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	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny View Care Center	410 N W Ash Drive Ankeny, IA 50023

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on observations, staff interview, and facility cleaning procedures, the facility failed to ensure resident rooms were free of odors to create a home-like environment for 1 of 59 resident rooms (Resident #71). The facility reported a census of 82. Findings include: The Minimum Data Set (MDS) dated [DATE] revealed Resident #71 with a Brief Interview for Mental Status score of 14, which indicated intact cognition. Diagnoses on the MDS include anxiety, cerebrovascular accident (stroke), chronic pain syndrome, depression, diabetes, hemiplegia, non-Alzheimer dementia, Parkinsons, and prostate cancer. The MDS noted Resident #17 utilizes either a walker or wheelchair for mobility. The Care Plan with a completion date of 12/2/24 indicated Resident #71 has had falls with minor injury due to poor balance. Interventions included staff to check urinal frequently and empty if needed to prevent spills. During an observation on 2/10/25 at 11:10 AM, an ammonia odor was present in the hallway from Resident #71's room. During a room observation on 2/10/25 at 2:05 PM, an ammonia odor was detected in Resident #71's room despite the presence of an odor diffuser. The carpet had a spongy, sticky feel when walking around the room, especially near the bed. During an interview on 2/10/25 at 2:05 PM, Resident #71 stated his preference to use a urinal while in bed. Resident #71 prefers the urinal to hang on the trash can next to the bed instead of a bed rail. When on the bed rail, the urinal is typically near the head of the bed. Resident #71 explained they do not wish to be that close to see or smell it. Resident #71 voiced when the urinal is full, there are times when it spills, either when placing it back onto the trash can or when trying to get to the bathroom himself to empty it in the toilet. In an interview on 2/11/25 at 12:35 PM, Staff H, Housekeeping, explained resident rooms are vacuumed and dusted daily. Carpets can be cleaned as needed. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/11/25 at 12:45 PM Staff G, Environmental Supervisor, noted that resident room carpets can be cleaned as needed. Especially after urinary or bowel incontinent events. Staff G acknowledged the frequency to which Resident #71 spills the urinal. There is no extra scheduled carpet cleaning of the room. Environmental Services rely on staff to inform if the room carpet needs cleaning due to odors. In a follow-up interview on 2/13/25 at 1:45 PM, Staff G discussed routine carpet cleaning addressed as part of the resident room's deep cleaning checklist. Staff G voice the goal is to complete 6 deep clean resident rooms per day. At this time, Staff G estimates environmental staff deep cleans only 3 rooms daily. Review of the document Environmental Services Checklist and Goals of Department, dated 2021, indicated each room shall be deep cleaned monthly with 6 rooms are deep cleaned daily. The Deep Clean Checklist outlined staff to extract carpet or use carpet spotter for stains.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on observation, family and staff interviews, and clinical record review, the facility failed to follow the physician's orders for 1 of 20 residents (#32). The facility reported a census of 82 residents. Findings include: 1. On 2/10/25 at 3:56 PM, Resident #32's visitor stated the resident missed several doses of Calcium Carbonate (Tums) during the last week of October 2024. She also stated there were several occasions when the resident's Voltaren External gel (topical analgesic used to treat pain and inflammation) was not given until after the prescribed time. On 2/10/25 at 5:29 PM, the resident's relative stated the resident received the Tums to provide calcium for a previously fractured T12 vertebrae. She also stated the Volteran gel was to be applied for the same reason. The Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #32 revealed a Brief Interview for Mental Status (BIMS) score was not obtained because the resident was rarely/never understood. It included diagnoses of Heart Failure, Chronic Kidney Disease (CKD), Diabetes Mellitus (DM), chronic pain, and spinal stenosis (narrowed spinal canal). It also revealed the resident required setup assistance with eating, supervision with oral and personal hygiene, maximal assistance with toileting hygiene and bathing, and was dependent with all other aspects of Activities of Daily Living (ADLs). The Electronic Health Record (EHR) included a physician order dated 2/15/22 for Calcium Carbonate Tablet chewable 500 mg; give two (2) tablet by mouth in the morning for indigestion. The EHR also included a physician order dated 9/27/24 for Voltaren External Gel 1% (Diclofenac Sodium (Topical)); apply to lower back 4 gm topically two (2) times a day for back pain after patch removed at 9 AM and apply at 2 PM. The Medication Administration Record (MAR) dated October 2024 revealed Staff A, Registered Nurse (RN) documented the resident did not receive the Calcium Carbonate on 10/25/24, 10/28/24, 10/29/24, and 10/31/24. The Progress Notes indicated the Calcium Carbonate was given on 10/26/24, 10/27/24, and 10/30/24 but was not on hand on 10/25/24 or 10/31/24. It also indicated the facility was waiting for a delivery on 10/28/24. There was no progress note entry for the resident's Calcium Carbonate omission on 10/29/24. On 2/13/25 at 7:20 AM, Staff B, Licensed Practical Nurse (LPN), stated nurses check other medication carts for stock medications if their cart doesn't have it. She also stated the nurses notify Staff C, Central Supply staff (CS) by text, even on weekends if they run out of a stock medication. She added they also notify the physician and document it in the progress notes. Staff A, RN was not available for an interview. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 2:32 PM, Staff C (CS), stated she was not in the current role in October and didn't have any method to check whether the facility ran out of stock medications at that time. The Care Plan revised 4/05/23 did not include interventions for Calcium Carbonate. On 2/13/25 at 3:20 PM, the Director of Nursing (DON) stated the staff should notify the pharmacy if stock medications are not available. 2. The Electronic Health Record (EHR) included a physician order dated 9/27/24 for Voltaren External Gel 1% (Diclofenac Sodium (Topical)); apply to lower back 4 gm topically two (2) times a day for back pain after patch removed at 9 AM and apply at 2 PM. On 2/12/25 at 7:36 AM, Resident #32 was observed asleep in her bed. The Medication Administration Record (MAR) indicated the resident's pain patch had been removed. At 7:54 AM, Staff D, Certified Nurse Aide (CNA), assisted Resident #32 to the dining room. She also revealed the resident's patch was removed but no topical gel was noted on the resident's back. At 10:01 AM, the Treatment Administration Record (TAR) indicated the resident had not received the Voltaren Topical gel to her back. At 10:06 AM, the resident was observed sleeping in her bed. At 10:33 AM, Staff E, Registered Nurse (RN), stated nurses apply the medicated cream (Voltaren) to the residents. She said the medicated lotion is scheduled at medication pass but if it is scheduled for a specified time, there is a 1-hour window before and after the scheduled time for medication administration. She also stated the Voltaren should be documented on the MAR. She said the process is to check the MAR during medication pass then check the TAR for medications that are timed. At 11:25 AM, Staff E, RN, stated if the resident refuses the medication, it is documented as refused and a subsequent progress note is documented. She also stated the refusal is entered into the communication book for the physician. She stated she had not applied the Voltaren because she was waiting for the resident to get back to her room. The Care Plan directed staff to administer analgesic medications as order by physician. The Administration Record History (ARH) revealed the Voltaren was administered over one (1) hour after the scheduled administration time on 2/04/25, 2/05/25, 2/06/25, 2/10/25, and 2/12/25. On 2/13/25 at 3:20 PM, the Director of Nursing (DON) stated it was unusual for topical medications to be scheduled for specific times but staff should administer medications within 1 hour before of after the scheduled dose. The facility did not have a policy specific to following physician's orders.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on health record review, facility document review, and staff interviews, the facility failed to communicate throughout departments current resident staff assistance level for 1 of 5 residents reviewed for nursing supervision (Resident #71). The facility reported a census of 82. Findings include: The Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #71 with a Brief Interview for Mental Status score of 14, which indicated intact cognition. Diagnoses on the MDS include anxiety, cerebrovascular accident (stroke), chronic pain syndrome, depression, diabetes, hemiplegia, non-Alzheimer dementia, and Parkinsons. The MDS noted Resident #17 utilizes either a walker or wheelchair for mobility. The MDS revealed Resident #71 is independent with chair/bed-to-chair transfers, toilet transfers, and walk 10 feet. The MDS recorded no falls since prior assessment. The Care Plan with a completion date of 12/2/24 indicated Resident #71 has a self-care performance deficit related to stroke with left-sided weakness. Interventions indicated Resident #71 independent with stand pivot transfers from wheelchair level to/from toilet and bed (initiated on 7/8/24), utilizes a wheelchair for primary mobility inside room (revised on 7/30/24), and independent to perform toileting tasks (revised on 7/15/24). Electronic health record review revealed Resident #71 has experienced 7 falls since the MDS was completed on 11/19/24. Falls occurred on 12/20/24, 12/14/24, 12/15/24, 1/13/25, 1/16/25, 1/23/25, and 2/2/25. Paper chart review revealed the following Activity Level and Recommendations Form from therapy, which was located in the Rehab and Therapy tab: 1. On 5/16/24: Staff assist of 2 for transfers with a hemi-walker 2. On 6/14/24: Changed from a staff assist of 2 to a staff assist of 1 for transfers using a hemi-walker 3. On 7/16/24: Staff walk to dine with wheelchair follow as tolerated No further recommendations from therapy found, paper or electronic, which indicated Resident #71 was changed from an assist of 1 to independent, as outlined on the Care Plan interventions from July'24. Paper chart review revealed a Fall and Safety Management Program form, dated 11/7/24, revealed Resident #71 as independent with transfers and ambulation status. This form was located in the Risk Assessment tab of the chart. The Physical Therapy Evaluation and Plan of Treatment, for the date of service 9/17/24-11/12/24, recommended Resident #71 perform transfers with stand-by staff assistance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physical Therapy Discharge Summary, for the date of service 11/27/24-1/10/25, recommended Resident #71 perform transfers with stand-by staff assistance. During an interview on 2/11/25 at 2:00 PM, Staff I, Certified Nursing Assistant, and Staff J, Licensed Practical Nurse, both unable to explain Resident #71's current staff assistance level. Staff J stated this information would be found in the Bio Worksheet Binder. Upon review of the binder, which was last updated on 2/12/25, Resident #71 listed as independent with stand pivot transfers to and from bed to toilet to wheelchair. During an interview on 2/13/25, Staff L, Licensed Practical Nurse, voiced Resident #71 not needing much assistance now as mainly in bed. Staff L believes Resident #71 has been a staff assistance of 1 since October. During an interview on 2/13/25 at 1:00 PM, the MDS Coordinator explained therapy will provide a copy of Activity Level and Recommendations Form. The MDS Coordinator will update the Care Plan and the Bio Worksheet. During an interview on 2/13/25 at 1:30 PM with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), the DON stated Resident #71's independent status is reflective of their current status. Resident #71 typically does not wait for staff help or will refuse assistance. During an interview on 2/13/25 at 2:00 PM, the Director of Rehab (DOR), did not feel the information on the Bio Worksheet reflected Resident #71's current status given the increase in falls. Upon review of the most recent Physical Therapy notes, the DOR indicated Resident #71 should have staff present during transfers. The DOR could not explain or provide documentation when Resident #71 became independent, as outlined on the Care Plan. The DOR could not explain the inconsistency between the Physical Therapy recommendations for stand-by staff assistance (from September'24 and January '25) and the Risk Assessment stating an independent level of assistance in November'24. The policy Care Plan Development Process, dated 2022, indicated the Care Plan will be reviewed and amended as needed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on observations and resident and staff interviews, the facility failed to provide resident assistance or follow-up with medical equipment for 1 of 2 residents reviewed for respiratory care (Resident #235). The facility reported a census of 82. Findings include: The Admission Minimum Data Set (MDS) dated [DATE] revealed Resident #235 with a Brief Interview for Mental Status score of 15, which indicated intact cognition. Diagnoses on the MDS include anemia, atrial fibrillation, hip fracture, obstruction sleep apnea, and osteoporosis. The facility admitted documented as 1/28/25. The Care Plan revised on 2/11/25, indicated Resident #235 had a self-care performance deficit due to right shoulder fracture and left femur fracture. Interventions include staff assist of 1 with a hemi-walker for transfer inside the room, weight-bearing as tolerated to left lower extremity, and staff assist of 1 to turn and reposition in bed. The Care Plan indicated Resident #235 is a fall risk due to weakness, decreased mobility, fall history, weight-bearing restrictions, and opioid medication use. During a room observation on 2/10/25 at 3:00 PM, a Continuous Positive Airway Pressure (CPAP) machine was sitting in Resident #235's bedside nightstand. During an interview on 2/12/25 at 1:10 PM, Resident #235 explained the CPAP is their own personal equipment. Family brought the machine to the facility shortly after admission. Resident #235 stated they could use the CPAP independently but needed help filling and emptying the water chamber. At least 2 one-gallon jugs of distilled water were seen sitting on the floor behind the bedside nightstand. Resident #235 voiced a desire to wear the CPAP while at the facility. Resident #235 explained asking facility staff for assistance but was told they could not as there is not a current physician order for the CPAP. Since that time, staff had not followed-up with Resident #235 regarding the CPAP nor provided any assistance. During brief interview on 2/12/25 at 9:00 AM, Staff M, Registered Nurse, was not aware of Resident #235's CPAP as this is typically worn at night. Staff M stated they work during the daytime. Staff M could not answer specific questions regarding the CPAP. During an interview on 2/12/25 at 2:30 PM, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were not aware of the CPAP machine. Both acknowledged the lack of physician order for the machine. The DON confirmed without a current order, staff unable to assist Resident #235 with the machine. During this time, the ADON placed a call to Staff N, Registered Nurse, via speaker, who typically works the overnight shift. Staff N confirmed the presence of the CPAP machine and observed Resident #235 wearing it at least one time. Staff N stated no assistance was provided and no orders were signed off. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/25 at 9:45 AM, Staff O, Registered Nurse, acknowledged the presence of the CPAP machine on the bedside night stand. Staff O unable to recall how may nights they had seen it nor when if was first seen. On 2/12/25 at 2:30 PM, the ADON voiced an expectation for staff to acknowledge the presence of medical equipment and to ensure physician orders are in place. In an email response, the Chief Nursing Officer reported there is not a facility policy addressing resident personal medical equipment.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on record review, staff interview, and policy review, the facility failed to ensure a yearly psychotropic medication (a medication that affects a person's mental state) gradual dose reduction (GDR) was attempted or appropriately declined for 3 of 3 resident (#32, #44, & #66). The facility reported a census of 82. Findings included 1. On 2/11/25 at 11:00 AM, Resident #32 was identified as a resident who received psychotropic medications. The Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #32 revealed a Brief Interview for Mental Status (BIMS) score was not obtained because the resident was rarely/never understood. It included diagnoses of Heart Failure, Chronic Kidney Disease (CKD), Diabetes Mellitus (DM), chronic pain, anxiety, and spinal stenosis (narrowed spinal canal). It also revealed the resident required setup assistance with eating, supervision with oral and personal hygiene, maximal assistance with toileting hygiene and bathing, and was dependent with all other aspects of Activities of Daily Living (ADLs). The Electronic Health Record (EHR) included a physician's three (3) orders for a) Alprazolam 0.5 mg; give 1 tablet by mouth at bedtime for insomnia and give 1 tablet by mouth every 24 hours as needed for anxiety dated 2/14/22; b) Buspirone Hydrochloride (HCL) tablet 15 mg; give 1 tablet by mouth two times a day for anxiety related to anxiety disorder dated 2/14/22; and c) Escitalopram Oxalate (medication use; anxiety, depression, obsessive compulsive disorder) 10 mg tablet; take 1 tablet by mouth every morning dated 11/16/22. The EHR also included an order dated 8/22/22 for Behaviors - monitor for the following: itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusing care every shift. The Progress Notes included documentation the resident exhibited monitored behaviors on 8/16/24, 11/30/24, and 12/25/24. The Care Plan revised 3/07/22 directed staff to consult with pharmacy and the MD to consider dosage reduction when clinically appropriate at least quarterly. A GDR for alprazolam dated 10/24/24 indicated the clinician documented anxiety as a clinical rationale for continued use. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A GDR for Buspirone dated 11/20/24 indicated the clinician documented no change with no included clinical rationale. A GDR for alprazolam dated 2/13/25 indicated the clinician documented no change with no included clinical rationale. No other GDR's were located in the resident's EHR. The Treatment Administration Record (TAR) revealed the resident exhibited behaviors on 8/16/24, 11/30/24, and 12/25/24. No behaviors were documented since 12/25/24. On 2/12/25 at 2:13 PM, Staff E, Registered Nurse (RN) stated target behaviors are documented in Progress Notes if observed. 2. On 2/11/25 at 11:00 AM, Resident #44 was identified as a resident who received psychotropic medications. The Minimum Data Set (MDS) dated [DATE] for Resident #44 revealed a Brief Interview for Mental Status (BIMS) score was documented as 99 which indicated the resident was not able to complete the assessment. It included diagnoses of Non-Alzheimer's dementia, Chronic Kidney Disease (CKD), anxiety, depression, bipolar disorder, and psychotic disorder. It also revealed the resident was dependent with all aspects of Activities of Daily Living (ADLs). The Electronic Health Record (EHR) included a physician's three (3) orders for a) Mirtazapine 7.5 mg tablet; take 3 tablets (22.5 mg) by mouth every night at bedtime for depression dated 10/26/23; b) Risperidone 0.25 mg tablet; give 1 tablet by mouth every morning and every night at bedtime related to bipolar disorder, current episode depressed, severe with psychotic features dated 1/22/24; and c) Sertraline Hydrochloride (HCL) 25 mg; take 1 tablet by mouth every morning dated 4/30/24. (Sertraline HCL can be used to treat depression, and also sometimes, panic attacks, obsessive compulsive disorder, and post-traumatic stress disorder.) The EHR also included an order dated 10/26/22 for Behaviors - monitor for the following: itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusing care every shift. The Progress Notes included documentation dated 9/01/24 which indicated the resident exhibited monitored behaviors. The Care Plan dated 2/06/24 directed staff to consult with pharmacy and the MD to consider dosage reduction when clinically appropriate at least quarterly. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A GDR for Sertraline dated 9/26/24 indicated the clinician documented no change - may increase target symptoms suggest she see <named psyche provider group> for delusional with no included clinical rationale. A GDR for Risperidone dated 2/12/25 indicated the clinician documented do not recommend GDR as she continues to hallucinations, delusions. GDR may exacerbate symptoms. No other GDRs were located in the resident's EHR. The Treatment Administration Record (TAR) revealed the resident had no documented behaviors since 9/01/24. On 2/12/25 at 3:03 PM, Staff F, Licensed Practical Nurse (LPN) stated the TAR is where resident target behaviors are documented if observed. 3. On 2/11/25 at 11:00 AM, Resident #66 was identified as a resident who received psychotropic medications. The Annual Minimum Data Set (MDS) dated [DATE] for Resident #66 revealed a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated severely impaired cognition. It included diagnoses of Parkinson's Disease, Diabetes Mellitus (DM), depression, Post Traumatic Stress Disorder (PTSD), and alcohol dependence. It also revealed the resident was independent with eating, oral and personal hygiene, and required moderate assistance with all other aspects of Activities of Daily Living (ADLs). The Electronic Health Record (EHR) included a Physician's Order for Escitalopram Oxalate oral tablet 5 mg; give 1 tablet by mouth in the morning related to depression for 1 week AND give 2 tablets by mouth in the morning related depression. The EHR did not include a physician order to monitor for behaviors nor a progress note which indicated observed resident-specific behaviors. The Care Plan dated 1/08/24 included antidepressant medication use, but did not provide any directives regarding dose reductions. A GDR for Escitalopram (Lexapro) dated 2/12/25 indicated the clinician documented no GDR per POA request for fear of increase in symptoms. No other GDR's were located in the resident's EHR. On 2/12/25 at 2:01 PM, Staff B, Licensed Practical Nurse (LPN) stated the TAR included to monitor for side effects behaviors noted. She stated she did not see where his target behavior was documented and was not aware of any other place to document these other than the progress notes. On 2/13/25 at 3:20 PM, the Director of Nursing (DON) and the Director of Clinical Services stated the Powers-of-Attorney for Resident #32 and Resident #66 declined to allow the facility to reduce the residents' psychotropic medications. It was not included on the completed GDR's. (continued on next page)

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	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny View Care Center	410 N W Ash Drive Ankeny, IA 50023

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility did not provide a policy specific to Gradual Dose Reductions.