wound consult was ordered. When asked if it should have been set up prior to her going to the hospital, she stated it got missed and she tried to get the consult set up. She	F 658		

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F 658	Continued From page 8 indicated she made multiple attempts to reach the wound clinic. On 1/16/25 at 1:48 PM the DON indicated she did not know what prompted her but she had reviewed order and noticed the wound consult was never done. She had reached out to the wound care clinic with the number she was given. They gave her an email address to use, she sent an email about Resident #4 needing an appointment. They sent her documents to complete and to be sent back. She had asked the ADON to complete them as she as on her way out to go on vacation. She added the ADON did not follow up to have them complete a consult for Resident #4. When the DON returned to work Resident #4 had sustained an injury that required a hospitalization, that lead to her being admitted back to the facility on hospice. At that time hospice took over her wound treatments and cares. The DON was asked to walk through the process when a physician comes to the facility and write new orders: a nurse will complete rounds with they physician, will make notes, if they make new orders the nurse will wait for them and process them. At times, like this situation, the physician will come for the visit and give orders to the nurse that as caring for the resident that day and those orders got missed. Once the orders are processed they will go through and do a second check on the order. The Assistant Directors of Nursing (ADON's) will do the second checks. When a physician orders lab, some of their swabs are in house. When Resident #3's labs were ordered the nurse that put the order in put it in as a 4 plex panel not realizing it did not include the strep test. She's not sure how the strep test got delayed but is looking in to it now. She would expect staff to follow and process the orders as they come in. Need to make sure the nurse or Infection Preventionist checks the orders	F 658		

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F 658	Continued From page 9 to ensure the strep portion of the tests was completed. The DON indicated she was not sure if there was a communication issue or if she misread the order that was in front of her when putting it in. The facility provided a document titled Medication and Treatment Order Practice with a revision date of November 2014, documented the purpose of this procedure is to establish uniform guidelines in the receiving, recording and the following of medication/treatment orders. Physician orders shall be followed, if unable to follow physician orders, notify the DON/designee and physician as appropriate.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews, and policy review the facility failed to assist 3 of 3 residents (Resident #5, #7 and #8) that were dependent on staff for Activities of Daily Living (ADLs) care when they were incontinent of urine and/or bowel. The facility reported a census of 72 residents. Findings include: 1. The quarterly Minimum Data Set (MDS) with a reference date of 10/22/24 documented Resident #5 had a Brief Interview of Mental Status (BIMS) score of 15. A BIMS score of 15 suggested no	F 677		

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F 677	Continued From page 10	F 677		

cognitive impairment. Resident #5 did not experience rejection of care during the review period. The MDS documented she was frequently incontinent of bowel. The MDS documented the following diagnoses for Resident #5: metabolic encephalopathy, diabetes mellitus, malnutrition, depression, schizophrenia, palliative care, stage 4 pressure ulcer to sacral region, and obesity.

The Care Plan with a revision date of 11/7/23 documented Resident #5 had activities of daily living (ADLs) self care performance deficit and impaired mobility related to activity intolerance, limited mobility, confusion, pain, and physician inactivity. The Care Plan documented she required substantial assistance of 1 staff for bed mobility and was dependent of one staff for toilet hygiene.

The Care Plan with a revision date of 6/7/24 documented Resident #5 displayed bowel incontinence related to confusion, impaired mobility, inability to communicate needs. The Care Plan documented she may use disposable briefs/pull-up briefs. Staff are to assist to change when wet/soiled as needed. The Care Plan documented Resident #5 would like staff to check her for incontinence episodes often. She required assistance to wash, rinse and dry her perineum.

On 1/14/25 at 2:07 PM Resident #5 sat in her wheelchair in her room, reading a book. Resident #5 stated last night she needed her pants changed because she sh*t them. She added she slept all night in her own sh*t because they came in twice and told her she was not dirty. She told them she was, she knew she was dirty and needed changed.

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F 677	Continued From page 11 2. According to the annual MDS assessment with a reference date of 10/19/24 documented Resident #7 had a BIMS score of 11. A BIMS score of 11 suggested Resident #7 had mild cognitive impairment. The MDS documented he was always incontinent of urine and frequently incontinent of bowel. The MDS documented the following diagnoses for Resident #7: stroke, atrial fibrillation, aphasia, seizure disorder, and depression. The Care Plan with a revision date of 11/16/22 documented Resident #7 had a history of a stroke resulting in left sided (non-dominant) hemiplegia and was dependent on staff for most cares. The Care Plan documented he required a total of 2 staff assistance for bed mobility and toileting. He also required assistance of 1 staff for toileting hygiene. The Care Plan with a revision date of 1/25/24 documented Resident #7 was in continent of bowel and bladder and wore a brief. The Care Plan directed staff to ensure the resident was clean and dry with each check and change. On 1/16/25 at 10:53 AM Resident #7 was tilted back in his wheelchair in his room. He indicated that he does have incontinent episodes and staff assist his to be changed. When asked if he ever needed to have his bedding changed because he was incontinent he shook his hand at the wrist to indicated so-so. When asked if he is gesturing so-so, he shook his head yes. 3. According to the quarterly MDS assessment with a reference date of 11/15/24 documented Resident #8 had a BIMS score of 15. A BIMS score of 15 suggested no cognitive impairment.	F 677		

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F 677	Continued From page 12 The MDS documented the resident did not reject care during the review period and she was always incontinent of bowel and bladder. The MDS listed the following diagnoses for Resident #8: chronic obstructive pulmonary disease (COPD), heart failure, quadriplegia, obesity, and rheumatoid arthritis. The Care Plan with a revision date of 5/18/24 documented Resident #8 had ADL self care performance deficit related to limited mobility, rheumatoid arthritis, sever aortic stenosis and chronic heart failure. The Care Plan documented she depended on two staff for repositioning and turning in bed. On 1/16/25 at 10:59 AM Resident #8 was sitting in her wheelchair in her room working on a word search puzzle. She stated if she becomes incontinent at night, she usually has to wait 30 minutes to get cleaned up. Staff either come around and check on her during the overnight shift or she will use her call light to get their attention. On 1/16/25 at 8:53 AM Staff B Certified Nursing Assistant/Certified Medication Aide (CNA/CMA) stated when she comes on shift after the overnight shift she has noticed residents to be soaked in urine or feces. She indicated there are 3 residents that come to mind that this happens frequently with. She added once resident you have to encourage her repeatedly to be changed. On 1/16/25 at 9:48 AM Staff C CNA stated when she follows the overnight shift she has found residents have soaked their beds with urine. She listed 3 residents that this commonly happens to with one resident that constantly goes to the	F 677		

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	165373	A. BUILDING _____ B. WING _____	C 01/16/2025

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F 677	Continued From page 13	F 677		

bathroom at night. Staff C added they have started doing rounds with the off going and on going shifts, this has helped with the number of residents that are found soaked in bed. She indicated there is one staff in particular that works overnights, where it's a continuous issue.

One 1/16/25 at 1:48 PM the Director of Nursing (DON) stated she had heard on occasion staff finding residents soaked in their beds after replacing the overnight shift. When she hears this, she interviews staff members to see what the root cause is. She added they do have residents that are heavy wetters and if staff start their rounds at 4 am by the time the AM shift starts their rounds at 6 am, residents will be wet. She has been doing education with staff and had a staff meeting but not a lot of people showed up. They talked about making sure staff are getting in their rooms and checking on the residents.

The facility provided a document titled Continence and Incontinence-Assessment and Management with a revision date of August 2022. If the resident does not respond and does not try to toilet, or for those with severe cognitive impairment that they cannot either point to an object or say their own name, still will use a check and change strategy. A check and change strategy involves checking the resident's continence status at regular intervals and using incontinent devices or garments. The primary goals are to maintain dignity and comfort and to protect the skin. The DON added they have started to do walking rounds with the oncoming and off going staff where they go to each room and talk about each resident's day. This helps hold everyone accountable. If they do notice residents need changed, they will go in there

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F 677	Continued From page 14 together to get it done. She indicated staff should be doing check and changes with residents that need to be checked on more frequently and should be doing rounds every 2 hours that includes checking and changing residents.	F 677		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, review of resident	F 725		

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F 725	Continued From page 15	F 725		

council notes and grievance/complaint logs, resident and staff interviews and facility policy review the facility failed to answer call lights in a timely manner. The facility reported a census of 72 residents.

Findings include:

On 1/15/25 at 7:58 AM noted room 20 had their call light on. At the nurse's station is a computer with a program displayed called Visonlink that displayed room 20 activated their call light at 7:40 AM and response was waiting. Staff walked in to the room at 8:03 AM, call light was turned off. The call light was activated for 23 minutes.

On 1/15/25 at 2:02 PM noted room 21 had their call light on. Observed staff had assisted the resident and turned the call light off at 2:24 PM. The call light was activated for 22 minutes.

Review of the resident council notes included the following resident council concern:
- On 9/3/24 residents expressed concerns in regards to Certified Nursing Assistants (CNAs) turning off the call light and not returning in a timely manner.
-On 10/2/24 residents expressed concerns in regards to call lights being on for an extended amount of time.
-On 11/3/24 residents expressed concerns in regards to call lights being on for an extended amount of time (Main and East Court), residents expressed concerns in regards to staffing. East Court needs more CNAs.
-On 12/3/24 residents expressed concerns in regards to call lights being on for an extended amount of time (Main, East Court and Terrace Hall). Terrace hall residents expressed concerns

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F 725	Continued From page 16 in regards to staffing. When there is one staff working there is extended wait time on call lights being answered and showers are not always being done. If showers are being done, there is no one to answer the call lights during those times. When the resident who needs assistance eating his meals is being helped there is no one in the dining room or no one to answer call lights. Review of the document titled resident grievance/complaint log documented the following: -August 2024 log documented in the nature of the grievance/complaint section 13 logged concerns about call lights/waiting long time for help -September 2024 documented in the nature of the grievance/complaint section two logged concerns about call lights. -October 2024 documented in the nature of the grievance/complaint section seven logged concerns about call lights. - November 2024 documented in the nature of the grievance/complaint section six logged concerns about call lights. - December 2024 documented in the nature of the grievance/complaint section two logged concerns about call lights. On 1/14/25 at 2:07 PM Resident #5 stated they do answer her call light timely, that has gotten better lately. She indicated before it could take 15 minutes to 1 hour. This was about a month ago on the overnight shift. Observed a digital clock on the wall to the right of her bed. On 1/15/25 at 11:01 AM Resident #1 stated it takes about 15 minutes for staff to answer her call light. She added their response times have gotten better recently.	F 725		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 725	Continued From page 17 On 1/15/25 at 11:08 AM Resident #3 indicated call lights are not answered timely. He has had to wait over an hour and it happens more than it should. This typically happens after lunch and has had accidents while waiting for help, he usually wets himself. Resident observed to have a clock on the walk on the left side of his bed. On 1/16/25 at 8:53 AM Staff B Certified Nursing Assistant/Certified Medication Aide CNA/CMA stated staffing can be short at times. When they are short on staff call lights do take longer than 15 minutes to answer. When asked roughly how long it takes to answer call lights she stated she could not speak on a definite time but it is longer than 15 minutes. On 1/16/25 at 9:48 AM Staff C CNA stated they try to get to call lights within 15 minutes but that all depends if something bigger is going on at that time. On 1/16/25 at 10:28 AM the Administrator indicated they do not have the means to pull call light response time reports. She indicated they have ben talking with staff about when call lights are the heaviest and will assign a float staff during that time to help with response times. They also started doing weekly rounds with residents and since they started that, call light response times have gotten better. On 1/16/25 at 1:48 PM the Director of Nursing (DON) stated once there has been a grievance about call light response times, she will talk with residents to find out specific information then she will talk with staff members and provide education. They have started doing rounding	F 725		

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F 725	Continued From page 18 angels where management is assigned to specific residents. They talk to their assigned residents once a week to talk about concerns. Staff will then follow the grievance process. She expects staff to answer call lights within 15 minutes of it being turned on. The facility provided a document titled Answering the Call Light with a revision date of September 2022, documented the purpose of this procedure is to ensure timely responses to the resident's requests and needs. Steps in the procedure: 1. Answer the resident call system timely. a. if the resident needs assistance, indicate the approximate time it will take for you to response. 2. If assistance is needed when you enter the room, summon help by using the call signal.	F 725		

Azria Health Longview Plan of Correction – Complaint Survey 1.14.2025-1.16.2025

F658 Services Meet Professional Standards

1. Resident #3 physician was notified, and order was carried out. Resident #4 no longer resides in the facility.
2. All residents have the potential to be affected.
3. Re-education with licensed nurses and medication aides started on 1/16/2025 regarding Medication and Treatment Order Practice policy.
4. DON or designee will complete a random audit of resident's active orders and ensure that medication order practice policy is being followed 3x/week x 2 weeks, then weekly for 4 weeks, then monthly for 3 months.

✓ **Compliance date:** 1.24.2025

F677 ADL Care Provided for Dependent Residents

1. Resident #5 , Resident #7 and Resident #8 were checked for incontinence on 1/16/2025 and interviewed regarding incontinence cares and no further concerns were voiced.
2. All residents have the potential to be affected.
3. Re-education with clinical staff started regarding Urinary Continence and Incontinence – Assessment and Management policy.
4. DON or designee will complete a random visual audit to ensure the facility Urinary Continence and Incontinence Assessment and Management policy is being followed 3x/week x 2 weeks, then weekly for 4 weeks, then monthly for 3 months.

Compliance date: 1.24.2025

F725 Sufficient Nursing Staff

1. Re-education was implemented with staff regarding the call light policy on 1/16/2025.
2. All residents have the potential to be affected.
3. Re-education completed with staff regarding the Answering a Call Light policy.
4. The administrator or designee will complete an audit of call light response times 3 times weekly x 2 weeks, then weekly for 4 weeks, then monthly for 3 months.

Compliance date: 1.24.2025