STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165261	A. Building B. Wing	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill-Pond	1201 SE Mill Pond Court Ankeny, IA 50021

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 35434 Based on clinical record review, policy review, and staff and resident interviews, the facility failed to ensure staff treated residents with dignity and respect for 1 of 1 residents reviewed for dignity (Resident #45). The facility reported a census of 57 residents. Findings include: 1. The Annual Minimum Data Set(MDS) assessment tool, dated 1/12/24, listed diagnoses for Resident #45 which included anxiety, heart failure, and post-polio syndrome. The MDS reported he had upper extremity impairment on one side and lower extremity impairment on both sides. The MDS stated he required partial/moderate assistance with upper body dressing and rolling and substantial/maximal assistance with toileting, hygiene, showering, and lower body dressing, and was dependent on staff for taking off foot wear. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15, which indicated intact cognition. The facility policy Vulnerable Adult Abuse Prevention Plan, modified January 2023, stated the facility would provide services of the highest quality to promote dignity and holistic well being. 1/11/23 Care Plan entries stated the resident had an activities of daily living(ADL) self-care performance deficit related to weakness, impaired range of motion, and post-polio syndrome. The Care Plan documented the resident required the assistance of 1 staff for dressing, grooming, and hygiene. 7/6/23 Care Plan entries stated the resident had the potential for a psychosocial well being problem related to the need for long term care placement, anxiety and physical limitations. The Care Plan directed staff to allow the resident time to answer questions to verbalize feelings, perceptions, and fears. The 1/17/24 facility Daily Assignment Sheet documented Staff J agency Certified Nursing Assistant(CNA) and Staff K agency CNA worked the evening shift. The 1/18/24 facility Daily Assignment Sheet documented Staff I, CNA worked the day shift. Staff J's name is on the schedule for the evening shift but had a line through it. The 1/19/24 Daily Assignment Sheet documented Staff K worked the evening shift. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER Mill-Pond		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 SE Mill Pond Court Ankeny, IA 50021	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a 1/19/24 3:42 p.m. email to the facility from Resident #45, the resident stated he had a very bad experience with two agency CNAs on 1/17/24. He stated that they tried to take his brace off without unlacing first and he yelled and told them to unlace his shoes first and then pull them off but they did not. He stated they kept pulling and yanking until he thought his ankles were going to break. He stated one of the aides looked down at his leg and said eeeooo, what happened to your leg?. He stated they had no respect for him and behaved as if they were extremely hurried. On 4/9/24 at 9:36 a.m., Resident #45 reported he had two agency CNAs that took care of him and were horrible. He stated they were unbelievably rough and he asked them to slow down. He stated they twisted his shoes in order to get them off and stated one of the CNA's looked at his leg and said ew, what happened to your leg?. He said he told them to get out. He stated the next day one of them came back and was swearing and accused Staff B Licensed Practical Nurse(LPN) of pushing her up against the wall and then called the police to report Staff B. In a subsequent interview on 4/10/24 at 10:46 a.m., the resident stated when the two staff members were trying to take his shoes off, it hurt and he even had pain in the left ankle the next day. He stated they hurt both of his feet and continued after he told them to stop. He stated they also hurt his left leg when they were taking his brace off and would not let him explain how to do things. He said he felt scared and frightened and said he did not feel like they hurt him deliberately but they would not listen. He said the next night one of the CNAs came back to the facility to work and the night after that the other came back to the facility to work. He stated he reported his concerns with the care to Staff H CNA on the night the police were called to the facility. On 4/10/24 at 3:26 p.m. Staff H CNA stated the resident reported to her when two female staff members took his shoes off, they were rough. She stated he told her about it the next day and she was pretty sure she told the nurse. On 4/10/24 at 4:07 p.m., Staff I CNA stated that when she came on to her shift on 1/18/24 the resident reported he was treated terribly the night before. He stated he was glad to see her and he had the worst aides who made fun of him, wound not listen to him, and hurt him. Staff I stated the resident described the staff members as African American females who were agency staff. Staff I stated she did not report this but kept the information that he told her in her mind. Staff I stated the resident told her this around 7:30-8:00 a.m. and later in her shift there was an agency staff member(Staff J CNA) who would not assist Staff B LPN with a resident transfer. Staff I stated Staff B and Staff J got into a verbal altercation and Staff J was using profane language. She stated the facility ended up asking Staff J to leave the facility and Staff J ended up calling the police to report Staff B for assault. Staff I stated in the midst of this altercation, the dots all connected and she wondered if Staff J was one of the staff members the resident had complained about to her earlier in the day. Staff I stated prior to Staff J leaving the facility she(Staff I) took her(Staff J's) picture at 5:27 p.m. and then showed it to the resident. Staff I stated the resident confirmed this was one of the staff members who mistreated him the night before. In a phone interview on 4/11/24 at 8:30 a.m., Staff J CNA stated she worked with the resident one night and had no problems with him other than accidentally dropping his leg down on the bed when they tried to take his brace off. She stated nothing was said about the situation until the next day when a resident's call light was going off and she was feeding. She stated a nurse was rude with her and she ended up calling her agency and they told her to leave the facility. (continued on next page)

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER Mill-Pond		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 SE Mill Pond Court Ankeny, IA 50021	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview on 4/11/24 at 8:42 a.m., Staff K CNA stated she assisted Staff J in helping the resident to bed. She stated as they pulled his leg over, his leg dropped on the bed by accident but stated nothing else occurred during the cares. She stated she did not hear anything else about the situation until 2 days later during her shift when she was feeding dinner when they told her she had to leave the facility. On 4/11/24 at 2:49 p.m., the Clinical Administrator stated the facility would report allegations of abuse within 2 hours and she expected staff to treat residents with kindness. She stated as soon as she received the email from the resident, she acted. She stated she was not aware that the resident reported the allegation to a staff member prior to this. On 4/15/24 at 12:37 p.m., the Clinical Administrator stated alleged perpetrators of abuse should be separated from residents immediately.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 35434 Based on clinical record review, policy review, and staff and resident interviews, the facility failed to report an allegation of abuse in a timely manner to the State Agency for 1 of 2 residents reviewed for abuse (Resident #45). The facility reported a census of 57 residents. Findings include: 1. The Annual Minimum Data Set (MDS) assessment tool, dated 1/12/24, listed diagnoses for Resident #45 which included anxiety, heart failure, and post-polio syndrome. The MDS stated he had upper extremity impairment on one side and lower extremity impairment on both sides. The MDS stated he required partial/moderate assistance with upper body dressing and rolling and substantial/maximal assistance with toileting, hygiene, showering, and lower body dressing, and was dependent on staff for taking off foot wear. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15, which indicated intact cognition. The facility policy Vulnerable Adult Abuse Prevention Plan, modified January 2023, stated the facility would provide services of the highest quality to promote dignity and holistic well-being. The policy listed an objective as to protect each resident from abuse by care givers. The policy stated residents had the right to be free from abuse and stated in the event of suspected maltreatment residents would be immediately assessed and separated from the alleged perpetrator to ensure safety. The policy stated once abuse was suspected or identified the facility would conduct a thorough investigation of the alleged violation and stated in the event of suspected maltreatment, the needs of the resident would be immediately assessed and separated from the alleged perpetrator to ensure the resident's safety. The policy stated the facility would report instances of maltreatment immediately and initiate an investigation. 1/11/23 Care Plan entries stated the resident had an activities of daily living (ADL) self-care performance deficit related to weakness, impaired range of motion, and post-polio syndrome. The Care Plan documented the resident required the assistance of 1 staff for dressing, grooming, and hygiene. 7/6/23 Care Plan entries stated the resident had the potential for a psychosocial well-being problem related to the need for long term care placement, anxiety, and physical limitations. The Care Plan directed staff to allow the resident time to answer questions to verbalize feelings, perceptions, and fears. The 1/17/24 facility Daily Assignment Sheet documented Staff J agency Certified Nursing Assistant (CNA) and Staff K agency CNA worked the evening shift. The 1/18/24 facility Daily Assignment Sheet documented Staff I CNA worked the day shift. Staff J's name is on the schedule for the evening shift but had a line through it. The 1/19/24 Daily Assignment Sheet documented Staff K worked the evening shift. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a 1/19/24 3:42 p.m. email to the facility from the Resident #45, the resident stated he had a very bad experience with two agency CNAs on 1/17/24. He stated that they tried to take his brace off without unlacing first and he yelled and told them to unlace his shoes first and then pull them off but they did not. He stated they kept pulling and yanking until he thought his ankles were going to break. He stated one of the aides looked down at his leg and said eeeooo, what happened to your leg?. He stated they had no respect for him and behaved as if they were extremely hurried. On 4/9/24 at 9:36 a.m., Resident #45 stated he had two agency CNAs that took care of him and were horrible. He stated they were unbelievably rough and he asked them to slow down. He stated they twisted his shoes in order to get them off and stated one of the CNA's looked at his leg and said ew, what happened to your leg?. He said he told them to get out. He stated the next day one of them came back and was swearing and accused Staff B Licensed Practical Nurse (LPN) of pushing her up against the wall and then called the police to report Staff B. In a subsequent interview on 4/10/24 at 10:46 a.m., the resident stated when the two staff members were trying to take his shoes off, it hurt and he even had pain in the left ankle the next day. He stated they hurt both of his feet and continued after he told them to stop. He stated they also hurt his left leg when they were taking his brace off and would not let him explain how to do things. He said he felt scared and frightened and said he did not feel like they hurt him deliberately but they would not listen. He said the next night one of the CNAs came back to the facility to work and the night after that the other came back to the facility to work. He stated he reported his concerns with the care to Staff H CNA on the night the police were called to the facility. On 4/10/24 at 3:26 p.m. Staff H CNA stated the resident reported to her when two female staff members took his shoes off, they were rough. She stated he told her about it the next day and she was pretty sure she told the nurse. On 4/10/24 at 4:07 p.m., Staff I CNA stated that when she came on to her shift on 1/18/24 the resident reported he was treated terribly the night before. He stated he was glad to see her and he had the worst aides who made fun of him, wound not listen to him, and hurt him. Staff I stated the resident described the staff members as African American females who were agency staff. Staff I stated she did not report this but kept the information that he told her in her mind. Staff I stated the resident told her this around 7:30-8:00 a.m. and later in her shift there was an agency staff member(Staff J CNA) who would not assist Staff B LPN with a resident transfer. Staff I stated Staff B and Staff J got into a verbal altercation and Staff J was using profane language. She stated the facility ended up asking Staff J to leave the facility and Staff J ended up calling the police to report Staff B for assault. Staff I stated in the midst of this altercation, the dots all connected and she wondered if Staff J was one of the staff members the resident had complained about to her earlier in the day. Staff I stated prior to Staff J leaving the facility she Staff I took her (Staff J's) picture at 5:27 p.m. and then showed it to the resident. Staff I stated the resident confirmed this was one of the staff members who mistreated him the night before. In a phone interview on 4/11/24 at 8:30 a.m., Staff J CNA stated she worked with the resident one night and had no problems with him other than accidentally dropping his leg down on the bed when they tried to take his brace off. She stated nothing was said about the situation until the next day when a resident's call light was going off and she was feeding. She stated a nurse was rude with her and she ended up calling her agency and they told her to leave the facility. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview on 4/11/24 at 8:42 a.m., Staff K CNA stated she assisted Staff J in helping the resident to bed. She stated as they pulled his leg over, his leg dropped on the bed by accident but stated nothing else occurred during the cares. She stated she did not hear anything else about the situation until 2 days later during her shift when she was feeding dinner when they told her she had to leave the facility. On 4/11/24 at 2:49 p.m., the Clinical Administrator stated the facility would report allegations of abuse within 2 hours and she expected staff to treat residents with kindness. She stated as soon as she received the email from the resident, she acted. She stated she was not aware that the resident reported the allegation to a staff member prior to this. On 4/15/24 at 12:37 p.m., the Clinical Administrator stated alleged perpetrators of abuse should be separated from residents immediately. The facility lacked documentation they reported the incident to the State Agency prior to 1/19/24.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 35434 Based on clinical record review, policy review, and staff and resident interviews, the facility failed to initiate an abuse investigation and failed to separate residents from alleged perpetrators of abuse in a timely manner after staff became aware of a resident report of maltreatment for 1 of 2 residents reviewed for abuse (Resident #45). The facility reported a census of 57 residents. Findings include: 1. The Annual Minimum Data Set (MDS) assessment tool, dated 1/12/24, listed diagnoses for Resident #45 which included anxiety, heart failure, and post-polio syndrome. The MDS stated he had upper extremity impairment on one side and lower extremity impairment on both sides. The MDS stated he required partial/moderate assistance with upper body dressing and rolling and substantial/maximal assistance with toileting, hygiene, showering, and lower body dressing, and was dependent on staff for taking off foot wear. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, which indicated intact cognition. The facility policy Vulnerable Adult Abuse Prevention Plan, modified January 2023, stated the facility would provide services of the highest quality to promote dignity and holistic well-being. The policy listed an objective as to protect each resident from abuse by care givers. The policy stated residents had the right to be free from abuse and stated in the event of suspected maltreatment residents would be immediately assessed and separated from the alleged perpetrator to ensure safety. The policy stated once abuse was suspected or identified the facility would conduct a thorough investigation of the alleged violation and stated in the event of suspected maltreatment, the needs of the resident would be immediately assessed and separated from the alleged perpetrator to ensure the resident's safety. The policy stated the facility would report instances of maltreatment immediately and initiate an investigation. 1/11/23 Care Plan entries stated the resident had an activities of daily living (ADL) self-care performance deficit related to weakness, impaired range of motion, and post-polio syndrome. The Care Plan documented the resident required the assistance of 1 staff for dressing, grooming, and hygiene. 7/6/23 Care Plan entries stated the resident had the potential for a psychosocial well-being problem related to the need for long term care placement, anxiety, and physical limitations. The Care Plan directed staff to allow the resident time to answer questions to verbalize feelings, perceptions, and fears. The 1/17/24 facility Daily Assignment Sheet documented Staff J agency Certified Nursing Assistant (CNA) and Staff K agency CNA worked the evening shift. The 1/18/24 facility Daily Assignment Sheet documented Staff I CNA worked the day shift. Staff J's name is on the schedule for the evening shift but had a line through it. The 1/19/24 Daily Assignment Sheet documented Staff K worked the evening shift. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a 1/19/24 3:42 p.m. email to the facility from the Resident #45, the resident stated he had a very bad experience with two agency CNAs on 1/17/24. He stated that they tried to take his brace off without unlacing first and he yelled and told them to unlace his shoes first and then pull them off but they did not. He stated they kept pulling and yanking until he thought his ankles were going to break. He stated one of the aides looked down at his leg and said eeeooo, what happened to your leg?. He stated they had no respect for him and behaved as if they were extremely hurried. On 4/9/24 at 9:36 a.m., Resident #45 reported he had two agency CNAs that took care of him and were horrible. He stated they were unbelievably rough and he asked them to slow down. He stated they twisted his shoes in order to get them off and stated one of the CNA's looked at his leg and said ew, what happened to your leg?. He said he told them to get out. He stated the next day one of them came back and was swearing and accused Staff B Licensed Practical Nurse (LPN) of pushing her up against the wall and then called the police to report Staff B. In a subsequent interview on 4/10/24 at 10:46 a.m., the resident stated when the two staff members were trying to take his shoes off, it hurt and he even had pain in the left ankle the next day. He stated they hurt both of his feet and continued after he told them to stop. He stated they also hurt his left leg when they were taking his brace off and would not let him explain how to do things. He said he felt scared and frightened and said he did not feel like they hurt him deliberately but they would not listen. He said the next night one of the CNAs came back to the facility to work and the night after that the other came back to the facility to work. He stated he reported his concerns with the care to Staff H CNA on the night the police were called to the facility. On 4/10/24 at 3:26 p.m. Staff H CNA stated the resident reported to her when two female staff members took his shoes off, they were rough. She stated he told her about it the next day and she was pretty sure she told the nurse. On 4/10/24 at 4:07 p.m., Staff I CNA stated that when she came on to her shift on 1/18/24 the resident reported he was treated terribly the night before. He stated he was glad to see her and he had the worst aides who made fun of him, wound not listen to him, and hurt him. Staff I stated the resident described the staff members as African American females who were agency staff. Staff I stated she did not report this but kept the information that he told her in her mind. Staff I stated the resident told her this around 7:30-8:00 a.m. and later in her shift there was an agency staff member (Staff J CNA) who would not assist Staff B LPN with a resident transfer. Staff I stated Staff B and Staff J got into a verbal altercation and Staff J was using profane language. She stated the facility ended up asking Staff J to leave the facility and Staff J ended up calling the police to report Staff B for assault. Staff I stated in the midst of this altercation, the dots all connected and she wondered if Staff J was one of the staff members the resident had complained about to her earlier in the day. Staff I stated prior to Staff J leaving the facility she (Staff I) took her (Staff J's) picture at 5:27 p.m. and then showed it to the resident. Staff I stated the resident confirmed this was one of the staff members who mistreated him the night before. In a phone interview on 4/11/24 at 8:30 a.m., Staff J CNA stated she worked with the resident one night and had no problems with him other than accidentally dropping his leg down on the bed when they tried to take his brace off. She stated nothing was said about the situation until the next day when a resident's call light was going off and she was feeding. She stated a nurse was rude with her and she ended up calling her agency and they told her to leave the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview on 4/11/24 at 8:42 a.m., Staff K CNA stated she assisted Staff J in helping the resident to bed. She stated as they pulled his leg over, his leg dropped on the bed by accident but stated nothing else occurred during the cares. She stated she did not hear anything else about the situation until 2 days later during her shift when she was feeding dinner when they told her she had to leave the facility. On 4/11/24 at 2:49 p.m., the Clinical Administrator stated the facility would report allegations of abuse within 2 hours and she expected staff to treat residents with kindness. She stated as soon as she received the email from the resident, she acted. She stated she was not aware that the resident reported the allegation to a staff member prior to this. On 4/15/24 at 12:37 p.m., the Clinical Administrator stated alleged perpetrators of abuse should be separated from residents immediately. The facility lacked documentation they initiated an investigation of the alleged incident immediately after the resident informed Staff I of his concerns on the morning of 1/18/24 and failed to ensure Staff J and Staff K did not return to work after the report.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44512 Based on observations, family and staff interviews, and record review, the facility failed to provide oral care after meals as directed and incontinent care for 1 of 3 residents reviewed for Activities of Living (Resident #51). The facility reported a census of 57 residents. Findings include: The Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #51 revealed the diagnosis of Alzheimer's disease, dementia, gastroesophageal reflux disease (acid reflux), and dysphagia (partial loss of language). The MDS documented the resident was totally dependent on one staff member for eating, oral care, and assistance of two staff for toileting and personal care. The MDS identified the risk for pressure ulcers. The Brief Interview for Mental Status (BIMS) score of 99 revealed severe impaired mental cognition. The Care Plan identified a focus area with initiated date of 12/29/23 as the resident with a deficit of activities of daily living related to weakness, impaired mobility, dementia with agitation, poor eyesight, and difficulty swallowing. The Care Plan directed staff to care for the resident with the following interventions: a. Oral care, the resident had his own teeth, and required assistance with mouth care b. Follow Speech Therapy (ST) recommendations for oral cares after all meals, oral intake and prior to breakfast or first meal of the day c. Dressing, Grooming, Hygiene required assistance of one staff member d. Provide assistance to check and change for incontinence upon rising, after meals and at bedtime During an interview on 4/8/24 at 10:35 a.m. Family Member stated Resident #51 was not being changed every 2 hours, he was unable to alert staff to needs, and he is in his reclining wheelchair (w/c) in the front living area without attention provided by staff. Observations on 4/9/24 revealed the following for Resident #51: a. At 9:31 a.m. Resident #51 in wheelchair in dining room, staff pushed him to front living room. Returned Resident #51 to the dining room at 11:30 a.m. b. At 1:00 p.m. staff pushed Resident #51 outside for activity. c. At 1:44 p.m. Staff F, CNA assisted Resident #51 to room and provided incontinent care. No oral care provided. During an interview on 4/9/24 at 1:44 p.m. Staff F, Certified Nursing Assistant (CNA) stated this was the first time to care for this resident. (continued on next page)

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Mill-Pond	1201 SE Mill Pond Court Ankeny, IA 50021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/9/24 at 1:45 p.m. Staff E, CNA gowned in Personal Protective Equipment (PPE) gown and gloves replaced Staff F to provide care. During an interview on 4/9/24 at 1:45 p.m. Staff E, CNA stated she had assisted Staff D, CNA to get Resident #51 out of bed to shower at 6:30 a.m. and not provided care during the morning. During an observation on 4/9/24 at 1:47 p.m., Staff D, CNA entered Resident #51's room wearing PPE gown and gloves, and assisted Staff E, CNA to transfer Resident #51 from w/c to bed by using the mechanical lift. Staff E provided catheter care and assisted Staff D to provide intontinence care for Resident #51. Staff G, Licensed Practical Nurse, (LPN) entered the room and applied ointment to Resident #51's buttocks. Staff E and Staff D used the mechanical lift to assist Resident #51 to his recliner. Neither CNA provided Resident #51 with oral care. During an interview on 4/9/24 at 1:47 p.m. Staff D, CNA stated she gave Resident #51 a bed bath at 6:30 a. m. and checked his skin then and did not provide oral care nor incontinent care after that as she was giving showers. During an interview on 4/9/24 at 1:52 P.M. Staff G, LPN stated she had provided a skin check for Resident #51 this morning during bath and applied ointment and had not seen him after that. During observations on 4/10/24 revealed for Resident #51: a. At 7:15 a.m. Resident #51 was in bed. b. At 8:30 a.m. Resident #51 was in the dining room then was moved to the front living room in the wheelchair. c. At 10:02 a.m. Restorative Aide moved Resident #51 to his room and provided Range of motion to upper and lower extremities then returned resident to the living room. d. At 10:53 a.m. Staff M, CNA and Staff L, CNA removed Resident #51 from the front living room to his room and provided incontinence care. No oral care provided. During an interview on 4/10/24 at 11:19 a.m. Staff M, CNA stated the facility provides a paper care plan for the agency CNA's. The undated and untitled document provided by the facility provided to the CNA's listed Resident #51 and directed staff to provide oral care before the first meal and after all meals/oral intake and to have the assistance of 2 persons for check and change. The Clinical Resident Profile for Resident #51 revealed special instructions to provide oral care after every meal. The Speech Therapy evaluation dated 12/19/23 revealed Res #51 presented with mild-moderate oropharyngeal dysphagia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER Mill-Pond		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 SE Mill Pond Court Ankeny, IA 50021	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Speech Therapy Progress Notes dated 2/21/24 revealed due to the documented physical impairments and associated functional deficits, without skilled therapeutic interventions, the patient is at risk for aspiration (choking). Oral care Point Of Care dated 3/28/24 through 4/8/24 for Resident #51 lacked documentation of oral care after meals. During an interview on 4/11/24 at 11:35 AM The Clinical Administrator stated the staff are to reposition, check and change residents after meals and to provide oral care as recommended by Speech Therapy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill-Pond	1201 SE Mill Pond Court Ankeny, IA 50021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 35434 Based on observation, clinical record review, staff interview, and policy review, the facility failed to notify the provider after a change in condition in a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers(Resident #37). The facility reported a census of 37 residents. Findings include: The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The Annual MDS assessment tool, dated 9/11/23, listed diagnoses for Resident #37 which included coronary artery disease, diabetes, and non-Alzheimer's dementia. The MDS stated the resident required limited assistance of 1 staff for transfers, and personal hygiene, extensive assistance of 1 staff for bed mobility, dressing, and bathing, and extensive assistance of 2 staff for toileting. The MDS stated the resident was at risk for developing pressure ulcers but had no unhealed pressure ulcers. The MDS stated stated the resident had inattention and disorganized thinking. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER Mill-Pond		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 SE Mill Pond Court Ankeny, IA 50021	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Skin Integrity Management Policy-Iowa and Wisconsin, modified October 2022, stated the facility would identify, assess, and monitor residents whose clinical condition increased the risk for impaired skin integrity and pressure injuries. The policy directed staff to notify the physician if any evidence of deterioration was noted. An 11/15/23 4:56 p.m. provider Progress Note stated the resident had a corn (a small, tender area of thickened skin) on his left heel and the provider ordered a corn pad. An 11/22/23 Body Audit stated the resident had a dark red scab noted on the left heel. A 11/29/23 Body Audit stated the resident had a scab on the left heel, dark red, and the abrasion measured 6.2 centimeters(cm) x 1.8 cm. A 12/4/24 1:51 p.m. (Late Entry) General Note stated the resident complained that he had pain in his left heel and he had a dark wound. The resident refused to walk to dine as it hurt him to walk. The 12/4/24 at 1:06 p.m. Skin and Wound Evaluation stated the resident had an unstageable(obscured full-thickness skins and tissue loss) pressure area to the rear left malleolus(ankle bone) acquired in house and the area was new. The wound measured 0.3 cm x 0.8 cm x 0.5 cm, and tender to touch. The December Medication Administration Record(MAR) listed a 12/5/23 order for Medihoney Wound/Burn Dressing(a gel which aided in the removal of dead tissue) and directed staff to apply to the left heel every 3 days. The facility lacked documentation of provider notification of the change in condition of the resident's heel from 11/22/23-12/4/23. A 12/4/23 Care Plan entry stated the resident had a pressure ulcer and would remain free from infection in the left heel. A 12/4/23 Care Plan entry directed staff to elevate the heel off the bed surface using pillows/heel elevation products while in bed. On 4/10/24 at 10:36 a.m., Staff A Hospice Nurse measured a wound on the resident's left heel as 3.2 cm x 2. 8 cm. The wound bed was covered with brown eschar and the rest of the resident's heel was red. On 4/11/24 at 2:49 p.m., the Clinical Administrator stated if there was a change in a wound, she would want staff to notify the provider and ask for a different treatment. On 4/15/24 at 10:23 a.m., Staff C Clinical Administrator stated she noticed that over the Thanksgiving holiday there was a difference in the wound when she looked through the Body Audits. She stated it was right before a holiday and staff were human and they missed it. She stated she could not find provider notification until 12/4/23. She stated during weekly skin checks if a wound was worse, staff should notify the provider.