

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165441	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2024
NAME OF PROVIDER OR SUPPLIER Sunny View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 410 N W Ash Drive Ankeny, IA 50023	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875</p> <p>Based on clinical record review, staff interviews and policy review, the facility failed to provide care and services according to accepted standards of clinical practice for 1 of 1 resident reviewed (Resident #5) for weight monitoring. The facility failed to obtain weights per physician order. The facility reported a census of 82 residents.</p> <p>Findings includes:</p> <p>Resident #5's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS identified Resident #5 was dependent on staff for bed mobility. The MDS documented Resident #5 did not get out of bed during the assessment period. The MDS revealed Resident #5 had an indwelling catheter and was always incontinent of bowel. Resident #5's MDS included diagnoses of neurogenic bladder (urinary bladder problems due to disease or injury to the central nervous system), septicemia (blood infection), urinary tract infection (UTI) in the last 30 days, quadriplegia (paralysis that affects the limbs and body from the neck down), edema, metabolic encephalopathy (brain dysfunction due to chemical imbalance in the blood), acute respiratory failure with hypoxia (low levels of oxygen in the body tissues), and cellulitis (skin infection) of right lower limb.</p> <p>A Physician order dated 2/28/24 directed staff to obtain a monthly weight in the morning starting on the 1st and ending on the 5th every month.</p> <p>The Care Plan dated 7/25/24 documented Resident #5 had a diagnosis of cardio/pulmonary fluid overload status post hospitalization and required a 2 liter fluid restriction. The Care Plan with a date of 4/13/23 revealed Resident #5 was on diuretic therapy related to edema. The Care Plan lack direction regarding weight monitoring and what to do if Resident #5 refused to be weighed.</p> <p>Resident #5's Weight Summary Record revealed Resident #5 had a weight documented on 8/4/23 of 235.6 lbs (pounds). The next weight recorded was on 3/4/24 of 205.2 lbs. The weight on 3/4/24 was struck out on 7/19/24 by the facility dietician with a strike out reason which indicated incorrect documentation. The next recorded weight was on 7/19/24 of 219.0 lbs and on 8/2/24 230.2 lbs.</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The March 2024 Treatment Administration Record (TAR) revealed Resident #5's weight was not recorded from 3/1/24 to 3/5/24. The TAR documented a 2 on 3/2 and 3/3 which indicated Resident #5 refused. The Progress Notes lacked documentation regarding attempts to obtain a weight or that Resident #5 had refused to be weighed from 3/1 to 3/5. The Progress Notes lacked documentation Resident #5 was educated on the risk and consequences on 3/2 and 3/3 when he refused to be weighed. The notes lacked documentation the Physician was notified that the weights were not obtained per order.</p> <p>The April 2024 TAR revealed Resident #5's weight was not recorded from 4/1 to 4/5/24. The Progress Notes lacked documentation regarding attempts to obtain a weight or that Resident #5 had refused to be weighed. The notes lacked any documentation that Resident #5 was educated on the risk and consequences of refusing to be weighed. The notes lacked documentation the Physician was notified that the weights were not obtained per order.</p> <p>The May 2024 TAR revealed Resident #5's weight was not recorded from 5/1 to 5/5/24. The Progress Notes lacked documentation regarding attempts to obtain a weight or that Resident #5 had refused to be weighed. The notes lacked any documentation that Resident #5 was educated on the risk and consequences of refusing to be weighed. The notes lacked documentation the Physician was notified that the weights were not obtained per order.</p> <p>The June 2024 TAR revealed Resident #5's weight was not recorded from 6/1 to 6/5/24. The TAR documented a 2 on 6/2 indicating Resident #5 refused and on 6/4 documented a 9 which indicated to see the progress notes. The Progress Notes lacked documentation regarding attempts to obtain a weight or that Resident #5 had refused to be weighed. The notes lacked any documentation that Resident #5 was educated on the risk and consequences of refusing to be weighed. The notes lacked documentation the Physician was notified that the weights were not obtained per order.</p> <p>The July 2024 TAR revealed Resident #5's weight was not recorded from 7/1 to 7/5/24. The Progress Notes lacked documentation regarding attempts to obtain a weight or that Resident #5 had refused to be weighed. The notes lacked any documentation that Resident #5 was educated on the risk and consequences of refusing to be weighed. The notes lacked documentation the Physician was notified that the weights were not obtained per order.</p> <p>A facility form titled Dietary Quarterly Review dated 4/25/24 documented Resident #5 had lost 13.2% in 7 months according to weight records. Resident #5's last weight was obtained in March and his most previous weight was in August. The Dietician recommended obtaining new weight to establish baseline, then continue monthly weights. If weight loss continues, recommend the addition of a nutrition supplement such as a magic cup as this is within the resident's food preferences.</p> <p>A Progress Note on 7/13/24 revealed Resident #5 had a mental status change, with an elevated temperature of 101.4, erratic blood pressure, unable to obtain pulse oximeter, hands very cold. The note documented 911 was called and Resident #5 was transferred to the hospital.</p> <p>A Hospital Discharge Summary dated 7/18/24 documented a chest x-ray impression completed on 7/13/24 revealed cardiomegaly and mild pulmonary edema.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility form titled Dietary Quarterly Review dated 7/25/24 documented Resident #5 was hospitalized from 7/13 to 7/18 with a diagnosis of urinary tract infection and sepsis. Resident #5 returned from hospital with a 2 liter fluid restriction. The note documented weight on 7/19/24 reflects a 16.6 lb weight loss in the past 11 months since last weight obtained on 8/4/23. The dietician recommended obtaining weekly weights for 4 weeks to establish accurate weight, then continue monthly weights.</p> <p>A Physician Progress Note dated 7/19/24 documented Resident #5 was seen for readmission due to sepsis and encephalopathy from a complicated UTI. Resident #5 was also found to have pulmonary congestion and placed on a 2000 milliter fluid restriction. Resident #5 has known diastolic heart failure but TTE (transesophageal echocardiography) showed preserved left ventricular function. The note directed staff to please ensure monthly weights are being obtained and recorded.</p> <p>The July TAR on 7/19/24 recorded Resident #5 weighed 219 lbs.</p> <p>Resident #5's weight summary record on 8/2/24 recorded Resident #5 weighed 230.2 lbs which was a 11 lb weight gain. The clinical record lacked a fluid overload assessment.</p> <p>A Progress note titled Nutrition/Dietary Note dated 8/8/24 documented Resident #5's weight is +11 lbs in 2 weeks. The note questioned the accuracy of the weight and recommended a reweigh.</p> <p>On 8/14/24 at 3:00 PM, the Director of Nursing (DON) reported she had recently taken over the weights from the previous Assistant Director of Nursing. She stated that Resident #5 would refuse to get weighed at times. She stated she would expect the refusals to be documented.</p> <p>On 8/14/24 at 4:32 PM, The DON reported Resident #5 does not get out of bed per his request and refuses to be weighed. The DON reported obtaining weights had been a concern and the facility was becoming more strict as of last week. She stated she would expect the physician order to obtain the weight be followed and if the weights were not able to be obtained the Physician would be notified.</p> <p>An undated facility policy titled Monitoring Weights documented all residents of the facility will be evaluated for weight stabilization for timely identification of weight loss and treatment will be provided when possible and accepted by the resident and/or surrogate decision maker to prevent weight loss unless the resident's physician has indicated a planned weight loss program. If the resident is moribund or refuses treatment, the physician will be made aware of the resident's refusal to have their weight monitored.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875</p> <p>Based on clinical record review, staff interview and policy review the facility failed to provide bathing assistance for 1 of 4 residents reviewed for bathing (Resident #1). The facility reported a census of 82 residents.</p> <p>Findings include:</p> <p>Resident #1's Admission Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. The MDS identified Resident #1 required substantial/maximal assistance shower or bathing. Resident #1's MDS included diagnoses of cancer, anemia, coronary artery disease (CAD) hypertension (high blood pressure), cirrhosis of the liver, and right humerus fracture.</p> <p>The Progress Note dated 7/16/24 revealed Resident #1 was admitted to the facility from the hospital.</p> <p>The Care Plan with a revised date of 07/18/24 identified Resident #1 required assistance of 1 staff member to provide showering tasks at least twice weekly and as necessary.</p> <p>The facility form titled Shower/Bath for July and August 2024 documented a shower/bath was completed for Resident #2 on 7/26/24, 8/6/24 and 8/9/24. The form documented shower/bath was refused on 7/19, 7/23, and 7/30. According to the documentation Resident #1 had one shower from 7/16 (date of admission) to August 5th.</p> <p>The clinical record lacked documentation of any other attempts to offer or encourage Resident #2 to shower or bathe.</p> <p>On 8/14/24 at 9:40 AM, the Assistant Director of Nursing (ADON) reported the facility was going to provide education to the staff regarding bathing expectations. She stated she would expect staff to re-approach and offer a bath/shower on a different time or day if the resident refused.</p> <p>On 8/14/24 at 3:20 PM, the ADON reported Resident #1 shower/bath days were scheduled on Tuesday and Friday.</p> <p>On 8/14/24 at 10:05 AM, the Director of Nursing (DON) verified she could not locate any other shower or bathing documentation for Resident #1. The DON reported she was providing education to the staff on bathing expectations. She stated she would expect staff to re-approach and reoffer a bath after a resident refused.</p> <p>A facility form title Shift Huddle-5 Minute Meeting dated 8/14/24 documented if a resident refuses a shower, the nurse was to be notified immediately. The nurse was to attempt to get the resident to shower or offer a bed bath. If the resident refuses, the nurse was to document. The resident was to be offered a shower the next day. If the resident continues to refuse, the nurse was to document.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An undated facility Policy titled Assisting a resident with a Shower documented all residents residing in the facility will receive care, treatment and services according to the resident individualized care plan. Based on the individual resident's comprehensive assessment, staff will ensure that each resident's abilities in activities of daily living including showering will not diminish unless circumstances of the residents' clinical condition demonstrates that the decline was unavoidable.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875</p> <p>Based on clinical record review, staff interviews, and policy review the facility failed to provide interventions necessary for the care and services, to maintain the residents' highest practical physical well- being for 1 of 6 resident reviewed (Resident #2). The facility failed to complete and document nursing assessments including neurological assessments after a report that a resident had hit his head on a wall. The facility reported a census of 82 residents.</p> <p>Findings include:</p> <p>Resident #2's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 05, indicating severe cognitive impairment. The MDS identified Resident #2 required substantial/maximal assistance with bed mobility, transfers, and toileting. Resident #2 's MDS included diagnoses of anemia, coronary artery disease (CAD) hypertension (high blood pressure), renal disease (kidney), diabetes mellitus, non-Alzheimer's dementia, anxiety, and depression.</p> <p>The Care Plan with initiated date of [DATE] revealed Resident #2 required total care in all activities of daily living (ADLs) secondary to decreased mobility related to right hip fracture, chronic pain and dementia. The Care Plan also identified Resident #2 was at risk for falls due to confusion, decreased mobility, deconditioning, psychoactive drug use and unaware of safety needs. The Care Plan directed staff to transfer Resident #2 with two staff members with walker to and from wheelchair per therapy recommendation. The Care Plan documented Resident #2 unable to sit on the toilet due to lack of trunk support.</p> <p>The Certified Nursing Assistant (CNA) Bio Sheet dated [DATE] revealed Resident #2 required assistance of two staff members with a front wheeled walker for transfers.</p> <p>An unsigned/undated Facility Summary Report documented a family member of Resident #2's roommate reported to the Director of Nursing (DON) on [DATE] that she had witnessed care provided to Resident #2 and wanted to make the facility aware. The report revealed on the evening of [DATE] a CNA came in the room and attempted to get Resident #2 from his wheelchair to his bed. The curtain was not closed all the way and the witness could see that the CNA stepped away and left Resident #2 sitting on the bedside to grab something. The witness reported she heard a thud and Resident #2 say, Ouch that hurt. The witness reported that she believed Resident #2 fell backwards and bumped his head on the wall.</p> <p>A handwritten statement (not part of the clinical record) dated for [DATE] signed by the Director of Nursing (DON) documented Resident #2 roommate's wife stopped this Registered Nurse (RN) to speak in regard to concerns she had witnessed with cares given to Resident #2. The witness stated that she had witness a CNA verbally abusing her husband's roommate during cares and she was transferring Resident #2 alone. The witness stated the curtain was not pulled and she heard the staff member telling the resident to sit down and asking the resident why he wasn't listening. CNA got the resident to sit down and she heard a noise against the wall once she walked away from the resident leaving him on the side of the bed. Head to toe assessment complete. No new injury. Resident denies any pain. Head checked. No injury. RN spoke to Resident #2's wife to let her know what was told to the staff.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's clinical record lacked documentation or assessments regarding the reported incident from [DATE]. The clinical record lacked neurological assessments, follow up neurological assessments and Physician notification that Resident #2 had potentially hit his head on the wall.</p> <p>On [DATE] at 12:15 PM, the DON reported she was working the floor as a charge nurse on [DATE] when Resident #2 roommate's wife (witness) approached her about a concern with Resident #2. The DON stated the witness reported an aide was verbally abusing Resident #2. The witness reported the aide was saying to Resident #2 you need to sit down and why aren't you listening. The DON stated the witness reported the curtain was not fully pulled. The DON stated the witness heard a noise against the wall and thought the noise was because Resident #2 had hit his head. The DON stated she had done a head to toe assessment and checked Resident #2's head. The DON stated she wrote the assessment in her statement and not in the clinical record. The DON reported her biggest concern and focus was on the verbal comments that had been reported. The DON reported she looked at the daily schedule and determined the aide was Staff D. The DON stated she did not recall Staff D, CNA saying anything about Resident #2 hitting his head and she did not recall any conversations with Staff D about transferring Resident #2 by herself. The DON stated she was focused on the way Staff D was talking to Resident #2.</p> <p>On [DATE] at 11:36 AM, Resident #2's wife reported she heard about the incident first from her husband's roommate's wife. She stated her husband's roommate's wife overheard everything. She stated she was told that the aide was not nice and kind of rough. She stated the aide walked away and her husband hit his head on the wall. She stated her husband's roommate's wife told her that her husband said, Ouch when he hit his head. Resident #2's wife reported the aide did not report that her husband had hit his head. She stated the only reason they found out was because the roommate's wife was in the room when it happened. She stated her husband has dementia and what would've happened if he died while he was sleeping. She stated it did not happen but it was very concerning. She stated the staff checked on him but they did not offer or mention anything about x-rays or an magnetic resonance imaging (MRI).</p> <p>On [DATE] at 3:15 PM, the DON reported when a resident was suspected of hitting their head, she would expect the staff to follow the neurological policy and monitor the resident for 72 hours. The DON reported she thought the Physician had been notified of Resident #2 potentially hitting his head. The DON reviewed the 5 days summary and her written statement and acknowledged the statements lacked documentation that the Physician was notified.</p> <p>On [DATE] at 3:39 PM, the facility Advance Registered Nurse Practitioner (ARNP) reported the facility had notified her of an allegation of rough treatment for Resident #2. When asked if she was notified Resident #2 had potentially hit his head, she stated Resident #2 had fallen before and had hit his head so she was not sure if it was this incident or a different one. She stated she had several facilities and would have to look in his chart to see what was reported. She stated the facility reported the allegations of rough treatment, that there were no injuries and that the staff member in question was terminated.</p> <p>A facility policy titled Neurological Assessments dated [DATE] documented each resident to receive, and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being, in accordance with the comprehensive assessment and plan of care. The policy documented neurological assessments to be performed at the following schedule:</p> <p>(continued on next page)</p>		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*every 15 minutes times four * every hour times four *every four hours times six *every eight hours for 72 hours

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875</p> <p>Based on clinical record reviews, observations, staff interviews and policy review, the facility failed to provide adequate nursing supervision to prevent accident and injuries for 1 of 1 residents reviewed (Resident #2). The facility reported a census of 82 residents.</p> <p>Findings include:</p> <p>Resident #2's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 05, indicating severe cognitive impairment. The MDS identified Resident #2 required substantial/maximal assistance with bed mobility, transfers, and toileting. Resident #2 's MDS included diagnoses of anemia, coronary artery disease (CAD) hypertension (high blood pressure), renal disease (kidney), diabetes mellitus, non-Alzheimer ' s dementia, anxiety, and depression.</p> <p>The Care Plan with initiated date of 12/5/23 revealed Resident #2 required total care in all activities of daily living (ADLs) secondary to decreased mobility related to right hip fracture, chronic pain and dementia. The care plan also identified Resident #2 was at risk for falls due to confusion, decreased mobility, deconditioning, psychoactive drug use and unaware of safety needs. The care plan directed staff to transfer Resident #2 with two staff members with walker to and from wheelchair per therapy recommendation. The care plan documented Resident #2 unable to sit on the toilet due to lack of trunk support.</p> <p>The Certified Nursing Assistant (CNA) Bio Sheet dated 8/1/24 revealed Resident #2 required assistance of two staff members with a front wheeled walker for transfers.</p> <p>An unsigned/undated Facility Summary Report documented a family member of Resident #2's roommate reported to the Director of Nursing (DON) on 7/6/24 that she had witnessed care provided to Resident #2 and wanted to make the facility aware. The report revealed on the evening of 7/5/24 a CNA came in the room and attempted to get Resident #2 from his wheelchair to his bed. The curtain was not closed all the way and the witness could see that the CNA stepped away and left Resident #2 sitting on the bedside to grab something. The witness reported she heard a thud and Resident #2 say, Ouch that hurt. The witness reported that she believed Resident #2 fell backwards and bumped his head on the wall.</p> <p>A handwritten statement dated for 7/6/24 signed by the Director of Nursing (DON) documented Resident #2 roommate's wife stopped this Registered Nurse (RN) to speak in regard to concerns she had witnessed with cares given to Resident #2. The witness stated that she had witness a CNA was rude to her husband's roommate during care and she was transferring Resident #2 alone. The witness stated the curtain was not pulled and she heard the staff member telling the resident to sit down and asking the resident why he wasn't listening. CNA got the resident to sit down and she heard a noise against the wall once she walked away from the resident leaving him on the side of the bed. Head to toe assessment complete. No new injury. Resident denies any pain. Head checked. No injury. RN spoke to Resident #2's wife to let her know what was told to the staff.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's clinical record lacked documentation or assessments regarding the reported incident from 7/5/24.</p> <p>On 8/15/24 at 12:40 PM, Staff A, CNA reported Resident #2 required assistance of two staff members with a transfer. Observed Staff A, CNA and Staff B, CNA transfer Resident #2 from the bed to the wheelchair. Staff supported Resident #2's upper back and Staff B supported his legs as the CNAs sat Resident #2 on the side of the bed. The air mattress on the bed was sinking in the middle and Resident #2 was leaning to his right side. Staff A assisted Resident #2 with his balance sitting up while Staff B applied the gait belt. Once the gait belt was on, the CNAs counted to 3 and stood Resident #2 up from the side of the bed. The CNAs provided Resident #2 with cues to move his legs while they pivoted him from the bed to the wheelchair. The CNAs gave verbal cues for Resident #2 to reach back and to sit down in the wheelchair. Staff B applied the wheelchair pedals to the wheelchair. Staff A adjusted the air mattress setting to a firmer setting.</p> <p>On 8/15/24 at 2:43 PM, Resident #2 roommate's wife (witness) reported the evening of the reported incident, she was sitting on her husband's bed and her husband was sitting in the chair. She reported the privacy curtain was closed around the chair and gaped open by the window. She stated she heard the CNA bring Resident #2 back from supper. She stated she listened to the CNA yell at Resident #2, You need to stand up. The witness reported Resident #2 was supposed to have two people to transfer and the CNA was by herself. She stated Resident #2 can not stand on his own and does not have good balance. She reported she heard a loud bang against the wall, she leaned back and looked around the curtain opened by the window and saw Resident #2 leaning back on his right side, half sitting up with his head up against the wall. The witness reported she thought the loud bang was from Resident #2' s head hitting the wall. The Witness stated the next day she came in earlier than normal (around 10-11/before lunch) and two CNAs came into the room. The Witness stated she told the aides what had happened the night before and asked them to feel the back of Resident #2's head. She stated the aides did not feel any bumps. The Witness reported the CNA should not have left Resident #2 sitting alone on the bedside.</p> <p>On 8/15/24 at 3:30 PM, the DON reported she did not fill out an incident report from the reported incident from 7/5/24 as there were no injuries.</p> <p>On 8/19/24 at 11:04 PM, Staff C, CNA reported Resident #2 likes to keep his legs crossed while standing and you have to give him direction. She stated Resident #2 required the assistance of two staff members with transfers.</p> <p>On 8/19/24 at 12:15 PM, the DON reported she was working the floor as a charge nurse on 7/6/24 when Resident #2 roommate's wife (witness) approached her about a concern with Resident #2. The DON stated the witness reported an aide was talking rude to Resident #2. The witness reported the aide was saying to Resident #2 you need to sit down and why aren't you listening. The DON stated the witness reported the curtain was not fully pulled. The DON stated the witness heard a noise against the wall and thought the noise was because Resident #2 had hit his head. The DON stated she had done a head to toe assessment and checked Resident #2 ' s head. The DON stated she wrote the assessment in her statement and not in the clinical record. The DON reported her biggest concern and focus was on the verbal abuse that had been reported. The DON reported she looked at the daily schedule and determined the aide was Staff D. The DON stated she did not recall Staff D, CNA saying anything about Resident #2 hitting his head and she did not recall any conversations with Staff D about transferring Resident #2 by herself. The DON stated she was focused on the way Staff D was talking to Resident #2.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/19/24 at 1:02 PM, Staff D, CNA reported after supper she got Resident #2 ready for bed. She stated she took Resident #2 to his room from the dining room. Staff D stated she sat Resident #2 on the side of the bed and laid him down to change him. She reported she did not have the curtain closed all the way. Staff D stated she transferred Resident #2 with a gait belt from the wheelchair to the bed. Staff D reported Resident #2 could stand. She reported everyone else was busy. She stated the girl that was going to help her was helping another resident who was a mechanical lift. She stated the Care Plan (biosheets) stated he could transfer with a gait belt. She stated the Care Plan (biosheets) were never right. She stated the Care Plan was probably changed after. Staff D reported she did not leave Resident #2 sitting on the edge of the bed himself. She stated she laid him down in a safe position before getting supplies that are kept in the room. Staff D reported she did not see or hear Resident #2 hit his head.</p> <p>On 8/19/24 at 3 PM, Staff E, CNA reported she looked at the bio sheets to know how to transfer a resident. She stated the biosheets tell you everything you need to know to take care of a resident. She stated the bio sheets are updated on a regular basis. She reported the biosheets have been accurate and a lot of help.</p> <p>On 8/19/24 at 3:15 PM, the DON reported she expected the CNA's to look at the biosheets for the resident transfer status. She stated the care plans in the clinical record and the biosheets should match. She stated the biosheets are updated whenever there are changes.</p> <p>On 8/19/24 at 3:50 PM, Staff F, CMA reported she has worked at the facility for 3 years. She stated Resident #2 has required assistance of two staff members for transfers the whole time he has been in the facility. She reported she would look at the biosheets to know how to transfer a resident. She stated the biosheets tend to be updated routinely.</p> <p>The undated facility policy titled Accident and Incident Policy documented the facility was committed to providing a safe and secure environment for resident, staff and visitors. The purpose of the policy was to outline procedures and guidelines to prevent accidents and manage hazards effectively within the facility. The primary objective of the policy was to minimize the risks of accidents and hazards, promote the safety and wellbeing of residents, staff and visitors and establish a framework for responding to incidents promptly and efficiently. The policy documented staff member must report accidents, incidents or potential hazards promptly to the staff member's immediate supervisor. The reporting staff member will use the facility's incident report and/or progress notes to document details of the incident including but not limited to date, time, location, individuals involved and detailed description of the incident. The Administrator will designate a team to investigate accidents, incidents and hazards thoroughly and completely to determine causal factors of the event or potential event.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875</p> <p>Based on staff interview, and clinical record review the facility failed to monitor and provide appropriate urinary assessment after a indwelling catheter was removed for 1 of 4 residents reviewed (Resident #4) for catheters. The facility also failed to document accurate urine output and follow a physician order when inserting an indwelling catheter. The facility reported a census of 82 residents.</p> <p>Findings include:</p> <p>Resident #4's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) was not able to be completed. A Staff Assessment for Mental Status indicated Resident #4 had severe cognitive impairment. The MDS identified Resident #4 was dependent on staff for bed mobility, transfers and toileting. The MDS revealed Resident #4 had an indwelling catheter, and was always incontinent of bowel. Resident #4's MDS included diagnoses of down syndrome, anxiety, depression, and non-Alzheimer's dementia.</p> <p>The Care Plan dated 6/27/24 revealed Resident #4 had a urinary catheter related to urine retention.</p> <p>A Progress Note dated 5/29/24 documented a Certified Nursing Assistant (CNA) reported to the nurse around 6 PM that Resident #4 had not voided (urinated) since the morning. The note documented the nurse went to assess Resident #4 and his abdomen was very distended. The on-call Provider was notified and gave a new order to do a straight catheter. The straight catheter was inserted and 750 milliliters (ml) of urine output was received and still draining. The on-call Provider was notified and directed to keep the foley in overnight and notify the facility Provider in the morning.</p> <p>A Progress Note dated 5/30/24 at 3:05 PM documented the Nurse Practitioner was notified of the temporary catheter and gave an order to obtain a UA (urinalysis).</p> <p>A Progress Note dated 5/30/24 at 6:13 PM documented the UA obtained and sent to the lab.</p> <p>A Physician order dated 5/31/24 directed staff to obtain UA with culture and sensitivity for diagnosis of urinary retention and to leave the catheter in for now and change every 30 days.</p> <p>The Pathology Laboratory Report for Resident #5 dated 5/31/24 revealed the urinalysis had no bacteria seen. The facility Nurse Practitioner dated/signed the form on 6/3/24 and wrote an order to discontinue Resident #5's catheter and monitor output.</p> <p>A Progress Note dated 6/3/24 at 1:14 PM documented Resident #4's UA results were reviewed by the Provider. A new order was received to discontinue catheter and monitor output. The note documented the foley was discontinued.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Progress Notes from 6/3/24 to 6/9/23 lacked urinary assessments and documentation Resident #4 was monitored for signs and symptoms of urinary retention after the catheter was discontinued. Resident #4's cognition was severely impaired and he was not able to voice if he was in pain or was not able to urinate.</p> <p>A Progress note dated 6/10/24 at 11:36 AM documented a CNA reported to the nurse that Resident #4 did not have a wet brief all night as reported by the night shift nurse and till now has not urinated. The note documented Resident #4's stomach was slightly distended. Staff attempted to toilet Resident #4 and he only had a bowel movement. The noted documented Resident #4 abdomen soft, non-distended and non tender per resident.</p> <p>A Progress note dated 6/10/24 at 9:40 PM documented a new order received to put a foley catheter in and leave in place if the residual was greater than 200 ml. According to the note, an 18 French Foley catheter was inserted using sterile technique. The progress note lacked documentation regarding how much urine output was received when the catheter was inserted.</p> <p>A Progress note dated 6/17/24 9:01 PM documented Resident #4 was seen by the Provider and a new order was given to change the foley bag and get a UA with culture and sensitivity.</p> <p>A Progress note dated 6/18/24 5:39 PM documented Resident #4 constipation medications were held due to loose stool and emesis during the day. The note also documented Resident #4's urine was dark in color, cloudy, foul smelling and there was not much urine output during both morning and evening shifts. The note documented the Nurse Practitioner notified.</p> <p>A Progress note dated 6/19/24 12:10 PM documented Resident #4 was seen by the Nurse Practitioner at the facility and new orders received to check labs and do an abdominal x-ray.</p> <p>A Progress note dated 6/19/24 at 12:40 PM documented Resident #4 UA results received with no new orders, awaiting culture and sensitivity results.</p> <p>A Progress note dated 6/20/24 at 6:30 PM reported Resident #4 was sent to the hospital due to excessive sweating, chills, multiple emesis, loose stools and output less than 250 ml during the shift.</p> <p>A Progress note dated 6/21/24 at 4:59 AM documented Resident #4 returned from the hospital with a new order for Amoxicillin-Clavulanate (antibiotic) 875 mg one tablet every 12 hours for 7 days for a urinary tract infection.</p> <p>On 8/19/24 at 9:20 AM, the Assistant Director of Nursing (ADON) reported the facility did not have a policy on monitoring urine output/retention after a catheter was discontinued. She stated she thought the Corporate Nurse was working on one.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/19/24 at 9:30 AM, Staff K, Registered Nurse (RN) reported after Resident #4's catheter was removed, the staff would monitor urine output by monitoring if Resident #4 was having a wet diaper or not. Staff K stated the facility did not have a bladder scanner so they had to go by the wet diapers. She stated the CNA would report to the nurse and the nurse would document in the progress if Resident #4 did not have a wet diaper. She stated if Resident #4 was having wet diapers after the catheter was removed then she would not document. She stated if Resident #4 was not having a wet diaper then that would be a concern and follow up needed. Staff K acknowledged she reinserted Resident #4's catheter on 6/10/24. Staff K reported the urine return when the catheter was inserted was hundred and something. She stated the urine output was not 200 ml but close to it. She stated she thought the physician order said to leave the catheter in if it was less than 200ml. She stated she chose to leave the catheter in and she had talked to the ARNP at some point in time but does not remember when. She stated she would have put the catheter in right away after the Provider gave the order. She stated sometimes the charting happens later in the shift.</p> <p>On 8/19/24 at 9:45 AM, Staff K reported to the facility's Nurse Practitioner in person that she had inserted Resident #4's catheter on 6/10/24 and left the catheter in even though there was not 200 ml residual per the original order. The facility Nurse Practitioner reported she probably would have instructed the staff to leave the catheter in regardless. The Nurse Practitioner stated she does not feel it changed any outcome. The facility Nurse Practitioner reported the facility had tried to remove the catheter once or twice before and there were concerns with retention. She stated with Resident #4's history and symptoms, she felt the catheter placement was appropriate.</p> <p>On 8/19/24 at 10:04 AM, Staff K, RN reported she reviewed her progress notes for Resident #4 and was trying to remember back. She stated she recalled the urine return was close to 200 ml when she inserted the catheter and the catheter was still draining so that is why she left it in.</p> <p>On 8/19/24 at 12:45 PM, the Director of Nursing (DON) reported she expected the staff to follow the standards of practice when a catheter was removed. She stated she would expect the staff to document and follow up to ensure the resident does not have any urine retention after the catheter was removed. She stated when a catheter was inserted she would expect staff to document an accurate output of immediate return and update the Physician as needed. She reported she would expect the Physician order to be followed.</p> <p>On 8/19/24 at 1:30 PM, the DON reported the facility does not have a specific policy on monitoring urinary output after a catheter was removed.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875</p> <p>Based on observations, clinical record review, staff interviews, and policy review, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for 2 of 4 resident reviewed for catheter care (Resident #5 and #3). The facility reported a census of 82 residents.</p> <p>Findings include:</p> <p>1. Resident #5's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS identified Resident #5 was dependent on staff for bed mobility. The MDS documented Resident #5 did not get out of bed during the assessment period. The MDS revealed Resident #5 had an indwelling catheter and was always incontinent of bowel. Resident #5's MDS included diagnoses of neurogenic bladder (urinary bladder problems due to disease or injury to the central nervous system), septicemia (blood infection), urinary tract infection (UTI) in the last 30 days, and quadriplegia (paralysis that affects the limbs and body from the neck down).</p> <p>The Care Plan with a target date of 10/19/24 revealed Resident #5 had a Foley catheter related to a neurogenic bladder. The Care Plan directed one staff member to assist with catheter care. The Care Plan revealed Resident #5 will not allow staff to put a dignity bag on his catheter and he preferred to have his catheter bag placed in a wash basin.</p> <p>On 8/14/24 at 8:30 AM observed catheter care with Staff G, Certified Nursing Assistant (CNA) and Staff H, CNA. When entering Resident #5's room, observed the catheter bag lying inside a pink wash basin on the floor. Both CNAs applied gowns and completed hand hygiene prior to entering the room. Staff G and Staff H applied gloves and rolled Resident #5 on his back from his left side. The catheter remained hanging over the edge of the bed while the resident was repositioned on his back. Staff G took several incontinence wipes from the wipe container and laid the incontinence wipes directly on the turning pad (no barrier) in between Resident #5's legs. Staff G took one wipe at a time and completed the peri care in the front. She cleansed around the catheter and down the tubing. Staff G removed her gloves, applied hand sanitizer and applied new gloves. She then applied powder to the peri area. She then removed the gloves, applied hand sanitizer and applied new gloves. Staff H and Staff G then rolled Resident #5 back on his left side and positioned him per his preference. The catheter bag was observed out of the pink basin and was lying directly on the floor. Staff G reported Resident #5 does like the catheter bag hanging from his bed and that he prefers it in the basin or lying on the floor. Staff G reported she thought the catheter bag had come out of the basin during the movement in bed. Staff H reported the resident does not like the catheter to be hung on the side of the bed as he thinks it causes his catheter to kink.</p> <p>A Progress Note on 7/13/24 at 4:30 PM revealed Resident #5 had a mental status change, with an elevated temperature of 101.4, erratic blood pressure, unable to obtain pulse oximeter, hands very cold. The note documented 911 was called and Resident #5 was transferred to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Hospital Encounter Note dated 7/13/24 documented Resident #5 was admitted due to sepsis likely secondary to complicated urinary tract infection and right lower extremity cellulitis with associated lactic acidosis in the setting of neurogenic bladder with chronic indwelling catheter.</p> <p>A Progress note on 7/18/24 at 12:00 PM documented Resident #5 returned from the hospital with a diagnosis of UTI and sepsis. Resident #5 on two antibiotics.</p> <p>A Physician Progress Note dated 7/19/24 at 5:49 PM documented Resident #5 was seen for readmission due to sepsis and encephalopathy from a complicated UTI.</p> <p>2. Resident #3's Quarterly Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 6, which indicated severely impaired cognition. The MDS identified Resident #3 required substantial/maximal assistance with bed mobility and was dependent on staff for transfers. The MDS revealed Resident #3 had an indwelling catheter and was always incontinent of bowel. Resident #3's MDS included diagnoses of renal disease (kidney), heart failure (inability for the heart to pump blood), retention of urine, and Alzheimer's disease.</p> <p>The Care Plan with a target date of 8/30/24 revealed Resident #3 had an indwelling catheter related to urinary retention. The Care Plan directed staff to use enhanced barrier precautions per policy related to the Foley catheter.</p> <p>On 8/14/23 at 11:40 AM, observed Enhanced Barrier Precaution sign on Resident #3's door. The sign directed everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for the following high contact resident care activities that include deceive care/use for indwelling catheters.</p> <p>On 8/14/24 at 11:45 AM, Staff I and Staff J washed their hands when entering the Resident #3's room and applied gloves. Staff I and Staff J did not apply gowns. Observed a bed pad folded up on the bedside table with a clean incontinence brief placed on top of the bed pad along with a package of incontinence wipes. Observed several incontinence wipes had already been taken out of the package and lying directly on top of the wipe container. The CNAs explained to Resident #3 what they were going to do. Staff I and Staff J did not apply gowns prior to starting the catheter care. Staff I handed the incontinent wipes that were sitting on top of the container to Staff J. Staff J used one wipe at a time going front to back and she cleansed down the catheter tubing. After cleansing the front peri area, Staff I and Staff J removed gloves and washed hands. Staff I and Staff J identified they were not wearing gowns and applied the gowns prior to finishing cares with Resident #5.</p> <p>On 8/14/24 at 4:32 PM, the Director of Nursing (DON) reported she would expect staff to use an appropriate barrier for the incontinent wipes and to wear a gown during the entire process. The DON reported the catheter should be monitored and go with the resident during repositioning to ensure the catheter does not get dislodged and is not on the floor.</p> <p>An undated facility policy titled Foley Catheter Care documented it was the policy of the facility that catheter care be provided to all residents with indwelling catheters twice daily and as needed due to soiling with feces or when it is deemed necessary by the nurse. The purpose of catheter care was to prevent the possible urinary tract infections from bacteria spreading from the perineal area and external catheter into the bladder. The policy documented to avoid the catheter tubing from touching the floor as much as possible.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An undated facility policy titled Enhanced Barrier Precautions (EBP) documented the facility follows recommendations and guidance from the Centers for Disease Control in order to keep all residents safe from Healthcare Acquired Infections (HAI). Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. On the recommendation and approval of the facility's Infection Preventionist in collaboration with the facility's Medical Director, Enhanced Barrier Precautions (EBP) are implemented as one intervention the facility uses to reduce transmission of resistant organisms that employs targeted Personal Protective Equipment (PPE) use during high contact resident care activities. Standard Precautions continue to apply to the care of all residents, regardless of suspected or confirmed infection or colonization status. The policy documented residents with indwelling medical devices that includes an indwelling catheter, regardless of MDRO colonization status, require EBP for all cares and services.</p>		