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	01/14/2026

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.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, staff interview and policy review the facility staff failed to provide care for a resident in an environment that maintained or enhanced dignity for two of five residents observed and required assistance for eating. The facility reported a census of 81 residents.Findings include: Observations on 1/12/2026 at 9AM revealed the following: Staff H, Certified Nurse Aide (CNA) in the dining room (DR) sitting beside a resident with but not interacting with the resident, having a personal conversation with Staff G, [NAME] as she walked around the DR cleaning up tables. Staff H would provide the resident a bite of food and continue to observe and talk to Staff G. Staff F, CNA was sitting between 2 residents, feeding 1 resident while the other resident independently fed herself. Staff F proceeded to engage in conversation with the independent resident, provide the other resident a bite of food and then proceed back to the conversation with the other resident. Staff F would only look at the resident when she provided him a bite of food and then the resident would have to wait 2-3 minutes after finishing the bite before receiving another bite of food as Staff F was talking with the other resident and not watching the resident she was feeding. Facility Resident Rights policy, undated, revealed each resident will be treated with dignity. Interview on 1/14/2026 at 9:30 AM, the Chief Nursing Officer stated expectation for staff to engage with and observe the resident while they are feeding the resident.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, providers' orders review and IPOST review, the facility failed to have the updated IPOST (Iowa Physician Orders for Scope of Treatment) for 1 out of 24 residents reviewed (Resident #8). Resident had a provider's order directing the code status for Resident #8 was Do Not Resuscitate (DNR) and an IPOST directing the code status for Resident #8 was CPR (Cardiopulmonary Resuscitation)/Attempt Resuscitation. The facility reported a census of 82 residents Findings include: An IPOST dated [DATE], directed staff to perform CPR on Resident #8 in the absence of breathing and a heart beat. On [DATE] on 2:34 p.m., Staff A, Registered Nurse (RN), stated to check a resident's code status she would look in the electronic health record (EHR). When asked if it would be anywhere else, she said 'you could look in their chart too.' On [DATE] at 10:15 a.m., it was noted that Resident #8 had a Dr's order for DNR in his EHR, but in his hard chart the IPOST directed CPR. On [DATE] at 10: 45 a.m., Staff B, Licensed Practical Nurse (LPN), stated she is in training. When asked if she had been trained or shown where to look for a resident's code status, she stated yes. She was sitting at the nurses' station and pulled the EHR up on the computer and said she would check there. At the same time of the above interview, Staff C, RN, was sitting at the nurses' station. She overheard the conversation and said she would check in the residents' hard chart (EHR) as that is where the IPOST is. She stated she would check the IPOST as she has worked at other places where the EHR was wrong, so it was best to check the IPOST. On [DATE] at 10:50 p.m., Staff D, LPN stated she would check code status in the hard chart by looking at the IPOST. At the same time Staff E, RN, stated she would go to the electronic health record. Staff E then pulled a resident's record up and pointed to the code status. On [DATE] at 11:00 a.m., Staff C looked at Resident #8's EHR and verified Resident #8's code status was DNR. She then looked at the IPOST in the EHR, and verified code status was a full code. She had dialogue with staff around her and it was determined that this resident was in Hospice. Staff C then went to the Hospice book and the IPOST was not in the Hospice book. When asked who is responsible to get the correct IPOST in the hard chart, Staff C stated she was going to reach out to Hospice and see if they have the order for the change. On [DATE] at 11:00 a.m., Staff C stated she got a hold of Hospice and they will be getting the updated DNR IPOST to the facility.On [DATE] at 4:00 p.m., The Administrator and the ADON acknowledged the above concern regarding Resident #8's IPOST was not correct with the doctor's order. A Cardiopulmonary Resuscitation policy dated 12/2021, directed the following: Purpose: To provide guidelines on the facility CPR procedures and the emergency procedures associated with providing CPR.Policy: Sunny View Care Center has systems in place to ensure resident desires for CPR are obtained, CPR status is communicated to staff, consistent trainings are completed for staff and these systems are audited.Procedure:1 . Cardiac arrest is defined as inadequate cardiac contractions resulting in insufficient blood flow throughout the body (pulselessness).2. Resident code status will be determined upon admission as communicated by the resident or the resident's decision maker.3. Resident code status will be documented in the resident's medical chart on the Iowa Physician Orders Sheet for Scope of Treatment ('POST).4. In the event that a resident or the resident's decision maker decides that their treatment will include CPR the resident will be a FULL-CODE.5. Identification of resident's that have selected CPR as part of their treatment will be identified by the following means:a. Medical Chart will have a name label that is green in color.b. FULL-CODE resident list posted at the nursing station and on the crash cartc. Purple dot on the label on the medical chartd. Purple dot on resident name platee. Purple dot on resident call light plate6. The care plan team will review resident CPR status with resident or resident's decision maker at least quarterly during the scheduled care plan review meeting.7. All licensed staff (RN/LPN) must have and maintain CPR/BLS certification from the American Red Cross or American Heart Association (AHA) prior to and during (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their employment.8. Upon hire all CPR/BLS certified staff will receive as part of their orientation training on the facility CPR]FULL-CODE procedures. Includes but not limited to:a. Identification of FULL-CODE resident(s)b. Crash cart locationc. CPR kit locationd. FULL-CODE/CPR Standard Work [NAME]. IPOST Form9. At least annually the facility will provide a CPR/BLS course that is certified by the American Red Cross, AHA or an on-tine option when in-person training can't be accommodated.10. The facility will conduct at least quarterly, mock code simulations.1 1 . Annually, the facility will conduct an in-service focused on facility CPR/BLS procedures and code status identification.12. Facility will monitor systems for compliance that include a minimum of:a. Crash Cartb. CPR Kitsc. Purple Dot Identification on name plates and call-light platesd. FULL CODE liste. FULL CODE chart labelf. Resident roster list13. Monitoring will be conducted by the Director of Nursing or as designated by the Director of Nursing.Emergency Procedure - Cardiopulmonary Resuscitation1. The facility's procedure for administering CPR shall incorporate the steps covered in the current American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care or facility BLS training material.2. The basic life support (BLS) sequence of events is referred to as C-A-B (chest compressions, ainNay, breathing).3. If a resident is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS shall initiate CPR unless it is known that a Do Not Resuscitate (DNR) order exists that prohibits CPR from being initiated.4. Upon identifying that the resident is a FULL-CODE activate the emergency response by call CODE-PURPLE and location across the walkie-talkie system or yelling it. Additionally, pull call light cord.a. All available CPR/BLS certified staff respond to CODE-PURPLE locationb. Responding staff obtain crash cart and deliver to CODE-PURPLE locationc. One (1) staff member contact 91 1 and inform dispatch CPR is in process (After call is made, wait for EMS to arrive and assist responders to FULL-CODE area)d. One (1) CPR/BLS certified staff member Assist with two (2) person CPRe. One (1) CPR/BLS certified staff member take notes and assist with CPR as needed (IF AVAILABLE)5. Following initial assessment, begin CPR with chest compressions rather than opening the airway and delivering rescue breathing.6. Delivering high-quality chest compressions is essential:1. Push hard to a depth of at least 2 inches (5 cm) at a rate of at [NAME] 100 compressions per minute.2. Allow full chest recoil after each compression.3. Minimize interruptions in chest compressions.4. Position resident on a hard surface (Floor, deflated air mattress, CPR board)7. Trained rescuers should also provide ventilations with a compression-ventilation ratio of 30:2.8. Continue CPR/BLS until relieved by EMS

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review, staff interview and policy review, the facility failed to provide the required Center for Medicare Services (CMS) Notice of Medicare Non-Coverage (NOMNC) forms to address beneficiary appeals and liability notice for one of three residents reviewed for advanced beneficiary notices (ABN) (Resident #72). The facility reported a census of 81 residents. Findings include: Record review revealed Resident #72 had skilled services 11/18/25 to 11/22/25 and remained in the facility. The record also revealed the facility issued the Skilled Nursing Facility Advance Beneficiary Notice of Non Coverage (SNFABN) CMS form #10055 and obtained verbal consent from the Power Of Attorney on 11/20/25 for therapy services that ended 11/22/25. However, the facility failed to issue a Notice of Medicare Non Coverage (NOMNC) CMS Form #10123 regarding the right to appeal further skilled therapy services within the required 48 hours of skilled serviced ending on 11/22/25. In an interview 1/14/26 at 7:30 AM, the Social Worker reported she provided the SNF ABN forms whenever skilled services were ending for residents. She was not aware there were two forms to provide and only provided one form (form 10055) when Resident #72's services were ending. An email on 1/14/26 at 7:31 AM, the Administrator wrote the SW was unaware that both the ABN and NOMNC were to be issued. The SW was educated and a cheat sheet given that explained when both are to be issued so she can reference that in the future. An undated Medicare Denial Notice (Advanced Benefit Notification-ABN) policy revealed the facility will inform each resident periodically during the resident's stay of services and charges for those services including any charges for services not covered under Medicare. The facility will provide written notification to residents with necessary information to decide whether or not to appeal a decision to terminate Medicare care and services at least three days prior to the planned change in payor status or discharge.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observations, and record review, the facility failed to ensure 1 out of 3 residents' property was inventoried and failed to replace his personal property after he reported that it was missing (Resident #81). The facility reported a census of 82 residents. Findings include: A Minimum Data Set (MDS) dated [DATE], documented diagnoses for Resident #81 included COPD (Chronic Obstructive Pulmonary Disease), anxiety and depression. A Brief Interview for Mental Status (BIMS), revealed a score of 13 out of 15, which indicated intact cognition. On 1/11/26 at 2:40 p.m., Resident #81 stated his only concern is that he is missing some of his things from when he moved to his current room from another room. He stated he was missing a narrow cabinet that also was an instrument from [NAME], 2 large books from [NAME] and Noble, and a statue about 1 1/2 feet tall (showed height with his hands). He said he would appreciate this being looked into. A Grievance Log provided by the facility showed a list of residents who reported having missing items from 3/27/25 to 1/10/26. Resident #81's name was not on this list.On 1/14/26 at 10:30 a.m., the Social Worker (SW), stated Resident #81 did report some items missing. When asked when this was reported she said Monday (1/12/26). She stated he reported 2 books, a statue and a dresser that was also an instrument of some kind. When asked what she did with the information, she stated she had reported it to housekeeping. The SW provided: a Complaint/Grievance Report dated 1/7/26. This report documented Resident #81 verbally communicated he was missing the following items: dresser/instrument, ceramic (statue), and anatomy books. The SW documented she notified housekeeping of missing items. An Inventory of Personal Effects dated 4/26/24. The sheet listed no items and had written on the top that (the facility) would do this resident's laundry. Both of these items were signed by the SW. On 1/14/25 at 11:25 p.m., this resident gave permission for the surveyor to reach out to his sister and ask about the missing items. He stated it was months ago when the items went missing. He repeated the items went missing when he had moved from a room down the hall to the room he presently was in. He stated he did not report the items the day of the move but he did a few days after the move when he noticed them missing. He reported it to the staff across the hall from him a few months ago. (SW's office). He said several people have looked for the items but all he has heard back was that nobody has found them. He stated he wants to know when the facility was going to replace them. On 1/14/25 at 11:33 p.m., Resident #81's sister stated she had not seen the dresser that was also an instrument. It was not in the items she had brought from home. She stated if he had something like that it must have been given to him after he was admitted to the facility. Same with the [NAME] and Noble books. He would not have gone to [NAME] and Noble after his admission, so someone must have given those to him. She did verify the Indian nation statue was with his things when he admitted to the facility on [DATE] at 11:40 p.m., the SW stated she did not know why the inventory was not taken when he was admitted . She said she is the one responsible to take inventory and she signed it but she must have been doing other things that day because she did not get it done. She stated the first time Resident #81 reported the missing items was last week. She had not heard anything about the missing items prior to this. This SW stated she had been employed at this facility for approximately 2 years. On 1/14/25 at 4:00 p.m., the Administrator and DON acknowledged the concern with missing items were reported per Resident #81 shortly after he had moved rooms to the person across the hall. They acknowledged the SW's office was directly across the hall from his current room. They acknowledged concerns that the inventory sheet was not done. They acknowledged the Grievance Log provided by the facility did not include Resident #81's items and they acknowledged no attempt had been made to replace the items. An undated MISSING ITEMS policy, directed the following:The Missing Items Report is used when attempting to locate any resident's, visitor's, or others' belongings determined to be missing or allegedly stolen.POLICYNursing personnel are (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible for completing the resident's Inventory Sheet on admission, when items are detivered to or removed from a resident's room, and updating it at least annuallyNursing personnel are responsible for filing the grievance and any other appropriate reports regarding missing items with the Administrator immediately and/or social worker o The department managers and others, as designated by the facility administrator, will begin an immediate investigation of the missing item. Any missing items located will be returned to the resident immediately upon the location of the item.PROCEDURES When an item is reported missing by a resident, the supervisor of the facility will initiate a search of the unit for the item The Director of Nursing, or facility administrator, is responsible for notifying the resident and/or family immediately if the item is not found at the time of the initial search.If the location of the missing item cannot be found in a reasonable time frame, the facility will replace the item at facility cost.Staff Responsible: All

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff interview the facility failed to complete upon discharge the recapitulation for a resident's stay for 1 of 3 residents reviewed (Resident #95). The facility reported a census of 81 residents. The Discharge Minimum Data Set for Resident #95, dated 12/1/25, revealed the resident was admitted to the facility on [DATE] and discharged to home/community on 12/1/25. Review of Resident #95's clinical record lacked a recapitulation of stay. Facility Discharge Policy with Criteria, undated, instructed the facility staff will develop a post-discharge plan of care and a discharge recapitulation form will be completed. Interview on 01/14/2026 at 1:19 PM, the Director of Nursing stated he was unable to find that a recapitulation of the resident's stay was completed. Interview on 1/14/2026 at 1:20 PM, the Chief Nursing Officer stated her expectation for a recapitulation of the resident's stay to be initiated by the social worker and then completed by each department assigned when a resident is discharged .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure 1 out of 1 resident reviewed received his prescribed medication upon a hospital return (Resident #8). Resident #8 returned from the hospital on [DATE] and did not receive the majority of his medications until 1/2/26 and 1/3/26. The facility reported a census of 82 residents. Findings include:A Minimum Data Set (MDS), dated [DATE], documented diagnoses for Resident #8 included hypertension (high blood pressure), diabetes, arthritis, non-Alzheimer's dementia, Post Traumatic Stress Disorder (PTSD), obesity, and low back pain. A Brief Interview of Mental Status (BIMS), revealed a score of 13 out of 15 which indicated intact cognition. This MDS indicated that Resident #8 was taking antipsychotic, antidepressant, diuretic, antiplatelet, hypoglycemic (including insulin) and anticonvulsant medications. A Nurse's Progress Note dated 12/31/25 at 2:57 p.m., documented that at 1:30 p.m., Resident #8 arrived from hospital after a lengthy stay and was treated for Urinary Tract Infection (UTI). Additional diagnosis as follows: Type II Diabetes mellitus (Insulin dependent), Chronic kidney disease Stage 4. Dementia, sleep apnea, HTN, Hyperlipidemia, Dyspnea, ETOH abuse, Chronic post-traumatic stress disorder, glucose intolerance, chronic pain. Upon hospital return assessment Resident #8 presented as very ill in appearance. He was difficult to arouse. This speaker (the author of this note) had to adjust tone very loud to get him to open his eyes. No verbal communication. Will occasionally shake head to yes or no questions. Shakes head No when asked if he is in pain. Conjunctiva (thin membrane that covers the eyelids and whites of eyes) pale bilaterally. Nares patent without drainage. Hard of hearing. Moderate signs/symptoms of dehydration noted. Orbits sunken, skin turgor poor. Skin warm and dry without cyanosis (bluish color of skin) or diaphoresis (perspiration). Tongue coated with very thick white substance. Per hospital report, this resident has not been eating and taking small amounts of fluid only in which he generally let's run out of his mouth. He is on full liquid diet only. Lung sounds essentially clear with decreased breath sounds in Right Lower Lobe. Moist sounding cough but not productive. Abdomen soft non-tender to palpation. Bowel sounds present. Has very strong body odor upon hospital return. Smearing soft brown stool from rectum. Briefs in place. Per history from hospital, this resident was treated for a fecal impaction while at the hospital. Foley catheter patent draining light yellow urine. No sediment noted. Catheter anchored to leg. EBP (Enhanced Barrier Precautions) in place secondary to catheter. 2+ pitting pedal edema (swelling) to bilateral feet and ankles. Had a right heel wound and a left heel wound. Wife contacted regarding grave condition upon hospital return and the inability to consume much fluid or any nutrition. Spoke with the Advanced Registered Nurse Practitioner (ARNP) who gave order for Hospice consult. Facility social worker working with wife on setting up hospice of her choice. Resident #8 repositioned for comfort and resting with shallow respirations as noted above. This note was documented by the Chief Nursing Officer.A Nurse's Progress Note dated 1/1/26 at 9:18 p.m., documented Resident is extremely antsy and attempting to walk most of the evening. His medications still have not arrived from the pharmacy. (the author) left a 2nd voicemail with the pharmacy requesting that the medications be delivered As Soon As Possible (ASAP) tomorrow so that staff can get his medications to him. Resident #8 is able to be redirected easily with 1:1 care. This note was documented by Staff Q, Licensed Practical Nurse (LPN). A Nurse's Progress Note dated 1/2/26 at 8:22 a.m., Resident #8 hasn't had routine medications since his return on 12/31/25. Pharmacy stated they will deliver the medications on their 10:00 am run. This resident is unsettled and hasn't slept all night. This resident will not stay in his wheelchair and had to be continually redirected and is not redirectable at times. Notified the Administrator. This note was documented by Staff K, Registered Nurse (RN).A Nurse's Progress Note dated 1/2/26 at 10:30 p.m., documented this resident was restless and antsy most of shift. He is ambulating without assistance and being non-compliant with using assistive devices. He is dragging foley cath on the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	floor while walking. This writer put a leg strap on the residents catheter (tubing) to help with tension at insertion point and resident removed thigh strap. Another strap was placed and resident removed it again. Resident is pleasant and easily redirected but does not stay in one place for long. This note was documented by Staff Q. There were no further progress notes documenting that most of this resident's medications did not arrive until 1/3/26. On 1/13/26 at 1:30 p.m., the pharmacy's Director of Operations (DOO), on a phone call over speaker with the Administrator, Director of Nursing (DON) , and the Chief Nursing Officer (CNO), the DOO stated the pharmacists enter the doctor's orders into the electronic health record (PCC) for the facility. He stated that on 12/31/25 the pharmacy closed early at 4:00 p.m., on that day for New Year's Eve. The pharmacist working that day entered the first half of the doctor's orders, The DOO stated nobody finished the 2nd half of the job and the fault was on them. He stated after the pharmacy closed on 12/31/25 until they opened again on 1/2/25, two on call pharmacists were working. The DOO stated that he talked with both of the on call pharmacists and neither of them received a call regarding Resident #8 from during the time they were on call. The DOO stated it looked like a terrible timing thing and it's an error on their part. The DON stated directly after the above call that the nurses fax the orders to the pharmacy and then the pharmacy enters the orders into PCC. The nurse then checks PCC against the faxed orders to ensure the orders are correct. The pharmacy has access to all of this facility residents' PCC records. On 1/13/26 at 1:40 p.m., the Administrator acknowledged that the nurses should have done more to ensure the medications got to the facility. On 1/14/26 at 10:50 a.m., Staff K stated that she was working in the back on 12/31/25 and 1/1/25. On 1/2/25 she covered the middle of the facility where Resident #8 (R#8) lived. She stated she found out R#8 didn't have his medications since he returned on 12/31/25 from the hospital. She stated this was ridiculous. She phoned Staff L, Advanced Registered Nurse Practitioner (ARNP), to let her know. Staff K called the pharmacy and let them know she needed the medications STAT (right away). When Staff K let Staff L know about this resident not receiving his medications since he returned from the hospital, they both thought the pharmacy would deliver all of the medications the facility had not yet received. Staff K stated that she found out later that when the pharmacy came to deliver the medications they only brought 2 medications with them. Staff K stated they had been able to give a few medications as his Insulins were still in the cart from prior to the hospitalizations and maybe some others. She stated she did not know if anyone tried to give him medications from their eKit (locked supply of medications at the facility accessed when needed). On 1/14/26 at 11:00 a.m., Staff L stated she found out that Resident #8 had not had the majority of his medications on 1/2/25 when Staff K told her. She stated at that time the pharmacy had been contacted and the medications were to be on their way. Staff L said that if someone would have contacted her to let her know that his medications were not in house earlier, she would have told them to keep trying the pharmacy. Staff L stated she assessed REsident #8 on the day he returned from the hospital and she was mostly concerned about getting him a Hospice consult as he was lethargic and not responding. She stated that he has perked up since then. An email sent by the Administrator on 1/14/26 at 11:04 AM, documented the following: After evaluating administration logs, charting, and progress notes the affected medications are listed below. An email sent by the Administrator on 1/14/26 at 11:04 AM, documented the following: After evaluating administration logs, charting, and progress notes the affected medications (medications that were prescribed but not available for this resident) are listed below. Melatonin 5mg (milligrams) (a hormone that affects sleep wake cycles)Not in E-KitRisperidone 1mg (antipsychotic)Not in E-kitTamsulosin HCL 0.4mg (relaxes smooth muscles in the prostate and bladder neck)Not in E-kitTrazodone HCL 50mg (antidepressant)In E-Kit but requires access code provided by pharmacy to pull a doseClonidine HCL 0.3mg (blood pressure medication)Not in E-KitCyclosporine Ophthalmic Emulsion 0.05% (increases tear production in dry eyes)Not in E-KitNystatin Mouth/Throat Suspension (antifungal for oral thrush)Not in E-KitAmlodipine 5mg (blood pressure medication)Not in E-KitAspirin 81mg (prevention of heart attack and stroke)Not in E-KitCholecalciferol 50 mcg (micrograms) (vitamin D)Not in E-kitFamotidine 40mg (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	01/14/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(reduces stomach acid)Not in E-KitFinasteride 5mg (treat symptoms associated with enlarged prostate)Not in E-KitFluconazole 100mg (treats yeast infection)Not in E-KitFluoxetine HCL 40mg (antidepressant)Not in E-Kit Hydralazine 100mg (blood pressure medication)Not in E-kitPartial delivery received mid-day on January 2ndGabapentin 300mg (treats partial seizures and nerve pain)100mg capsules in E-KitWas not pulled (facility had this medication available but did not get it out of their E-Kit to administer it to him.) Unaffected medications (these medications were available upon Resident #8's return to the facility):Insulin AspartInsulin GlargineTylenolBisacodyl suppository (treats constipation)Milk of Magnesia (treats constipation)Nitrostat (for chest pain) An email sent on 1/14/25 at 11:49 AM, requested clarification for the following: The evening doses on the 2nd for Rispridone, Trazadone, and Melatonin were signed as given, were they delivered by pharmacy along with the hydralazine? Were the Lidoderm external patches left in the cart while he was in the hospital?An email prepared by the Director of Nursing and sent on 1/14/26 at 1:51 PM, documented the following:On 1/2/2026 at 1036 a delivery was received containingResperidone (2nd dose) delivered and administeredTrazodone delivered and administeredMelatonin delivered and administeredHydralazine delivered and administered Lidoderm external patches were in the cart from prior to his hospitalization. An undated Medication Ordering and Receiving from Pharmacy Provider policy, directed the following:Policy Medications will be delivered to the facility in packaging to facilitate proper administration of the medication.Procedures The Administrator, Director of Nursing, and provider pharmacy establish a daily delivery and pick-up for medication orders. The schedule lists the pharmacy's regular and after business hours, applicable telephone numbers, and routine medication order and delivery times, and other pertinent information, such as the poison control center telephone number. The dispensing pharmacy shall have an on-call system available for after-hours to deliver medications as needed. This includes weekends and Holidays. On-call hours for the pharmacy will be posted to obtain the medications in a timely manner. Solid oral medication forms (tablets and capsules) are supplied by the provider pharmacy in packing strips, which are delivered each evening to be placed in the respective medication carts. Medication packages are labeled by the provider pharmacy and placed in the medication storage system for each resident. Veterans may receive medications from an approved VA pharmacy provider in bulk bottles of medications if the medications are appropriately labeled per pharmaceutical regulations. Daily strips are available for each resident that are in pill form that includes each medication listed on the packing strip. Liquid medications will be labeled according to pharmaceutical standards. Any problems noted with the packaging of a medication shall be reported immediately to the provider pharmacy. If a medication is ordered and is not available in a timely manner (within 24-hours) of the physician's order, the nursing staff will notify the pharmacy of the needed medication. The physician may clarify the order to indicate the medication may be started when the medication is available; OR the physician may clarify the order to indicate the medication is required to be given now or stat and the dispensing pharmacy will be responsible for communicating with the ordering physician and locating an alternate source for the medication; OR the physician may discontinue the order and order a medication that is available within the facility's E-kit or is available for stat delivery from the dispensing pharmacy. The consultant pharmacist who completes the drug regimen review will communicate with the dispensing pharmacy any significant irregularities identified during the monthly consultation. The Director of Nursing and/or facility administrator may request the dispensing pharmacist to attend meetings as requested at the facility to review any irregularities noted in service.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews, and policy review the facility failed to maintain infection control practices for 2 of 3 residents reviewed (Resident #44 and Resident #68). The facility failed to ensure use of enhanced barrier precautions (EBP) when required. The facility reported a census of 81 residents. Findings include:1.The Minimum Data Set (MDS) for Resident #44, dated 12/3/25, included diagnoses of Non-Alzheimer's Dementia and retention of urine. The MDS identified the resident was dependent on staff for toilet hygiene. The MDS indicated the resident had a indwelling catheter (tube into bladder to drain the urine from the bladder). The MDS indicated the resident had a BIMS score of 2, indicating severe cognitive impairment. Resident #44's Care Plan with target date 3/3/26, documented the resident had an indwelling catheter and intervention to utilize enhanced barrier precautions per policy related to the foley catheter. Observation on 1/12/26 at 1:47 PM, Staff I, Certified Nurse Aide (CNA) and Staff J, CNA entered Resident #44's room and applied gloves only. Staff I and Staff J proceeded to transfer the resident from the wheelchair to the bed and provided peri care, catheter care, and emptied the catheter. Interview on 1/12/26 at 2PM, Staff I stated Resident #44 was on EBP due to the catheter and she should have worn a gown for the resident's cares. Interview on 1/12/26 at 3:30 PM, the Director of Nursing stated training had previously been provided to all staff regarding EBP and the expectation to use EBP (gown and gloves) when providing care to a resident with a catheter. 2. The MDS assessment dated [DATE] revealed Resident #68 had diagnosis of a Stage 3 pressure ulcer, dermatitis, and excoriation skin picking disorder. The MDS documented the resident had a Brief Interview for Mental Status score of 6, indicating severely impaired cognition. The MDS revealed the resident had incontinence. The Care Plan revised 11/25/25 revealed the resident had an altered skin integrity related to incontinence, immobility, MASD (moisture associated skin disorder), and a Stage 3 pressure ulcer on the coccyx. The Care Plan directed staff to to provide good peri-care after each incontinence episode to prevent skin breakdown or infection. The Care Plan lacked info about EBP's. The Back North Hallway Biosheet updated 10/22/25 revealed under Other Information that Resident #68 was on EBP's due to wound care. The Order Summary revealed an order for silvadene cream to the coccyx and buttocks topically two times a day for wound care started 12/23/25 and doxycycline (an antibiotic) by mouth two times a day for cellulitis to buttocks for 10 Days started on 1/12/26. A skin assessment dated [DATE] revealed the resident had an unstageable pressure ulcer to the coccyx and her left heel. Observations revealed the following: a. On 1/12/26 at 9:09 AM, Staff N, CNA, entered the room, washed her hands, and donned a pair of gloves. Staff M, CNA, and Staff N used a mechanical lift and transferred the resident from a wheelchair to bed. At 9:13 AM, Staff M, donned a pair of gloves, removed the resident's pants and brief, and provided incontinence care. Staff N (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assisted the resident to roll onto her side and assisted Staff M with cares. b. On 1/13/26 at 7:48 AM Staff P, CNA, wore gloves and removed foam boots from the resident's feet. A dark black pressure area was observed on the left heel. Staff P provided incontinence care then placed a sling under the resident. Staff P did not wear a gown before or during cares. At 8:05 AM, Staff P and Staff O, CNA, connected the sling to a mechanical lift and transferred the resident from the bed to the wheelchair. Staff P and Staff O did not wear a gown when they transferred the resident. In an interview 1/13/26 at 7:55 AM, Staff P, CNA, reported the resident had a sore on her heel and her bottom. In an interview 1/13/26 at 8:15 AM, Staff O, CNA, reported she did not think Resident #68 was on EBP. The EBP sign on door was from another resident that was in that room. Staff O reported EBP's required anytime a resident had a catheter or a skin condition. Staff O confirmed a gown and gloves should be worn whenever a resident on EBP's. In an interview 1/13/26 at 8:20 AM, Staff P reported a gown and gloves worn whenever she provided cares to residents on EBP's. Staff P acknowledged she forgot to wear the gown when she provided cares for Resident #68. Staff P reported she got nervous with State watching her and she just forgot to put the gown on. In an interview 1/14/26 at 1:05 PM, the Assistant Director of Nursing (ADON) reported EBP required for residents with a wound or catheter. The ADON reported she expected staff wear a gown and gloves whenever staff performed cares or transferred a resident that was on EBP's. An undated Enhanced Barrier Precautions policy revealed the facility followed recommendations and guidance from the Center for Disease Control in order to keep all residents safe from Healthcare Acquired Infections (HAI), such as multi-drug resistant organisms (MDRO). EBP are implemented as one intervention to reduce the transmission of resistant organisms and employed the use of Personal Protective Equipment (PPE) during high contact resident care activities. A gown and gloves worn prior to and during high-contact care activities including whenever staff toileted a resident or changed their briefs, provided catheter care, and whenever transferred a resident who had a wound or indwelling medical device such as a catheter.