STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165441	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny View Care Center	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)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and facility policy review, the facility failed to ensure the 5 rights of medication administration were followed resulting in 1 of 1 residents receiving another resident's medications (Resident #6) in addition to the resident's own medication which required an admission to the hospital due to sinus bradycardia (resting heart rate that is slower than normal) requiring further hemodynamic (blood flow movement and circulation through the heart and blood vessels) monitoring. The facility reported a census of 92 residents.Findings include: Review of Resident #6's census in the Electronic Health Record (EHR) revealed the resident was hospitalized [DATE] to 3/23/26. Review of the Minimum Data Set (MDS) assessment for Resident #6, dated 2/24/26 revealed a list of diagnoses which included hypertension, Alzheimer's disease and toxic encephalopathy (change in how the brain functions). The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 3 which indicated severe cognitive impairment. Review of Resident #6's March 2026 Medication Administration Record (MAR) revealed the resident received the following ordered medications on 3/22/26 during the morning medication pass:a. Aspirin 81 milligrams (MG) 1 [NAME]. Calcium Carbonate 600 MG 1 tabc. Vitamin C 500 MG 1 tabd. Vitamin D 25 micrograms (MCG) 1 tabe. Fluoxetine 20 MG 1 tab f. Furosemide 40 MG 1 tab (medication to pull excess fluid off the body)g. Galantamine Hydrobromide 12 MG 1 tabh. Lidocaine external patch 4% (topical pain medication)i. Memantine Hydrochloride (HCL) 10 MG 1 tab (medication to decrease anxiety, and or mood disturbance)j. Acetaminophen 325 MG 2 tabsk. Oxycodone HCL 5 MG 0.5 tab as needed (prn) (opioid class used for moderate to severe pain)Review of facility Incident Report (IR) #2275 dated 3/22/26 at 10:10 AM prepared by Staff A, Licensed Practical Nurse (LPN) revealed Resident #6 was in the dining room when the resident was given the wrong medications. Staff A notified the nurse on-call and the doctor was notified. The IR documented the resident to be oriented to person only. Review of the EHR revealed a Nurse's Progress Note entered 3/22/26 at 11:04 AM documented Resident #6 was giving another resident's medications which included the following: a. Metoprolol 60 MG (medication to lower heart rate)b. Lyrica 75 MG (narcotic medication used to calm overactive nerves)c. Oxycodone 7.5/325 MG (opioid class of medication for moderate to severe pain)d. Furosemide 40 MG (medication used to pull excess fluid off the body)e. Celebrex 100 MG (nonsteroidal anti-inflammatory drug for reducing pain, for example arthritis, acute pain, and menstrual pain)f. Prozac 60 MG (anti-depressant known for it's long extended release factor)g. Hydroxyzine 10 MG (can be used for sedative, anti-anxiety, and anti- itch)h. Cetirizine 10 MG (allergy medication)i. Neuriva j. Protonix 20 MG k. Potassium + 99 MG l. Multivitamin m. Vitamin D3 The Progress Note dated 3/22/26 at 11:04 PM further revealed these medications were given in addition to the resident's regular morning medications including a as needed (prn) Oxycodone that were given around 8:00 AM. The resident's blood pressure (BP) was originally 100/50, then 85/48 and 73/48. The resident complained of not feeling well and was increasingly fatigued. Staff A informed the on-call provider and was given orders to send the resident to the emergency room (ER) for treatment and evaluation. The Power of Attorney (POA) was notified, emergency services were contacted and the resident was transported out of the facility at 11:00 AM to a local ER. Review of Nurse's Progress Notes dated (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 0760 Level of Harm - Actual harm Residents Affected - Few	3/22/26 at 5:29 PM revealed the ER was contacted for an update on Resident #6's condition. The resident had been hypotensive (low blood pressure) upon admission and had required two (2) bags of fluid to increase the residents blood pressure (BP). Review of the History & Physical (H&P) hospital notes dated 3/22/26 at 9:30 PM revealed the chief complaint as drug overdose after accidental ingestion of another resident's multiple medications in addition to the resident's own medications. Poison control was contacted and provided recommendations which were executed in the ER. However, after the recommended observation the resident continued to have sinus bradycardia and thus was recommended for admission for further hemodynamic monitoring. During a phone interview 4/29/26 at 11:10 AM Staff A, LPN reported Resident #6 had been screaming and yelling and she didn't realize there had been two (2) residents with the same first name in the back hallway. Staff A reported it was her first time working in the back hallway after her training was completed. Staff A acknowledged there were pictures in the EHR to help identify the residents but felt they were small. Staff A stated she didn't know the residents but realized it right away when she gave medications to the wrong resident and contacted the physician. Staff A reported the physician was only concerned about the BP meds and directed staff to monitor Resident #6's BP and if it went down to transfer the resident out which they did. Review of facility policy titled, Medication Management, dated 2023 directed staff to identify the resident before administering medication. Review of employee records for Staff A, LPN revealed the following: Date of Hire: 12/31/25Termination Date: 3/23/26Review of facility form titled, Medication Occurrence Report Form, dated 1/20/26 revealed Staff A administered the wrong medications including Lasix (Furosemide), and potassium to a resident. Review of facility form titled, Employee Warning Notice, dated 2/6/26 revealed Staff A received a final warning related to unprofessional and inappropriate conduct toward residents and their family members. Staff A documented not being familiar with residents due it being the 2nd time on the cart and as a measure to prevent reoccurrence to ask staff in not sure.Review of facility form titled, Employee Warning Notice, dated 3/23/26 revealed Staff A received notification of termination related to substandard work including a medication error that resulted in a resident being hospitalized . Description of Infraction: Inadvertently gave a resident another resident's medication which resulted in the resident having to be hospitalized for hypotension. Failed to follow the 5 rights of medication pass to ensure resident safety while administering resident medications. Pictures of both residents were available in the EHR for reference. Plan for Improvement: Staff A had a previous medication error, disciplinary documents in Staff A's file on 1/20/26 and had been counseled on medication administration expectations. Consequences of Further Infractions: The facility elected to terminate Staff A's employment effective immediately due to the significant medication error infraction. Staff A had given a 2 week notice voluntary resignation however the facility accepted it immediately. On 4/28/26 at 1:29 PM the Administrator revealed any education provided to Staff A, LPN would have been in the attachment of Staff A's disciplinary action. The Administrator further revealed Staff A did not have an orientation checklist and a Quality Assurance Performance Improvement (QAPI) had been started on orientation checklists.