STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165616	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Bridges at Ankeny	3510 Northwest Abilene Road 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 25854 Based on clinical record review and staff interview the facility failed to maintain a complete and accurate Care Plan for 1 of 3 residents reviewed. (Res #1) The facility identified a census of 84 residents. Findings include: On an Encounter Note for Resident #1 dated 3.26.25 the Physician typed an addendum dated 5.14.25 with information that included the following: a. The patient was admitted to the facility under hospice care, with the diagnosis of a malignant neoplasm of the brain and lung. Part of the treatment included oral inhalers for breathing assistance. She was instructed to rinse her mouth after each dose of the inhalers. She refused to rinse her mouth after each inhaler treatment and she unfortunately developed stomatitis (a condition that caused painful swelling and sores inside the mouth.) It had been the Physician's opinion, within a reasonable degree of medical certainty, that the cause of the stomatitis was the patient's refusal of the oral rinses after the inhaler treatment. Review of the resident's Care Plan (not dated) revealed the facility failed to have addressed the stomatitis and the resident's continued refusal to have rinsed her mouth post inhaler usage.

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 25854 Based on observation, record review and staff interview, the facility failed to administer medications according to the Physician's order and in a timely manner for 4 of 4 residents reviewed. (Res #1, #2, #4 and #8) The facility identified a census of 84 residents. Findings include: 1. Review of the facilities Medication Administration Audit Report form dated 5.9.25 at 10:19 a.m. revealed the facility staff failed to administer the following resident medications according to their Physician's orders: Resident #1 - a. Morphine Sulfate (for pain) 20 milligrams (mgs) per milliliter (ml) 0.5 ml by mouth (po) every four (4) hours for pain, air hunger and/or shortness of breath (sob). On 4.15.25 the physician ordered time of admission had been 12 p.m. and 8 p.m. however staff actually administered the medication at 4:46 p.m. and 9:56 p.m. b. Magic mouthwash (thrush) 5 ml po every day (qd). On 4.16.25 the medication had been ordered at 7 a.m. but administered at 12:28 p.m. c. Ativan (anti-anxiety) 0.5 mg tablet po every 4 hours. On 4.16.25 the medication had been ordered at 8 a.m. and 12 p.m. but administered at 12:27 p.m. and 4:57 p.m. Resident #2 - a. Midodrine Hydrochloride (HCL) (orthostatic hypotension (low blood pressure) tablet 10 mgs one (1) tablet po three times a day (tid). On 4.20.25 the medication had been ordered at 12 p.m. but administered at 1:18 p.m. b. Enoxaparin Sodium Injection Solution (aftercare of a femur fracture) 40 mg/0.3 ml one syringe subcutaneously (sq) two times a day (bid). On 4.20.25 the medication had been ordered at 7 p.m. and administered 4.21.25 at 12:09 a.m. c. Acetaminophen 325 mg two tablets po TID. On 4.20.25 the medication had been ordered at 7 p.m. but administered on 4.21.25 at 12:09 a.m. d. Lidocaine External Patch 4 % applied topically to areas of concern bid for pain. On 4.20.25 the medication had been ordered at 7 p.m. but administered on 4.21.25 at 5:39 a.m. Resident #4 - a. Atrovastatin Calcium (cholesterol) 1 tablet po at bedtime (hs) and Sucralfate (recent gastrointestinal bleed) 1 gram tablet four times a day (qid). On 5.6.25 the medication had been ordered at 7 p.m. and administered at 11:10 p.m. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #8 - a. Lidocaine External Cream 3% applied to buttocks topically qd. On 5.6.25 the medication had been ordered at 7 a.m. and administered at 11:06 a.m. b. Insulin Glargine injection 25 units sq bid. On 5.6.25 the medication had been at 7 p.m. and administered at 11:02 p.m. 2. An observation 5.8.25 at 10:18 a.m. revealed Staff F, Certified Medication Aide CMA as she passed medications to Resident #8. Review of the Medication Admin Audit Report form dated 5.8.25 at 10:40 p.m. revealed the resident received the following medications ordered for 7 a.m. but administered as documented below: a. Lispro insulin 10 units tid and Glargine Insulin 25 units bid for Hyperglycemia - administered at 9:06 a.m. b. Lidocaine external cream 3 % to buttocks qd, Senna S 8.6-50 mg two tablets po qd for constipation and Ropinirole HCL 0.5 mg tablet po qd for restless leg syndrome - 10:16 a.m. c. Lasix 60 mg po bid for congestive heart failure, Ferrous Sulfate 325 mg qd for anemia, Clopidogrel Bisulfate 75 mg tablet po qd related to Paraxysmal Atrial Fibrillation, Aspirin 81 mg po qd of heart health, Finasteride 5 mg po qd for Benign Prostatic Hyperplasia and Hydrocodone/Acetaminophen 7.5-325 mg po qd for pain - 10:14 a.m. d. Amiodarone HCL 100 mg po qd for paraxysmal atrial fibrillation - 10:13 a.m. i. Clopidogrel Bisulfate 75 mg tablet po qd related to Paraxysmal Atrial Fibrillation, Aspirin 81 mg po qd of heart health Finasteride 5 mg po qd for Benign Prostatic Hyperplasia and Hydrocodone/Acetaminophen 7. 5-325 mg po bid for pain - 10:14 a.m. 3. During an email 5.13.25 at 5:46 p.m. the Director of Nursing (DON) confirmed the above documented medications from the Medication Administration Audit Report as administered late. 4. During an interview 5.9.25 at 11:01 a.m. Staff E, CMA indicated she had been aware of a families concern with medication administration times. Staff F, CMA had administered medications late however she had been new to the facility and when Staff E asked her about the medications administered late she confirmed she ran behind the day in question but failed to tell anyone and administered the medications for Resident #2, 20 minutes late on an unknown date in question.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 25854 Based on observation, clinical record review, resident and staff interview and facility policy review, the facility failed to provide proper perineal care for 1 of 3 residents reviewed. (Res #4) The facility identified a census of 84 residents. Findings include: According to a Minimum Data Set (MDS) assessment dated 5.8.25 Resident #4 had diagnosis that included Renal Insufficiency, Anxiety, Chronic Respiratory Failure, muscle weakness and required assistance with personal cares. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 (moderately impaired cognitive skills) and required substantial/maximum assistance with toileting hygiene. A Care Plan addressed a Problem area and Interventions as stated and dated below: a. Self-care deficit as evidence by required assistance with activities of daily living (ADL's), impaired balance during transitions and required assistance with ambulation. (revised 4.22.25) 1. Assistance of one (1) with a front wheeled walker (FWW) and provision of perineal care with every incontinence episode and as needed (PRN). (revised 4.23.25) An observation 5.8.25 at 9:08 a.m. revealed Staff D, Certified Nursing Assistant (CNA) and Staff G, CNA as they entered the resident's room. The resident requested no male assistance so Staff G went into the resident's bathroom. While positioned in bed Staff D assisted the resident onto her right side, removed bed pan positioned under the residents buttocks (full of urine) and cleansed the resident's mid-gluteal region with one (1) swipe only but failed to cleanse the resident's vaginal area, her buttocks and/or thighs. The staff member removed a brief positioned under the the resident and replaced it with a clean brief. During an interview at the same time Staff D had been asked if the brief presented soiled/wet, the staff member mumbled and ignored the question. Staff G had then been asked if the brief removed from under the resident had been soiled/wet at which time he responded a little wet. Both staff members then repositioned the resident while Staff G noted another pad positioned under the resident appeared soiled/wet so he removed the pad. During another interview at 9:18 a.m. Staff D confirmed she failed to have cleansed the resident's vaginal area and proceeded to pull back clean brief anteriorly, cleansed the resident anteriorly and replaced the same soiled brief. Staff proceed to position the resident for comfort, provided for her current needs and exited the room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview just after all the staff had left the resident's room, the resident indicated last week when she asked for the bed pan an unknown staff member directed her to have peed in her depends which pissed off the resident as she stated, who said things like that, I would have liked to have seen her pee her pants. A Perineal Care policy dated 2.2018 indicated the purpose as follows: The purposes of this procedure included the provision of cleanliness and comfort to the residents, prevention of infections and skin irritation and observance of the resident's skin condition. The Steps in the Procedure for a female resident included the following: a. Wash the perineal area as they wiped front to back. 1. Separation of the labia and to have washed downward from front to back. 2. To have washed the perineum as staff moved from the inside outward to the thighs. 3. Position the resident on her side with the top leg slightly bent, if able. 4. To have washed the rectal area thoroughly from the base of the labia with the extention over the buttocks.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 25854 Based on observation, a call light audit report, resident, family and staff interview, Resident Council Notes and facility policy review, the facility failed to answer resident call lights in a timely manner (within 15 minutes) for 2 of 7 residents reviewed. (Resident #1, #6) The facility identified a census of 84 residents. Findings include: 1. An observation 5.8.25 revealed the call monitor located at the nurse's station on the 300 hallway with the following: The call light on for Resident #10 for 16 minutes so far. The time on the monitor itself read 10:13 a.m. on the bottom right hand corner. Now the monitor read the call light on for 17 minutes then staff responded and turned the call light off. A Location Event Report form dated 5.8.25 included the following late call light response times: a. 9:56 a.m. until 10:13 a.m. - 17 minutes. 2. An observation 5.8.25 at 1:33 p.m. revealed the call light monitor at the nurse's station on the 600 hall with a call light on for Resident #9 for 18 minutes which had been turned on at 1:15 p.m. The time on the upper right hand corner of the computer monitor itself read 1:33 p.m. A Location Event Report form dated 5.8.25 included the following late call light response times: a. 1:15 p.m. until 1:33 p.m. - 18 minutes. b. 4:17 a.m. until 4:38 a.m. - 21 minutes. 3. During an interview 5.7.25 at 2:38 p.m. a family member of Resident #1 confirmed family timed the resident's call light on for an average time of 32 minutes as they used a stop watch on their cell phones. The family member indicated one (1) time the family timed the call light on for three (3) hours. 4. During an interview 5.7.25 at 3:53 p.m. a family member for Resident #6 confirmed she timed her call light as on for 1 hour as she used the clock in the room which caused the resident to have felt disappointed so the family provided cares rather than the facility staff. The resident and the family member confirmed the call lights had been an issue since she admitted to the facility plus she fell without injury recently on a date unknown but at approximately 4 a.m. because the facility staff failed to answer her call light timely and she had to go to the bathroom so she stood up on her own and fell . The resident indicated this issue caused feeling of having been sorry, sad, angry and anxious. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an interview 5.9.25 at 9 a.m. Staff A, Licensed Practical Nurse (LPN) confirmed staff as unable to answer resident call lights within 15 minutes due to staffing issues and their inability to meet the needs of all of the individual residents. During an interview 5.9.25 at 9:56 a.m. Staff B, Certified Nursing Assistant (CNA) confirmed staff as unable to answer resident call lights within 15 minutes as she described the staff as to busy and the facility failed to provide enough staff to have met the individual resident needs. 6. Review of the facilities Resident Council Notes revealed the following as dated: a. 1.7.25 - Call lights took to long. Several residents in attendance indicated they waited over 1/2 hour. b. 12.3.24 - Call lights not answered timely. c. 11.5.24 - Residents waited to long for the call lights, especially on the evening shift. 7. During an interview 5.9.25 at 11:15 a.m. the Administrator confirmed he had been aware of continued problems with call lights. 8. An Answering Call Light policy and procedure dated 3.2021 indicated the purpose as the following: The purpose of this procedure included an assurance of timely responses to the residents' requests and needs.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 25854 Based on observation, clinical record review, staff and resident interview and facility policy review, the facility staff failed to follow appropriate infection control practices during an outbreak status and when 1 of 3 residents (Resident #4, #5) presented on barrier precautions. The facility identified a census of 84 residents. Findings include: 1. According to a Minimum Data Set (MDS) assessment dated 5.8.25 Resident #4 had diagnosis that included Renal Insufficiency, Anxiety, Chronic Respiratory Failure, muscle weakness and required assistance with personal cares. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 (moderately impaired cognitive skills) and required substantial/maximum assistance with toileting hygiene. A Care Plan addressed a Problem area and Interventions as stated and dated below: a. Self-care deficit as evidence by required assistance with activities of daily living (adl's), impaired balance during transitions and required assistance with ambulation. (revised 4.22.25) 1. Assistance of one (1) with a front wheeled walker (FWW) and provision of perineal care with every incontinence and as needed (prn). (revised 4.23.25) b. Required enhanced barrier precautions related to the presence of a pressure area on her left heel. (initiated 4.23.25 and revised 5.13.25) 2. Staff adhered to enhanced barrier precautions related to the presence of a pressure area to the left heel. (initiated 4.23.25 and revised 5.13.25) An observation 5.8.25 at 9:22 a.m. revealed Staff D, Certified Nursing Assistant (CNA) as she dropped her name tag in the middle of the resident's bathroom floor. An observation 5.8.25 at 9:20 a.m. Staff G, CNA went into the resident's bathroom and told Staff D her name tag fell on the floor in the bathroom so Staff D picked up the name tag at 9:22 a.m. and clipped it to her scrubs but failed to sanitize the name tag. According to an email 5.16.25 at 12:58 p.m. the Director of Nursing (DON) indicated in the event as stated above she would have expected the staff member to have sanitized her name tag with a registered disinfectant for the required contact time per manufacturer's instruction or throw it away and have asked for a new one. During an interview 5.8.25 at approximately 9:25 a.m. following staff's provision of perineal cares the resident asked, what had been going on because staff wore gowns during cares and they never wore gowns. The resident described the situation as just crazy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation 5.8.25 at 9:40 a.m. revealed Staff H, Certified Medication Aide (CMA) as she entered the resident's room, checked the resident's temperature, dropped the thermometer on the floor in the room, picked up the device and set it on the resident's oxygen concentrator which had been in use and attempted to check the resident's blood pressure with a wrist device but without success. At 9:43 a.m. Staff H left the resident's room with the blood pressure device and thermometer and placed them on top of a medication cart without a barrier and/or sanitization of the devices. During a interview 5.8.25 at 9:48 a.m. Staff H confirmed the above documented observation. An observation at 9:49 a revealed the staff member as she placed the blood pressure machine on her left wrist to have checked it functionality as it failed to register when she attempted to check the resident's blood pressure just prior. The staff member confirmed the device as functional so at 9:52 a.m. she returned to the resident's room and checked the resident's blood pressure which measured 131/71, left the room and again placed the device on top of the medication cart but again failed to have sanitized the device. 2. An observation 5.8.25 at 12:16 p.m. revealed Staff, Registered Nurse (RN) as she entered the resident's room DONNED (put on) in Personal Protective Equipment (PPE) and with med cups which contained medications set up at the medication cart at the nurse's station along with three (3) separate eye drop boxes/containers. The staff member placed the eye drop boxes and medication cups on the resident's bedside stand/table without a barrier. The staff checked for proper gastrostomy tube placement and stomach content's residual, flushed the tube, administered crushed meds diluted in water, followed by liquid meds and flushed the device again. With the same gloved hands the staff member reached into her scrub pockets and removed a sharpie to have dated the items in the resident's room. (i.e .tube feeding bags, tube feeding water bags and etc) At this point, Staff C, RN and the Assistant Director of Nursing (ADON) picked up the resident's call light device/button, positioned on the ground/floor and attached it to his bed but failed to sanitize the device prior. 3. According to an email 5.16.25 at 1 p.m. the DON confirmed the facility had been in outbreak status from 4. 9.25 thru 5.7.25. According to an email 5.7.25 at 11:53 a.m. during the facilities outbreak status 4.2025 the facility had 10 residents who tested positive, and seven (7) staff members. During an interview 5.14.25 at 12:48 p.m. Staff C, Registered Nurse (RN) and Assistant Director of Nursing (ADON) confirmed during the time of the outbreak there had been multiple times staff had been redirected related to proper mask placement and especially with the laundry staff . During an interview 5.9.25 at 9:56 a.m. Staff B, CNA confirmed she went into resident rooms without proper PPE when the facility had been in an outbreak status in April 2025. 4. According to an email 5.16.25 at 12:39 p.m. the DON confirmed she expected staff to have placed a barrier when the placed an item down in a resident's room such as eye drops and etc. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an interview 5.9.25 at 11:15 a.m. the Administrator confirmed he had been aware of continued problems with infection control. The facilities Enhanced Barrier Precautions sign included the following directives the providers and staff must have performed: a. Wore gloves and gowns for the following high contact resident care activities: 1. Dressing, bathing, transfers, linen change, personal hygiene, change of brief and/or toileting assistance, device care with items such as catheters, central lines, feeding tube, tracheostomy and etc and wound care. 6. An Infection Prevention and Control Program policy dated 10.1.22 included the following Policy Statement: An infection prevention and control program had been established and maintained for provision of a safe, sanitary and comfortable environment and to have helped in the prevention and development of transmission of communicable diseases and infections. The Prevention of Infection section included the following directives: a. Important facets of infection prevention included: 1. Education of staff for assurance that they adhered to proper techniques and procedures. 2. Implementation of appropriate isolation precautions when necessary. 3. Established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC). The Monitoring Employee Health and Safety section included the following directives: a. Those with potential direct exposure to blood or body fluids had been trained in and equipped to have used appropriate precautions and personal protective equipment. 1. The facility provided personal protective equipment and checked for proper usage.