

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165616	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER The Bridges at Ankeny		STREET ADDRESS, CITY, STATE, ZIP CODE 3510 Northwest Abilene Road 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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817</p> <p>Based on clinical record review, observations, staff interview, and policy review the facility failed to provide toileting assistance and care for a resident in an environment that maintained or enhanced dignity for one of ten residents sampled (Residents #7). The facility reported a census of 87 residents.</p> <p>Findings include:</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had diagnoses of liver cirrhosis and cancer. The MDS indicated the resident had dependence on staff for transfers and toileting hygiene. The MDS documented the resident had frequent bowel incontinence.</p> <p>The Care Plan revised 7/18/24 revealed the resident had bowel incontinence and at risk for impaired skin and infection in the periarea. The resident also required assistance with activities of daily living (ADL's) due to incontinence. The Care Plan directed staff to provide assistance of two for toileting and keep the call light within reach for the resident to notify nursing he needed to use the toilet or had an incontinence episode.</p> <p>The Progress Note dated 8/23/24 at 6:10 AM revealed the resident took Lactulose four times daily until four bowel movements produced to reduce ammonia levels.</p> <p>Observations on 9/16/24 at 2:10 PM, Resident #7 told Staff F, Certified Nursing Assistant (CNA), he needed to go to the bathroom. Staff F asked Resident #7 if he had to go number (#) 1 or #2. Resident #7 stated #2. Staff F asked Staff C, Certified Medication Aide (CMA), if he heard that Resident #7 needed to go to the bathroom. Staff C had just arrived to work. Staff C stated he was told he was passing meds (medications) this afternoon. Staff C and Staff F left the area and walked to the nurse's station to check his assignment. At 2:18 PM, staff stood by the 200 hall nurse's station talking. At 2:21 PM, a staff member said thanks, have a good night, and then proceeded to leave the unit. Continuous observation of staff during shift hand off report revealed no mention to the oncoming staff that Resident #7 needed to go to the bathroom. At 2:22 PM, Staff G, CNA, briefly stopped outside Resident #7's doorway, said hello and asked Resident #7 how he was, then walked down the hall to the other residents' rooms to briefly introduce herself and check in on the residents. At 2:30 PM, Resident #7 continued to sit in a wheelchair in his room.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/18/24 at 11:50 AM, Staff D, Assistant Director of Nursing, stated she expected staff to provide assistance to residents for toileting as requested.</p> <p>A Supporting Activities of Daily Living Policy revised 3/2018 documented as follows; Residents will be provided with care, treatment and services as appropriate care and services provided for residents unable to carry out ADL's including assistance with elimination (toileting).</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>49990</p> <p>Based on direct observation and staff interview, the facility failed to maintain a safe, clean, and homelike environment due to food being left on the floor of the dining hall for multiple days without having been cleaned. The facility reported a census of 87.</p> <p>Findings include:</p> <p>A direct observation on 09/16/24 at 12:19 PM of the memory care unit dining hall revealed eggs with a dried appearance on the floor and the tables of the dining hall, a garbage can overflowing with trash from previous dining services, as well as smears of jelly and and unidentifiable substance on the floors. These were not cleaned before seating residents in the dining hall and serving them lunch.</p> <p>A second direct observation of the memory care unit dining hall on 09/16/24 at 05:03 PM revealed the eggs and other food items remained on the floor from an earlier meal. The garbage had not been emptied.</p> <p>A third direct observation on 09/17/24 at 12:44 PM revealed the food items still on the floor, easily identified as now dry egg, smears of jelly, and unidentifiable substances remained in the same locations as earlier observations. Only the trash had been emptied.</p> <p>In an interview with a family member on 09/17/24 at 12:46 PM she stated that the room is filthy. She noted it is often unclean in appearance.</p> <p>In an interview on 09/19/24 at 09:11 AM with the Certified Dietary Manager (CDM), she stated it is her expectation staff members are to sweep and clean the dining rooms after every meal, with a deep cleaning and sanitation performed after the evening meal. She feels that dietary aides have ample time to perform their job over the course of the day and there should be no reason it was not done.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>49990</p> <p>Based on direct observation, family and staff interviews, and facility document review, the facility failed to follow Care Plans for 1 of 18 residents observed (Resident #3). The facility reported a census of 87.</p> <p>Findings include:</p> <p>The Quarterly Minimum Data Sample (MDS) for Resident #3, dated 07/19/24, documented relevant diagnoses of cerebral infarction (stroke), anxiety disorder, and non-Alzheimer's Dementia. It further documented a history of falls, and a daily behavior of scratching oneself. The MDS documented the resident had severely impaired cognitive skills for daily decision making.</p> <p>The Care plan, last revised on 08/07/24, documented the need for Geri-Sleeves (protective sleeves for the arms or legs that are designed to protect the resident's skin against skin tears, bruising, and abrasions) as well as fall mats to be placed by the bed while the resident is laying in bed to prevent injury in the event of a fall.</p> <p>The Medication Administration Record (MAR) dated from 09/01/24 to 09/18/24 directed staff as follows; (start date 1/10/24) Geri-Sleeves to both upper extremities on at all times, only to be removed when soiled, during showers, and during skin checks. The MAR was signed on 09/16/24 during both the day and evening shifts. This is discrepant with observations. The MAR was signed on 09/17/24 during the day shift, but was unsigned during the night shift. The MAR documented the following directions with start date 9/12/24 to staff as follows; skin tear to right arm- cleanse with wound cleanser apply vaseline gauze, cover with Telfa and wrap with kling once a day until healed.</p> <p>A direct observation on 09/16/24 at 10:57 AM showed Resident #3 was without fall mats on the floor, and to not be wearing Geri-sleeves to protect his arms. During the observation, Staff M - Certified Nurses Aide (CNA) - entered the residents room and immediately asked where his Geri-sleeves were. She woke the resident up and asked him where his sleeves were, to which the resident replied that he did not know. She asked him if he would like to wear his Geri-sleeves, and after repeating the question several times so Resident #3 could hear it, he agreed to put them on. Staff M notes at this time she is on break, and currently working a different floor, but that she will let the nurse know.</p> <p>A direct observation on 09/17/24 at 01:57 PM revealed Resident #3 was again not wearing Geri-sleeves, and no fall mats were noted on the floor at this time.</p> <p>In an interview with a family member on 09/16/24 at 03:11 PM, the family member stated that he knew Resident #3 is supposed to be wearing protective sleeves, as he often scratches at himself, but that he rarely sees him wearing the sleeves.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 09/19/24 at 11:54 AM with the Director of Nursing (DON), reported she expects staff to follow the care plan as written. She acknowledged the fall mats were not present on the floor when Resident #3 was moved to another room on 09/17/24, though she did not notice if he was wearing Geri-sleeves at that time. She stated staff members are made aware of changes in the care plan through a post care conference staff meeting, but they are also to follow the walking or pocket care plan.</p> <p>The facility policy titled Assistive Devices and Equipment, last revised in July 2017, did not document the procedure for wearing or placing assistive devices.</p>		

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<p>F 0689</p> <p>Level of Harm - 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** 34817</p> <p>Based on clinical record review, observation, resident and staff interview, and policy review the facility failed to ensure staff utilized a gait belt and safely transferred a resident on a weight chair, and failed to appropriately transfer residents using a mechanical lift for 3 of 5 residents reviewed for transfers (Resident #8, #10, and #4). The facility reported a census of 87 residents.</p> <p>1. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 had diagnosis of diabetes, congestive heart failure, and anemia. The MDS revealed the resident had a Brief Interview for Mental Status (BIMS) of 7, which indicated severely impaired cognition. The MDS documented the resident required substantial to maximum assistance for transfers and toileting.</p> <p>The Care Plan initiated 5/16/24 revealed the resident had a risk for falls related to impaired balance, poor safety awareness, and the use of medications that increased her fall risk. The Care Plan directed staff to encourage the resident to ask for assistance for transfers and ambulation, and provide assistance of one staff for transfers.</p> <p>The Progress Notes revealed the following:</p> <p>a. On 9/8/24 at 9:00 AM, a Certified Nursing Assistant (CNA) called Staff B, Registered Nurse (RN), over the walkie to go to the resident's room immediately. Upon entering the room, resident lying on the floor in front of the toilet face down on her left side with her head on the floor and her feet toward the sink. Blood was running from the right side of her head. Nurse instructed CNA to apply pressure as the nurse notified the Emergency Medical Technicians (EMT's) and the physician. Resident #8 sent to the hospital for treatment.</p> <p>b. On 9/9/24 at 1:07 AM, resident had six sutures placed to right forehead.</p> <p>c. On 9/9/24 at 11:21 AM, resident had limited movement to her right wrist and thumb. New order received from Advanced Registered Nurse Practitioner (ARNP) to x-ray area. Tylenol (APAP) administered. Maintenance to fix the weight chair.</p> <p>At 6:35 PM, right wrist x-ray report received. Orders for a brace to the right wrist, and referral to Orthopedic physician.</p> <p>d. On 9/13/24 at 1:43 PM, resident returned from an Orthopedic appointment with a diagnoses of right scaphoid (wrist bone below the base of the thumb) fracture. A cast placed on her right arm/wrist.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An incident report dated 9/8/24 at 9:01 AM revealed the CNA called Staff B, RN, to the room. Upon entering the bathroom, resident lying on her right side with her head in front of the toilet and her feet toward the sink. The resident had blood running from the right side of her forehead. Pressure applied to the right forehead as the EMT's, physician, and on-call manager notified. Resident oriented to person, place and situation, and ambulated with assistance of one and an assistive device at the time of the fall. Resident sent to the Emergency Department (ED) for treatment. Injuries included a right hand fracture and a laceration to the top of her scalp. The incident report revealed the environmental factors due to the equipment malfunctioned. The resident was in the weight chair when the leg of the weight chair came off, and she fell to the floor. The incident report revealed the box next to the gait belt on and in use left blank (not marked) on the form under the predisposing situational factors section.</p> <p>The Facility Investigation Summary for Self-Report revealed Resident #8 had a fall with fracture on 9/8/24. The resident had a BIMS of 7, and required the assistance of one for Activities of Daily Living (ADL's), transfers, and toileting. The investigation summary documented on 9/8/24 at approximately 9:00 AM, Resident #8 fell while being weighed on a weight chair in the bathroom with Staff A, CNA. Staff A stated she assisted Resident #8 onto the weight chair when the resident began to fall. The resident hit her forehead and right arm/wrist on the ground. Staff B, RN, evaluated the resident and sent the resident to the ED due to the fall. The resident had a right arm/wrist x-ray and was sent back to the facility. On 9/9/24 at approximately 4:00 PM, the facility received communication the resident had a right wrist fracture. The Medical Director reviewed the incident and determined it was not a major injury. Resident not admitted to a higher level of care and the injury had not changed her functional capacity. Staff A stated she had no indication something was wrong with the weight chair. The chair moved/rolled like normal. Upon review of the weight chair post fall, it was observed that a wheel had dislodged or dislocated from its [NAME]. Other staff stated they had never had issues with the weight chair or noticed anything being off. One staff member mentioned they had put in a work order regarding the accuracy of the scale but had no issues otherwise. The weight chair was repaired by facility maintenance. Maintenance logs and work orders for the weight chair were reviewed. A work order to adjust the weight scale accuracy on the chair was received but no structural concerns were received.</p> <p>The investigation summary's conclusion revealed based on the investigation and interviews the facility believed the root cause to be the weight chair wheel spontaneously dislodged. The staff and facility had no knowledge the weight chair wheel was faulty as the chair had passed routine maintenance inspection. The weight chair wheel was repaired.</p> <p>A Weight Chair Checks documented revealed the weight chair on the 100/200 hall checked on 5/17, 6/14, 7/2, 8/23/24 and had passed inspections.</p> <p>During observation on 9/16/24 at 12:20 PM, Resident # 8 sat in a wheelchair by a counter in the dining room. The resident had a cast on her right arm, a yellowish bruise to the right side of her face, and a sore to her forehead.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview 9/17/24 at 12:55 PM, Staff B, RN, reported Resident #8 was modified independent in her room prior to her fall with a fracture. The resident got herself up and dressed, and took herself to the bathroom. The CNA helped put on her [NAME] hose and obtained her weight. The resident had just come back from the hospital a couple days prior to her fall. After she came back from the hospital, she required the assistance of one staff for dressing, toileting, and getting her weight. On the day of the resident's fall, Staff B stated she was on the 100 hall. She got a call to go to Resident #8's room quickly. She was on her way to the resident's room and got another call over the walkie to hurry. She walked into the room and saw the resident lying on the floor in the bathroom. Her head was in front of the toilet and her feet faced toward the sink. She asked what happened. The CNA told her she didn't know what happened but she was getting the resident's weight and the leg came off of the weight chair. She had the CNA apply pressure to the area (on her head). She left the room to get supplies and the Hoyer (mechanical lift). When she returned, she noted blood dripping from the rag. She decided to send the resident to the hospital and called 911. Staff A told her the front right wheel (of the weight chair) was on the floor. The wheel had just popped off and she didn't know why. She had never had any incidents with the weight chair before. Staff B reported the incident happened over a weekend, so she placed a tag on the weight chair and put the chair by the maintenance room. Resident #8 came back from the hospital and had six sutures in her head. They found out later her wrist was broken.</p> <p>During an interview 9/17/24 at 1:35 PM, Staff A, CNA, reported she was unsure what Resident #8's level of function was prior to her fall. Resident #8 had been in the hospital and had a catheter put in. Staff A stated as far as what she was told from (shift) report and what she witnessed, Resident #8 was able to independently move from her bed to the weight chair. She told the resident to wait for her because she had to leave the room to go get something. When she returned to the room, the resident had already moved herself from the bed to the weight chair. She had the wheels locked and the resident had moved herself over onto the weight chair. She unlocked the wheels on the weight chair, and moved her from the side of the bed (where the chair was parked) to the bathroom. As she turned the weight chair into the bathroom, the resident's right side was parallel to the sink and all of a sudden her body went to the left. She fell to the left, and did a 180 onto the floor. Her head ended up by the base of the toilet and her legs were toward the sink. She couldn't catch her in time. She then noticed a wheel on the ground. The wheel had come off of the weight chair. Staff A stated she didn't know if the resident hit her head on the toilet or something else. There was blood coming from her forehead. She did not lose consciousness. Staff A called for help. She asked Staff B if they should even move her. Staff B decided not to move Resident #8 and called the EMT's. Staff A stated she moved the towel she used to apply pressure, and there was a perfectly round hole to her right forehead. Another aide went and got her some more towels to apply to the resident's head wound, and then the EMT's showed up. Staff A stated this was the first time she had any issues with the weight chair. Whenever equipment malfunctioned or needed repaired, a Tag out /Lock out placed and the equipment, and the issue reported to maintenance. The incident happened on a Sunday AM. Maintenance wasn't in the facility at that time that she knew of. Somebody took care of the weight chair and pulled it out of service.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In a follow up interview on 9/18/24 at 2:10 PM, Staff A, CNA, reported she did not have a gait belt on the resident on the day she pushed Resident #8 in the weight chair to the bathroom. The wheel came off but she did not see a bolt, a screw, or anything. Just the wheel lying on the floor. Staff A reported she used a pocket care plan to know what cares needed to be done or how a resident transferred. She got a new pocket care plan each day from the area she worked in. She checked the therapy book on how a resident transferred if the information not listed on the pocket care plan. Staff A unsure who updated the pocket care plan since the facility had changes in management.</p> <p>During an interview 9/18/24 at 10:40 AM, the Maintenance Director reported he checked all weight chairs monthly. He used the TELS system to know which equipment needed PM (preventative maintenance). Staff call him or his maintenance assistant when something needed repaired. Staff also could enter a work order into the TELS system. The maintenance director reported he heard a resident had a fall related to the weight chair when he came to work at 6:45 AM the day after the incident. He went down to the unit to get the chair. He checked the weight chair but the weight chair had already been adjusted. Someone had already screwed the wheel back in. A bolt goes up into the wheels but able to loosen the nut/bolt and adjust the chair up or down but the wheel had already been fixed. He didn't think the wheel fell off but it had been screwed down to the lower position. The weight chair had been checked on 7/28/24, and again on 8/23/24, and it passed inspection. The incident happened 1-2 weeks later.</p> <p>He thinks maybe one of the lug nuts on the front wheel was loose. The front left wheel (if sitting in the chair) was what reportedly had came off.</p> <p>During an interview on 9/18/24 at 10:55 AM, Resident #8 sat in a wheelchair in her room and had a cast on her arm. The resident reported she broke her arm when staff pushed her in a chair into the bathroom. The chair tipped, she fell out of the chair, and hit her head on the toilet. She had to have six stitches in her right forehead. The sutures and a dark bruise were visible to her forehead.</p> <p>During an interview on 9/18/24 at 11:10 AM, the Director of Nursing (DON) reported she had worked at the facility for 3 weeks. The DON stated she was notified when Resident #8 had a fall from the weight chair. The front wheel on the weight chair came loose and the chair tipped. The DON stated she didn't see the weight chair. The weight chair was taken off the floor and maintenance fixed it.</p> <p>During an interview 9/18/24 at 2:25 PM Staff C, certified medication aide (CMA), reported Resident #8 independent in her room and required stand by assistance (SBA) prior to her fall/fractured arm. Staff C stated a gait belt used even if a resident a SBA just to be ready.</p> <p>During an interview 9/18/24 at 3:00 PM, Staff D, Assistant Director of Nursing (ADON), reported she expected staff used a gait belt whenever a resident required assistance of one or two staff or used a mechanical lift. A gait belt always used unless the resident was independent. The ADON reported she wasn't at the facility at the time of the incident with Resident #8 but she heard the wheeled popped off of the weight chair. The weight chair was taken out of service and maintenance fixed the weight chair the next day.</p> <p>During an interview 9/18/24 at 3:35 PM, Staff I, CNA, reported she regularly worked the hall where Resident #8 resided and familiar with the resident. Resident #8 used a gait belt and a stand-by assistance of one for ambulation and transfers. Staff I confirmed a gait belt always used whenever a resident required the assistance of one staff.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/19/24 at 11:05 AM, the DON reported the facility didn't have a gait belt policy.</p> <p>A Safe Lifting and Movement of Residents policy revised 7/2017 revealed the facility used appropriate techniques and devices to move residents in order to protect the safety and well-being of staff and residents.</p> <p>49990</p> <p>2. The Quarterly Minimum Data Sample (MDS) for Resident #10, dated 06/24/24, which documented relevant diagnoses of heart failure, hypertension, renal failure, and respiratory failure. It documented Resident #10 is fully dependent for transfers, requiring two-person assistance and a mechanical lift device.</p> <p>The Care plan for Resident #10, last revised on 07/18/24, documented the resident requires two-person assistance with use of a mechanical lift device for all transfers.</p> <p>A direct observation on 09/17/24 at 12:20 PM revealed Staff K, Certified Nurses Aide (CNA), and Staff L, CNA, performing a mechanical lift transfer for Resident #10. During the transfer, Staff L failed to engage the stability legs to ensure the safety of the resident during the transfer. Additionally, Staff K failed to notice the stability legs were not engaged during the transfer. Additionally, staff members did not participate in a time-out to ensure safe strap placement for the resident before beginning to transfer.</p> <p>3. In an interview on 09/18/24 at 11:14 AM with Resident #4, she stated she had previously been dropped out of a Hoyer (mechanical lift). She was unsure how it happened but said that the Hoyer tipped over, she landed on the ground and hit her head. She stated she is now afraid of transfers, as she worries she will be dropped again. Review of Resident #4's MDS, dated [DATE], documented a brief interview for mental status (BIMS) score of 14, which indicated intact cognition.</p> <p>Incident Report dated 8/26/24 at 6:50 PM documented during a Hoyer transfer the right sling strap slipped off the hook and the resident fell to the floor, hitting her head on the floor. Injury type described as follows; bruise on left side back of head.</p> <p>Review of a facility document titled N Fall investigation worksheet, dated 08/26/24, documented Resident #4 experienced a fall while being assisted with a mechanical lift transfer. It further documented she was not experiencing behaviors at the time of the incident, and that training and education had been provided to both CNAs regarding mechanical lift transfers, to make sure proper sling safety is used by conducting time-outs to insure all straps are secure.</p> <p>Progress Note dated 8/28/24 at 9:21 PM documented Resident #4 had complaints of head pain towards the back left of her head, and mid chest pain, ice pack applied and pain medicine given for pain control.</p> <p>In an interview on 09/18/24 at 04:01 PM with the Direct of Nursing (DON), she stated it was her expectation staff members perform a mechanical lift transfer in accordance with the standards of practice. She stated those standards of practice include a time-out to ensure proper strap placement as well as the use of the stability legs if present on mechanical lifts.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a facility provided document titled Lifting Machine, Using a Mechanical, last revised July 2017, documented staff members should ensure a mechanical lift is stabilized, as well as double check the placement of straps before a resident is moved away from a bed or chair.		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>49990</p> <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on direct observation, clinical record review, and family and staff interviews, the facility failed to administer oxygen and other respiratory treatments in accordance with physician orders and resident Care Plans for 1 of 13 residents on oxygen or respiratory therapies (Resident#3). The facility reported a census of 87.</p> <p>Findings include:</p> <p>The Quarterly Minimum Data Sample (MDS) for Resident #3, dated 07/19/24, documented relevant diagnoses of cerebral infarction (stroke), anxiety disorder, and non-Alzheimer's Dementia, congestive heart failure, respiratory failure, cerebral vascular event (stroke), chronic obstructive pulmonary disease (COPD). The MDS documented the resident had experienced shortness of breath when laying flat, and was on oxygen therapy.</p> <p>The Care plan, last revised on 08/07/24, documented the need for continuous oxygen via a nasal cannula. It did not specify what oxygen saturation was within a normal or ideal range for Resident #3.</p> <p>Review of the electronic health record (EHR) documentation for pulse oxygen (O2) saturation from 01/01/24 until 09/17/24 revealed 98 separate occasions in which Resident #3 was assessed for oxygen saturation while currently on room air as opposed to the ordered continuous oxygen titrated from 2-6 liters per minute. The lowest recorded oxygen saturation while on room air was 84%.</p> <p>In a direct observation on 09/17/24 at 12:08 PM, Resident #3 was observed in his room asleep, with oxygen titrated to 4 liters per minute, he was receiving oxygen therapy through an oxygen mask, which was around his neck below his chin at the time of the observation. Resident #3 did not appear in acute distress at this time.</p> <p>In a continuous direct observation on 09/17/24 from 02:00 PM until 02:44 PM, Resident #3 was again observed to not be wearing his oxygen mask. It was down around his neck and his chin was resting on top of it. Resident #3 and the oxygen mask appeared to be in the same position as in the earlier observation. At 02:20 PM Resident #3 began calling for help. Resident #3 called for help five times from 02:20 PM until 02:25 PM before settling back down, staff did not respond. At this time his oxygen was still off. At this time staff were participating in shift change, just two doors away from Resident #3's room, shift change did not include walking rounds. Resident #3 continued without his oxygen mask off until 02:40 PM, at which time a family friend entered his room and immediately reported to nursing staff that Resident #3's oxygen mask was off.</p> <p>In a direct observation on 09/17/24 at 05:20 PM, Resident #3 could be heard loudly calling for help. A family member was assisting Resident #3 in attempting to calm down, reminding him to breathe through his nose. Resident #3 was wearing a nasal cannula at this time, his pulse oxygen levels read as 79%.</p> <p>Review of progress notes from 09/14/24 until 09/19/24 document that Resident #3 was sent to the hospital on 09/14/24 for respiratory distress. Progress notes document Resident #3's oxygen levels were fluctuating from 90% to 80%. Resident returned from the hospital on 09/16/24.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 09/17/24 at 05:04 PM with a family member, he stated this is not the first time he has seen Resident #3 without his oxygen on. He acknowledged Resident #3 was not wearing oxygen when he entered the room and confirmed he was the individual who told nursing staff his oxygen was off.</p> <p>In an interview on 09/16/24 at 03:11 PM with another family member, he stated that his family member is often without oxygen when they visit him in the facility. He noted resident #3 often calls out for help when his blood oxygen saturation is low, often when he is not wearing his mask. He provided images that showed Resident #3 with an oxygen mask on his forehead. Metadata from the image showed a timestamp of 09/17/24 at 06:12 AM.</p> <p>In an interview on 09/18/24 at 04:01 PM with the Director of Nursing (DON), she stated her expectation is for staff members to assess residents at shift change, as well as more frequently assess a resident who recently returned from the hospital.</p> <p>In a facility provided document titled Oxygen administration, last revised in October of 2010, it documented that a resident should be assessed while receiving oxygen therapy for signs of cyanosis, hypoxia, oxygen toxicity, as well as perform checks on their vital signs.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817</p> <p>Based on observations, call light event report, resident, family and staff interviews, and policy review, the facility failed to answer call lights in a timely manner within 15 minutes and adequately assess and ensure sufficient staff to meet the residents' needs for 6 of 6 nursing units. The facility reported a census of 87 resident.</p> <p>Findings include:</p> <p>Observations revealed the Palatium Care Alert monitor located on the counter at the nurse's station revealed the following:</p> <ul style="list-style-type: none"> a. On 9/17/24 at 12:28 PM, room [ROOM NUMBER]'s call light had been on for 20 minutes. b. On 9/17/24 at 12:49 PM, room [ROOM NUMBER]'s call light had been on for 32 minutes, room [ROOM NUMBER]'s call light had been on 18 minutes, and room [ROOM NUMBER]'s call light had been on for 21 minutes. c. On 9/18/24 at 3:31 PM, room [ROOM NUMBER]'s call light had been on for 33 minutes. <p>The Detailed Event Report dated 9/11/24 - 9/16/24 revealed call light response times greater than 15 minutes in a 24-hour period on the following dates:</p> <p>9/11/24 -50 times</p> <p>9/12/24 -81 times</p> <p>9/13/24 -88 times</p> <p>9/14/24 -95 times</p> <p>9/15/24 -96 times</p> <p>9/16/24 -82 times</p> <p>During confidential resident interviews starting on 9/16/24 at 1:30 PM, five of seven interviewable residents reported the facility didn't have enough help. The residents reported they waited 20 to 60 minutes before staff responded and provided assistance. One resident reported it didn't matter what time of day, she waited all hours of the day for staff to help her. Another resident reported she thought the facility needed to provide more staff training so they knew what to do to take care of the residents.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a family interview 9/17/24 at 8:15 AM, a family member reported the facility didn't have enough Certified Nursing Assistants (CNA's), and at times the CNA worked 16-hour shifts back to back. The family member reported some residents needed two staff to do their cares and transfers, but only one CNA assigned to work on a hall. Another family member reported two CNA's took her mother to the bathroom, but didn't come back to take her off the toilet for 45 minutes. The family member reported she pushed the call light for the resident, but staff didn't come back until 45 minutes later. The resident said her bottom hurt from sitting on the toilet so long. A family member reported she tried to call the facility several times but unable to reach staff because staff didn't answer the phone in the evening. She even called another nurse's station but the phone rang and rang.</p> <p>During an interview 9/17/24 at 12:55 PM, Staff B, Registered Nurse (RN), reported they were very short-staffed. Staff B stated only one CNA and one nurse assigned to 15 residents.</p> <p>On 9/17/24 at 1:35 PM, Staff A, CNA, reported some days staff called in and they worked short if no replacement found. Staff A stated sometimes it took longer to get to the residents when they had less staff working, but she didn't think there had been any bad outcomes. The 100 hall and 200 halls had one CNA and one nurse on each hall, and one staff floated between the areas, but the number of staff assigned to work each area depended on the acuity of the residents. Staff had to call someone from another hall to help if a resident needed the assistance of two staff.</p> <p>During an interview 9/18/24 at 11:25 AM, the Staffing Coordinator reported she typically scheduled the following:</p> <p>On the 100-200 Hall:</p> <p>1 CNA on each hall for the day, evening, and night shifts. Sometimes she scheduled one float on the day and evening shift but it depended upon the census.</p> <p>2 nurses on the day and evening shifts</p> <p>2 nurses or 1 nurse and 1 certified medication aide (CMA) on the night shift</p> <p>On the 300- 400 Hall:</p> <p>1 CNA on each hall with 1 restorative aide (RA) to float on the day shift</p> <p>1 CNA on each hall on the evening shift</p> <p>2 nurses on the day and evening shifts.</p> <p>1 CNA and 1 nurse on the night shift</p> <p>On the 500 -600 Hall:</p> <p>2 CNA's with 1 RA float on the day and evening shift.</p> <p>1 CNA and 2 nurses on the evening shift until midnight.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1 CNA and 1 nurse on after midnight</p> <p>The Staffing Coordinator reported she scheduled the same number of staff on the weekend staffing. She also tried to find staff to cover open shifts and the call-ins. The staffing coordinator stated she felt the facility had enough staff but when they had a few call-ins it made it more challenging to cover the schedule.</p> <p>On 9/18/24 at 11:45 AM, the Director of Clinical Services reported the facility used a Primeview program to determine the facility's staffing needs. She checked staffing numbers and they averaged a Per Patient Days (PPD) of 4.0. The PPD on 9/16/24 was 3.8. She felt the facility had appropriate staffing.</p> <p>During an interview on 9/18/24 at 11:55 AM, Staff H, CNA, reported she didn't think the facility had enough staff. They only had one CNA on each hall at night. The facility told them the nurses could help the CNA's but the nurses don't help because they have their own job to do. Staff H reported the facility had cut staff since the new company took over, and sometimes they only had one nurse for 40 residents.</p> <p>During an interview 9/19/24 at 7:29 AM, Staff E, Licensed Practical Nurse (LPN) reported the facility kept cutting staff, and had cut down to one nurse in the 100/200, 300/400, and 500/600 halls at midnight. They only had 1-2 CNA's on 100/200 hall at night. The 100-200 hall is the skilled unit. Staff E reported it wasn't safe, and he/she had concerns for their nursing license. Staff E stated some residents required 2 staff for assistance on the night shift.</p> <p>During an interview 9/19/24 at 11:00 AM, the Executive Director (ED) reported he started to work at the facility on 8/1/24. When he began to work at the facility, residents resided on only four of the six halls but currently had residents residing in six halls. The ED confirmed the facility had a census of 87 residents in-house when the surveyors entered the facility on 9/16/24. The ED reported they aimed for one CNA for 1-10 residents and assigned a float to go between the 100 to 400 halls. Staff were expected to use a walkie to request assistance. There was no hard ratio for the number of nurses to the number of residents.</p> <p>The number of nurses daily:</p> <p>One nurse scheduled to each hall on the 100-200 hall, which was the skilled area.</p> <p>One nurse and one CMA on the 300-400 hall with up to 28 beds.</p> <p>Two nurses or one nurse and one CMA on the 500-600 hall.</p> <p>6 nurses worked from 6 PM - 12 AM, and 3 nurses worked from 12 AM - 6 AM.</p> <p>The ED reported the number of CNA's scheduled daily:</p> <p>On the Day shift: 10-11</p> <p>On the evening shift: 9-10</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On the night shift: 5-6</p> <p>The ED reported the call lights were an area for improvement and he was in the process of understanding the systems in place and why, as well as setting the expectations of staff. The facility had more staff than any other buildings he had been in. The facility had a lot of changes and transitions in staff. A number of staff became unhappy with the changes the new company made, and some staff left. Staffing adjustments and reassignments are made based on the residents' acuity level.</p> <p>Answering the Call Light policy revised 3/2021 revealed the facility ensured timely response to the resident's requests and needs.</p> <p>The Facility Assessment updated on 3/2024 revealed the facility assessment updated as indicated and whenever a significant change such as the facility capacity or the services provided. A facility assessment utilized to determine the resources needed to care for the resident population served during day-to-day operations as well as during emergency situations.</p> <p>The facility's assessment included the following:</p> <p>a. Part 1 - Resident Profile</p> <ul style="list-style-type: none"> - Average census: 45-59 - Average Skilled Care residents per day: 15-25 - Average long-term care residents per day: 60-75 <p>The facility assessment included the acuity of residents and the Activities of Daily Living (ADL) assistance required for residents on the 300-400 and 500-600 halls. The assessment documented 0-5 residents were independent, 15-30 residents required assistance of 1-2 staff, and 5-15 residents were dependent on staff for ADL's on the 300 to 400 and the 500 to 600 halls. The facility assessment lacked information for residents on the 100-200 halls.</p> <p>The assessment revealed the facility will have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by the facility assessment, resident assessments, and individualized plan of cares. The individual needs of the population in each area drove the staffing decisions by determining the type, ratio and level of staff required to meet the needs of each of the unit's resident populations.</p> <p>b. Part 3 - Facility Resources Needed to Provide Competent Support and Care for the Resident Population each day and during emergencies:</p> <ul style="list-style-type: none"> -Average census range: 50-66 residents -Total number of staff needed: <p>Registered Nurses / Licensed Practical Nurses: 16-21</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Medication Aides / Nursing Assistants: 25-31</p> <p>An email from the ED on 9/19/24 at 12:17 PM, the ED wrote that he thought the former Administrator made a clerical error on the average census in the Facility Assessment for 3/2034 along with the PPD for staffing the building as of 3/2024. The Daily Census Report showed the average YTD (year-to-date) census at 92.9.</p> <p>49990</p> <p>2. In an interview on 09/16/24 at 11:26 AM with Resident #1, she stated she does not feel the facility has enough staff. She notes call light times can be extremely long, and the dining service always takes much longer than posted on the wall. A review of the annual MDS dated [DATE] for Resident #1 documented BIMS score as 12, indicating moderately impaired cognition.</p> <p>In an interview on 09/18/24 at 03:26 PM with Staff J, Registered Nurse (RN), she stated the facility used to have more staff floating between the halls. She felt it was much safer and provided much faster and efficient care to residents when they had more floats. She stated meal times are often the hardest, as most residents require a two person assist to get up for the meal, allowing only one resident to be assisted at a time. This slows an already slow meal service.</p> <p>In an interview on 09/19/24 at 12:18 PM with a Resident's family member, she stated she does not see staff as often as she thought she would. She notes she doesn't feel they have enough staff members to take care of everyone in the unit. She stated the call light times have been above 15 minutes often, and she has personally waited for nearly one hour for assistance for her family member.</p> <p>In an interview on 09/19/24 at 12:35 PM with Staff N, Certified Nurses Aide (CNA), she stated they do not have enough staff to complete all of their tasks. She stated the units always feel short staffed. They often rely on the float worker, but that means residents can wait significant periods of time.</p> <p>In an interview on 09/19/24 at 12:39 PM with Staff O, Certified Medication Aide (CMA), she stated they do not always have enough staff to get the job done. She stated when residents are having behavioral episodes they notice it the most. It makes it impossible to get things done in a timely fashion. She noted she has reported these issues to prior leadership, but does not feel it is getting better. She noted often it is the activities of daily living (ADLs) like bathing, brushing teeth, and other hygiene tasks that don't get done as a result of staffing issues.</p> <p>In an interview on 09/19/24 at 12:43 PM with Staff P, CNA, she stated the facility does not have enough staff to get everything done. She stated she has previously worked short in units that have multiple residents who require a two-person transfer. She has called for help and been told no one is coming, forcing her to be unable to transfer residents who request getting out of bed or help them back in to bed in a timely manner. She felt this was worse on the night shift, though she noted the day shift is often behind.</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49990</p> <p>Based on direct observation, staff interview, and facility document review, the facility failed to serve each resident with a nourishing, well-balanced diet that takes into consideration the preferences of the resident for 1 of 18 residents assessed (Resident #6). The facility reported a census of 87.</p> <p>Findings include:</p> <p>A direct observation of the meal service on 09/17/24 at 12:44 PM revealed a slow, chaotic service in which lunch did not begin being served until 01:13 PM. During the service kitchen and nursing staff were seen assisting residents in the dining room, but no assistance was provided to residents who chose to eat in their rooms or were otherwise confined to their beds. Meal service in the dining hall ended at 01:53 PM, at which point the remaining food, including two resident meals, was removed from the floor.</p> <p>A direct observation on 09/17/24 from 2:00 PM until 02:50 PM showed that after lunch service in the dining hall ended, the residents who had not dined with their peers in the dining hall were never offered or served room trays.</p> <p>An interview on 09/17/24 at 2:33 PM with Resident #6 she stated she was never brought a meal. She acknowledged she had refused to get up for lunch but had wanted to eat in her room. She noted she is still hungry. A review of the minimum data sample (MDS) dated [DATE] for Resident #6 documented her brief interview for mental status (BIMS) score as 13, indicating intact cognition.</p> <p>In an interview on 09/19/24 at 9:11 AM with the Certified Dietary Manager (CDM) it was stated nursing staff are required to serve residents who are on a modified diet or who require feeding assistance. She acknowledged the kitchen staff was not informed Resident #6 had requested a meal tray.</p> <p>In an interview on 09/18/24 at 3:26 PM with Staff J, Registered Nurse (RN), she stated it was not uncommon for the kitchen to forget to serve room trays. She acknowledged it was the job of nursing staff to serve and feed residents on modified diets or who require feeding assistance. She stated she has had to remind CNAs in the past that room trays were required for those on modified diets, and has had to request those room trays from the kitchen because they were never sent.</p> <p>In an interview on 09/16/24 at 11:26 AM with Resident #1, she stated she doesn't eat in her room very often because she will not get her room tray at all. As a result, she eats in the dining room now. A review of the annual MDS dated [DATE] for Resident #1 documented BIMS score as 12, indicating moderately impaired cognition.</p> <p>A review of a facility provided document titled Frequency of Meals last revised in June of 2017, documents each resident shall receive at least three meals daily, at times comparable to typical meal times in the community, or in accordance with each resident's needs, preferences, and the plan of care.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.</p> <p>34817</p> <p>Based on facility assessment review, and resident, family, and staff interviews, the facility failed to adequately evaluate their resident population and identify required resources and staffing levels needed to provide the necessary care and services needed for current residents. The facility reported a census of 87 residents.</p> <p>Findings include:</p> <p>A review of the Facility Assessment updated on 3/2024 revealed the facility assessment updated as indicated and whenever a significant change including facility capacity or the services provided. A facility assessment utilized to determine the resources needed to care for the resident population served during day-to-day operations as well as during emergency situations.</p> <p>The facility's assessment included the following:</p> <p>a. Part 1 - Resident Profile</p> <ul style="list-style-type: none"> - Average census: 45-59 - Average Skilled Care residents per day: 15-25 - Average long-term care residents per day: 60-75 <p>The facility assessment included the acuity of residents and the ADL (activities of daily living) assistance required for residents on the 300-400 and 500-600 halls. The assessment documented 0-5 residents were independent, 15-30 residents required assistance of 1-2 staff, and 5-15 residents were dependent on staff for ADL's on the 300 to 400 and the 500 to 600 halls. The facility assessment lacked information for residents on the 100-200 halls.</p> <p>b. Part 3 - Facility Resources Needed to Provide Competent Support and Care for the Resident Population each day and during emergencies:</p> <ul style="list-style-type: none"> -Average census range: 50-66 residents -Total number of staff needed: <p>Registered Nurses / Licensed Practical Nurses: 16-21</p> <p>Medication Aides / Nursing Assistants: 25-31</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165616	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER The Bridges at Ankeny		STREET ADDRESS, CITY, STATE, ZIP CODE 3510 Northwest Abilene Road Ankeny, IA 50023	
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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The assessment revealed the facility will have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by the facility assessment, resident assessments, and individualized plan of cares. The individual needs of the population in each area drove the staffing decisions by determining the type, ratio and level of staff required to meet the needs of each of the unit's resident populations.</p> <p>During confidential resident interviews 9/16/24 to 9/18/24, five of seven interviewable residents reported it took staff 20 minutes to 1 hour before staff answered their call light and provided assistance. One resident reported she had to plan ahead and call for assistance to use the bathroom so it didn't become an emergent situation.</p> <p>During family interviews, a family member reported the resident needed two staff for some cares and transfers, but when the facility only had one aide working on the unit it took longer to find someone to help. Another family member reported it took 45 minutes for staff to return and help the resident off the toilet. The facility didn't have enough CNA's (certified nursing assistants) to assist residents with feeding and other ADL's. Families reported meals were often served late.</p> <p>On 9/16/24 at 12:51 PM, a CNA complained to kitchen staff that they needed to find more people, because the CNA was still getting people up for lunch and it was almost 1:00 PM. The CNA told Resident #1 they are always short staffed and don't have enough staff to get everyone up.</p> <p>During an interview 9/19/24 at 11:00 AM, the Executive Director (ED) reported the former Administrator put the Facility Assessment together. The ED reported he started to work at the facility on 8/1/24. When he began to work at the facility, no residents resided on two of the six hallways but now each hall had residents. The ED confirmed the facility had a census of 87 residents in-house when the surveyors entered the facility on 9/16/24, and the census was 91 on 9/19/24.</p> <p>An email from the ED on 9/19/24 at 12:17 PM, the ED wrote that he thought the former Administrator made a clerical error on the average census in the Facility Assessment for 3/2034 along with the PPD for staffing the building as of 3/2024. The Daily Census Report showed the average YTD (year-to-date) census at 92.9.</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** 34817</p> <p>Based on clinical record review, observation, staff interview, and policy review the facility staff failed to wear gloves and follow Enhanced Barrier Precautions (EBP) and infection control practices for 1 of 10 residents reviewed (Resident #7). The facility reported a census of 87 residents.</p> <p>Findings include:</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had diagnoses of liver cirrhosis, cancer, chronic kidney disease, and neurogenic bladder. The MDS documented the resident had a catheter.</p> <p>The Care Plan revised 9/10/24 revealed Resident #7 had a catheter and on EBP. The resident also had a history of urinary tract infection and sepsis (a life-threatening complication of infection). The Care Plan directed staff to use enhanced barrier precautions during completion of high contact activities.</p> <p>During observation on 9/16/24 at 1:50 PM, Staff F, Certified Nursing Assistant (CNA), donned a gown and a pair of gloves. Staff F obtained supplies and drained the urine contents from Resident #7's catheter bag into a graduate container. After Staff F cleansed the catheter port with alcohol and replaced the port into the holder on the catheter bag, she removed her gloves, then took the graduate with urine into the bathroom, and placed the graduate with urine on a towel on the back of the toilet. Staff F reported 375 milliliters in the graduate. Staff F picked the graduate container up and emptied the urine contents into the toilet. Staff F turned the graduate container upside down and placed it on the towel on the back of the toilet, and washed her hands. Staff D, Assistant Director of Nursing (ADON) stood in the room and observed while the surveyor observed.</p> <p>During an interview on 9/18/24 at 11:50 AM, Staff D, ADON, reported she expected staff wore gloves whenever they worked with or touched body fluids, and she expected staff rinsed the graduate container after the graduate emptied.</p> <p>The facility's Personal Protective Equipment- Gloves policy revised 7/2009 revealed all employees must wear gloves when handled body fluids and whenever the employee's hands could likely come in contact with body fluids.</p> <p>The facility's Enhanced Barrier Precautions policy dated 3/25/24 revealed EBP's are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. EBPs employ gown and glove use during high-contact resident care activities including indwelling device care or use.</p>		