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	03/19/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and policy review, the facility failed to attempt a gradual dose reduction for a resident prescribed psychotropic medication (medication that affect a person's mental state) for 1 of 5 residents reviewed for medications (Resident #16). The facility reported a census of 55 residents. Findings include:The Minimum Data Set (MDS), dated [DATE], documented Resident #16 had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS included diagnoses of heart failure, anxiety disorder and depression. The MDS indicated Resident #16 took antianxiety and antidepressant medications during the lookback period. The Care Plan Focus revised 8/21/25 indicated Resident #16 used an antianxiety medication (lorazepam) due to a diagnosis of anxiety. The goal reflected Resident #15 would be free from discomfort or adverse reactions related to antianxiety therapy through the review date. The interventions included:a. Administer medications as ordered.b. Monitor/document side effects and effectiveness.c. Inform resident, family and caregivers about risks, benefits and the side effects and/or toxic symptoms of antianxiety medications being given. Review of the Electronic Health Record (EHR) for Resident #16 revealed an order dated 3/18/24 for lorazepam (antianxiety) 0.5 mg at bedtime for anxiety. The order lacked a discontinue date. Review of the EHR for Resident #16 revealed no attempt at a gradual dose reduction (GDR) since March 2024 for lorazepam. Review of the facility consulting pharmacy monthly reviews for psychotropic medication revealed they didn't have the lorazepam listed for Resident #16. Review of the EHR for Resident #16 revealed an annual psychotropic medication evaluation completed 8/12/25. It documented Resident #16 received antianxiety medication, lorazepam. The evaluation further documented the last GDR was from 0.75 mg nightly to 0.5 mg nightly on 3/18/24. The evaluation documented a GDR was not contraindicated for the medication. Review of the EHR for Resident #16 revealed a quarterly psychotropic medication evaluation completed on 2/5/26 documented Resident #16 didn't currently receive antianxiety medications. During an interview 3/19/26 at 8:58 AM, the Director of Nursing (DON) stated the pharmacy had access to their EHRs and reviewed the EHR before sending the facility their monthly medication reviews. The facility MDS coordinator did a quarterly review as well for all residents on psychotropic medications. The Clinical Coordinator completed a psychotropic evaluation of the residents on psychotropic medications completed quarterly and annually. The DON acknowledged the facility missed the psychotropic medication lorazepam on the last psychotropic evaluation completed in February 2026 for Resident #16. The DON acknowledged the facility hadn't attempted or discussed a GDR for the psychotropic medication lorazepam since 2024 for Resident #16. The DON stated not only did the consulting pharmacy review miss the recommendation for a GDR on this psychotropic medication, but the facility also missed that it was not completed since 2024. The DON stated there should have been a GDR recommendation in the last year and stated an expectation of an attempt at a GDR or a rationale from the Primary Care Physician (PCP) as to why a GDR should not be attempted.Review of the facility Psychotropic Medication Use policy, modified March 2025, documented gradual dose reduction/tapering of a medication dose will be implemented under the direction of a physician and (continued on next page)

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

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with clinical monitoring as per CMS regulation unless clinically contraindicated. Pharmacist consultant has primary responsibility to monitor GDR attempts. Household Coordinator/Resident Services and Clinical Coordinator jointly monitor results of GDR attempts. This will be documented during the MDS assessment process using the Psychotropic Medication Assessment. The goal of tapering a medication dose or Gradual Dose Reduction (GDR) is to seek the appropriate dose and duration for each medication and minimize the risk of adverse consequences.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review, the facility failed to ensure the drug regimen is free from unnecessary drugs, to include a resident on an antibiotic for excessive duration and without adequate monitoring for 1 of 5 residents reviewed for unnecessary medication (Resident #47). The facility reported a census of 55 residents. Findings include: The Minimum Data Set (MDS), dated [DATE], documented Resident #47 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident had diagnoses to include medically complex conditions and acne, unspecified. The MDS documented Resident #47 took an antibiotic in the look back period. The Care Plan Focus initiated 3/5/25 Resident #47 had the potential for an infection related to acne (preventative antibiotic use). The goal reflected the resident will remain free from complications through the next review date. The interventions directed the following:a. Give resident medications per orders.b. Monitor for increased symptoms of infection which may include increased temperature, altered mental status, lethargy or redness of site.c. Monitor lab results per physician orders.d. Monitor vital signse. Observe for and document signs/symptoms of a Urinary Tract Infection (UTI). Review of the Electronic Health Record (EHR) revealed Resident #47 took a daily prescribed antibiotic since admission to the facility on 2/18/25. Review of the EHR for Resident #47 revealed an order dated 2/18/25 for doxycycline hyclate oral tablet (Antibiotic) 100 milligrams (mg), give one tablet by mouth one time a day for prophylaxis (preventative) for chronic skin related to acne, unspecified. The order directed to discontinue on 6/26/25. Review of the EHR for Resident #47 revealed an order dated 6/26/25 for doxycycline hyclate oral tablet (Antibiotic) 50 mg, give one tablet by mouth one time a day for prophylaxis (preventative) for chronic skin related to acne, unspecified. The order didn't include a discontinue date.Review of the EHR for Resident #47 revealed a Medication Regimen Review (MRR) from the facility consulting pharmacist dated 12/21/25 with recommendations related to the resident taking an antibiotic doxycycline 50 mg daily for prophylaxis, antimicrobial stewardship refers to the careful and correct use of antibiotics, due to the increase in antibiotic resistance, there is an attempt to evaluate and document the continued need for antibiotics and requested the facility provide information to include:a. Antibiotic diagnosis, the facility responded acne.b. Clinical rationale for continued need, the facility responded acne, will have resident follow up with dermatology.c. Is antibiotic use prescribed by a specialist, the facility responded will follow up with dermatology.d. How often does the resident see specialist, the facility responded no recent follow up, will set up. e. Has the resident failed trial off therapy, the facility responded no.f. Please give re-evaluation date, the facility did not respond with a date. The General Note, dated 1/5/26, reflected the staff spoke to Resident #47 about Dermatology. Resident #47 to see the Dermatologist, will update doctor. The Medication Administration Note dated 1/7/26 indicated the staff spoke to Resident #47 about their Dermatology preference. Resident #47 reported she didn't want to go to the Dermatologist, as she wanted her doctor to take care of her dermatology issues as well. The staff left a note for Nurse Practitioner (NP) the day before with no new orders. The staff added Resident #47 to the Doctor (Primary Care Physician - PCP) list for tomorrow. Review of the EHR lacked documentation the PCP followed up with the review for Resident #47's prescribed antibiotic. During an interview 3/18/26 at 8:37 AM, the Director of Nursing (DON) acknowledged Resident #47 took a daily prescribed antibiotic since her admission to the facility in February of 2025. In January 2026, after the pharmacy recommendation to review the prescribed antibiotic, Resident #47 did not want to follow up with a Dermatologist. The review went to the resident's PCP in January 2026. During an interview 3/18/26 at 9:45 AM, the DON stated the facility didn't have any medical records or notes from the Dermatologist who initially prescribed the antibiotic for Resident #47. The DON reported there is no documentation since October 2025 from Resident #47's PCP regarding the acne and the need for the daily antibiotic. The DON further reported there is no documentation in the EHR about a referral made (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the PCP in January 2026 to follow Resident #47 for the antibiotic after the resident declined to return to the Dermatologist. The DON stated the nursing staff dropped the ball in January 2026 and did not make the referral to the resident's PCP to follow Resident #47 related to her acne and prescribed antibiotic. The DON couldn't find documentation about the PCP managing Resident #47's acne, the prescribed antibiotic, or documentation the PCP reviewed the prescribed antibiotic after the pharmacy recommendation in December 2025 for review of continued need for the antibiotic. The DON stated when a resident is on a long term, continuous antibiotic this is referred to the facility Infection Preventionist (IP) to follow. Resident #47's continuous antibiotic was not referred to the IP for review to monitor and assess side effects of the continuous antibiotic and the need for the continued use of the antibiotic. The DON stated the PCP last had a routine visit with Resident #47 in February of 2026, on the 16th. The PCP did not review the acne at that time or document a rationale to continue the prescribed antibiotic. During an interview 3/18/26 at 12:45 PM, the Infection Preventionist (IP) stated as the facility IP she receives a monthly infection report and a report when a resident is placed on an antibiotic. If a resident is admitted to the facility on an antibiotic a report will be sent to her as well. The IP stated she did not receive a report on Resident #47 when she admitted to the facility that the resident was on an antibiotic. The IP stated she should have received a report of the resident being on an antibiotic. Since the resident's admission in February of 2025 until now, Resident #47 has not been on her list of residents on an antibiotic and she has not been monitoring the resident's antibiotic use. The IP stated she keeps a log of all residents who are on an antibiotic and this log is updated monthly and reported on monthly. The IP stated Resident #47 should have been on the log, and the IP should have been monitoring her antibiotic use. The IP should have been monitoring Resident $#47 for adverse side effects of the antibiotic and if the antibiotic was effective. The IP should have reviewed lab work at least yearly for renal function for Resident #47. Resident #47's antibiotic was added to the IP's list today for residents on an antibiotic. Review of the facility policy Infection Control-Antibiotic Stewardship Procedure, modified November 2022, documented the staff nurse would complete progress note documentation at the start and end of an antibiotic regimen. They will monitor/review response to antibiotics and laboratory results when available to determine if the antibiotic is still indicated. The Infection Control and Prevention Specialist will complete the infection control log line list document form which is to be kept up to date throughout the month with any new antibiotic orders, analyze the data for trends, clusters, antibiotic stewardship and prophylactic antibiotic use. Review of the facility policy Clinical Medication Review, dated September 2018, documented the purpose was to ensure residents have clinically significant medication issues identified and addressed in a timely manner. The consulting pharmacist completes drug regimen review; it is the responsibility of the licensed nurse to communicate those items that could be clinically significant to the primary care provider.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interviews and policy review, the facility failed to date, seal, and label open food items stored in the kitchen pantry. The facility reported a census of 55 residents. Findings include:On 3/16/26 beginning at 12:45 PM observed the dry pantry storage area in the main kitchen, with the Certified Dietary Manager (CDM) present. The observation revealed the following items:a. 1 bag of dried croutons opened and unsealed without a label of the date received or opened.b. 1 bag of dried cereal opened and unsealed without a label of the date received or opened.c. 3 bags of dried pasta opened and unsealed without a label of the date received or opened.d. 1 bag of almonds opened and unsealed without a label of the date received or opened. The CDM stated they expected the opened bags of food should have a label when opened and securely sealed when stored in the pantry. During an interview 3/16/26 at 12:15 PM, the Administrator stated they expected opened bags of food stored in the pantry should have a label with the date opened and be securely sealed. Review of the facility policy Safe Food Storage, updated May 2019, documented employees who receive and store food will maintain the storage areas including dry, refrigerated and frozen storage areas utilizing the following guidelines: a. Make sure all goods are dated with received dates.b. Label, date and properly cover all food items upon opening of package.