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 03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Bridges at Ankeny	3510 Northwest Ablilene 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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review and staff interviews, the facility failed to ensure all residents received medication as ordered by a physician and failed to prevent potentially serious medication errors when staff administered the wrong medications or dosage for 3 of 3 residents reviewed (Residents #103, #105 and #102). Resident #103 received the wrong medications, transferred to the hospital where he was admitted to the hospital and had bradycardic episodes (temporary or sustained drop in heart rate below 60 beats per minute). The facility reported a census of 90 residents.The facility corrected the immediate concern prior to the survey on 3/9/26 when the facility staff implemented the following corrective actions: The facility conducted a root cause analysis of how and why the medication errors occurred. The facility did evaluations of medication pass with staff that are responsible for giving residents medications. The facility provided medication pass education, and review of the policy for medication pass to all staff responsible for distributing medications to the residents. The facility developed a Room Change Medication Safety Checklist for staff to ensure safe and accurate medication administration following any resident room change, in accordance with CMS medication safety and profession standards. The scope and severity was lowered from a G to a D at the time of the survey after ensuring the facility implemented the corrective actions. Findings include: 1. Resident #103's admission Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score as a 14, indicating intact cognition. The MDS listed diagnoses of stroke, cognitive communication deficit, and a urinary tract infection. Resident #103's Incident Report for 1/31/26 documented the following; the resident had received the wrong medications, and a short while later was pale with head drooping and not able to speak at this time. The nurse assessed him and his blood pressure and heart rate were low. He was sent to the hospital. Review of the facility's Investigation Summary documented Staff A, Registered Nurse (RN) noted resident #103's blood pressure and heart rate were low. Staff A was called to the Medication Cart by Staff B, Certified Medication Aide (CMA) and at that time it was noted Staff A gave Resident #103 another resident's medications that morning. Staff A then called the on-call doctor and the doctor ordered to send the resident to the hospital for fluids and to be monitored. The medications Resident #103 received were as follows; Losartan (used to treat high blood pressure) 100 milligrams (mg), Carvedilol (used to treat high blood pressure by relaxing blood vessels and slowing the heart) 25 mg, Diltiazem (used to treat high blood pressure) 180 mg extended release, Hydroxyzine (antihistamine which can cause drowsiness) 25mg, Eliquis (blood thinner)5 mg, Donepezil (used to treat confusion and memory loss in Alzheimer's disease) 10mg, Ezetimbe (used lower cholesterol) 40 mg, Fluoxetine (used to treat depression) 40mg, and Rosuvastatin (used to lower cholesterol) 40mg, all of which were not prescribed to him. Resident #103 had moved rooms and Staff A pulled the medications from the wrong room spot in the medication cart. The investigation documented Staff A had taken the medications out of the cart, crushed them and gave them to the resident. The facility investigation (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0760 Level of Harm - Actual harm Residents Affected - Few	lacked documentation of staff or resident interviews to determine if there were any concerns noted in the past or present with medication administration. Review of the hospital records for Resident #103 documented he had episodes of bradycardic, down to 35 beats per minute for his heart rate. He had intravenous fluid boluses (rapid dose of fluids). The half-life (time required for the body to reduce concentration of the drug by 50%) of the medications that were given range from 2 to 20 hours. In addition, he was not supposed to be on Eliquis (blood thinner) until he had a repeat scan of the brain due to his stroke. He was admitted to the hospital to for monitoring due to half life of medications. On 3/10/26 at 11:25 AM Staff A, RN reported on 1/31/26 she had a CMA that day working with her. Staff A reported at 8:00 AM she went to do Resident #103's meds. She grabbed the last person's meds in 115 spot in the medication cart since Resident #103 was in 115. Staff A reported at the time the CMA was on the computer at the cart so she just popped the medications and gave them. Staff A reported she did not look to see if it was Resident #103's name on the medication packs and did not compare the medications to the Medication Administration Record (MAR). A short while later at breakfast she noted Resident #103's head was down and seemed off so she checked his blood pressure twice with the automatic cuff and it was low. Staff A reported she went to get a manual blood pressure cuff. When she was looking for a cuff, Staff B, CMA came and said she gave the wrong medications. Staff A reported she went to the cart to verify that yes it was the wrong medication she gave to Resident #103. Staff A then went back to Resident #103 in the dining room and the daughter was with the resident. The daughter asked what was wrong with him. Staff A told the daughter at that time that she gave him the wrong medication. Staff A took him to his room and aides assisted him and she called the doctor and the doctor said to send him out. Staff A called 911 at that time. Staff A reported it is not her normal practice to give medications without verifying with the MAR or checking the name. Staff A reported I would never do that again. On 3/10/26 at 12:54 PM Staff B, CMA reported she worked on 1/31/26 as the medication aide. Staff B reported she gave Staff A, RN the keys to the medication cart to let her do the g-tube residents first since she cannot do them. Staff B reported she went to do other things and when she came back to the cart Staff A gave the keys back. Staff B reported a short while later she saw Staff A and she was looking around. Staff B then asked Staff A what she was looking for. Staff A reported a manual blood pressure cuff due to Resident #103 having a low blood pressure Staff B reported Resident #103 was doing good prior to this incident when she saw him go by for breakfast. Staff B reported that as long as she knew Resident #103 she never had heard of him having a low blood pressure that she was aware of, so she wondered about his medications. Staff B reported then looked into her medication cart and she noticed Staff A gave the wrong medications to Resident #103. Staff B reported she is not sure how Staff A made the error. Staff B reported she informed Staff A of the medication error and showed her whose meds she gave. Staff B then called for the Certified Nurses Aides to come help with Resident #103 so Staff A could do all the stuff she needed to for him. Staff B reported the daughter was here at the time of the incident and was upset. Staff B stayed in the dining room with the other residents while Staff A was working with Resident #103. Staff B reported she was not told to write a statement of what happened that day at all by the facility. On 3/10/26 at 3:30 PM the Administrator and Director of Nursing (DON) reported Staff A was verbally educated that day about the 6 rights of medication administration (the right of medication administration to ensure resident safety by verifying: right resident, right dose, right medication, right dose, right route, right time and right documentation). The DON reported the staff are trained on the 6 rights in orientation on the checklist during training. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 3/11/2026 at 10:35 AM the Medical Direct reported he filled out the he filled out Major Injury Determination Form on Resident #103 because he required hospitalization. The Medical Director reported the medications that were given could drop the resident's blood pressure and heart rate. He reported the medication error could have been prevented. The facility policy titled Medication Administration revised 2025 documented staff are to ensure the 6 rights of medication administration are followed, review the MAR to identify the medication to be administered, and compare the medication bubble pack with the MAR to verify resident name, medication name, form, dose, route and time. It further directed staff to sign the MAR after administration of the medication. 2. Resident #105's admission MDS assessment dated [DATE] identified a BIMS score as a 15, indicating intact cognition. The MDS listed diagnosis of dementia. Resident #105's Incident Report dated 2/1/26 documented Staff A, RN received Donepezil 10 mg from pharmacy, the medication was administered by Staff A upon receiving it. Staff B had the cart keys so the medication was placed in the computer on the medication cart and Staff A then went to the DON's office as requested. Upon Staff A returning to the floor Staff B reported she gave the pill that came from the pharmacy and Staff A then reported she had already given it. On 3/10/26 1:20 PM Administrator reported Staff A, RN gave the medication for the 2/1/26 med error but didn't sign it out when she gave it, left the meds at the cart and went to the DON because she was asking for her. Staff A reported Staff B saw the medication and didn't see it signed out so gave the medication and signed it off. Staff A reported to the Administrator when she came back to the floor, Staff B reported she started the medication for the resident. Staff A then reported to Staff B that she already gave it. An assessment done on the Resident #105 and no concerns noted. The Administrator reported the family, physician and DON notified of the medication error. On 3/10/26 at 1:49 PM Staff A, RN reported there was a medication that Resident #105 didn't have a certain medication at the time Staff B, CMA gave him his morning medications. Staff A reported when the medication came from the pharmacy and Staff A gave it to him. Staff A reported she didn't sign it out that she gave it to him on the MAR. Staff A reported she put the medication between the computer. Staff A reported she had compared it to the MAR but forgot to sign it out. Staff A reported she does not normally leave the medications out on the med cart they should be locked. Staff A reported it is not her normal process to not sign the medication once given. Immediately she was educated on the medication error. 3. The admission MDS assessment dated [DATE] revealed Resident #102 admitted to facility on 1/13/26 from the hospital and required after care following surgery on her digestive system. The resident also had diagnoses of cancer, anemia and diabetes. The MDS revealed the resident had a surgical wound and took opioid (narcotic) pain medication. The MDS documented the resident rated her pain at an 8 during the look-back period. The Care Plan initiated 1/14/26 revealed Resident #102 had a risk for pain related to rectal cancer. The resident had a surgical incision to the rectum and to the abdomen due to a colostomy site and JP drain. The Care Plan directed staff to administer scheduled/PRN (as needed) pain medications as ordered and monitor for medication effectiveness and side effects. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The Order Summary Report dated 1/14/26 revealed Tramadol 100 milligrams (mg) by mouth (PO) every 6 hours PRN for pain management started on 1/13/26. The Order Summary Report also revealed to give 2 tablets of Tramadol 50 mg PO every 6 hours PRN for pain with a note in capital letters: ORDER IS FOR 100 MG SO GIVE 2 TABS started on 1/19/26. A Medication Error report dated 1/19/26 at 11:00 AM revealed Resident #102 received Tramadol 50 mg PO every 6 hours on 1/16/26, 1/17/26, 1/18/26, and part of 1/19/26. The Order for Tramadol was for 100 mg every 6 hours. The resident did not know that she only received half the dose of the Tramadol. Nurse Practitioner (NP) was notified. New orders were written regarding the discrepancy. The Controlled Drug Receipt Form revealed 12-Tramadol 50 mg tablets received on 1/13/26. The label contained directions to take 1 tablet PO every 6 hours as needed but a line was drawn through hours as needed. Tramadol 50 mg was documented as removed and administered on 1/16 at 6 PM and 11:28 PM, on 1/17 at 5:05 AM, 11:45 AM, 6 PM, and 10:05 PM, on 1/18 at 5:05 AM, 12 PM, 5:10 PM and 11:05 PM and on 1/19 at 5 AM. A Controlled Drug Receipt Form revealed 60-Tramadol 50 mg tablets received on 1/17/26 and a 2 had been written over the 1 in the typed directions (to administer tablet PO every 6 hours). Documentation revealed that 2 tablets was documented as removed starting on 1/19 at 10:30 AM. The Medication Administration Record (MAR) dated 1/1/26 to 1/31/26 revealed the following: a.Tramadol 100 mg PRN administered on 1/13 and 1/14. b. Tramadol 100 mg (but only 50 mg was administered) documented as given 1/16 (6 PM dose), 1/17 x 4 (scheduled times: 12 AM-8AM-12PM-6PM), 1/18 x 4 (at scheduled times), 1/19 x 2 (for 12 AM and 6 AM dose) (but only 50 mg was administered). c. Two - Tramadol 50 mg tablets administered 1/19/26 (at 10:30 AM). d. Dilaudid 2 mg was administered on 1/19/26 starting at the 3:00 PM dose. Pain rated at 6. Progress Notes revealed: a. On 1/19/26 at 8:52 AM, the resident complained of her bottom hurting. Nurse and charge nurse assessed the area. Resident was originally admitted to the facility with absorbent sutures in place to the rectum. Suture site on admission was scabbed over and in the healing process. Upon assessing area this AM, sutures dehisced and exposed wound site about 4-5 cm (centimeter) in length and 2-3 cm in width. Call placed to the doctor. b. On 1/19/26 at 11:00 AM, charge nurse reported to nurse manager that a medication error had occurred on the resident. Hospital discharge orders on admit stating the following:Tramadol 100 mg (1-2 tablets) po every 6 hours PRN for pain management.Lower dose of Tramadol 100mg (1 tablet) po every 6 hours PRN was initiated on admission on [DATE]. On 1/16/26, a family member approached nurse to see about scheduling resident's pain medications due to increased discomfort because the resident will not ask for pain medication if she needed it. Tramadol order was changed to the following:Tramadol 100mg (1 tablet) po every 6 hours scheduled for pain management. Pharmacy was notified. Upon pharmacy delivery on 1/16/26, Tramadol 50 mg tablets were delivered to the facility. Scheduled Tramadol 50mg (1 tablet) was given every 6 hours on 1/16/26, 1/17/26, 1/18/26, and part of 1/19/26. Tramadol 100 mg was supposed to be given on these days, however, half the dose was given. Staff did not compare the bubble pack order to the order in the computer prior to giving the medication to the resident. Staff education provided. NP saw resident on rounds today and gave new orders regarding the discrepancy. c. On 1/19/26 at 1:32 PM, the NP documented that nursing requested her to visit the resident for reports of pain and rectum wound dehiscence. Resident reported pain 10/10 that is not relieved by current tramadol orders. Resident is on scheduled tramadol 100 mg every 6 hours. In an interview on 3/10/26 at 2:03 PM, Staff A, Registered Nurse (RN), reported the nurses and the Unit Manager entered the orders in the computer and processed the orders. (continued on next page)

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F 0760

Level of Harm - Actual harm

Residents Affected - Few

In an interview on 3/10/26 at 2:35 PM, Staff D, certified medication aide (CMA), reported she clicked on the resident's name on the MAR in the computer whenever she planned to pass medications. Staff D reported she pulled the medication card bubble pack and checked the name, medication and dose on the card. In an interview on 3/11/26 at 10:05 AM, Staff K, Assistant Director of Nursing (ADON), reported she expected staff who passed medications followed the 6 Rights of medication pass. She also expected staff to always compare the bubble pack to the physician's order. She expected the staff to come to her if they had any question or concern about a medication order so they could trouble shoot it. She also encouraged staff to look at the actual order. Staff K reported the nurse entered the physician's order and another nurse on duty or on the following shift double checked the orders. In an interview on 3/12/26 at 10:34 AM, Staff L, NP, reported she saw Resident #102 for an open rectal wound on 1/19/26. The resident had problems with pain during the course of her stay. The resident was getting PRN Tramadol, and then changed to getting Dilaudid in-between the doses of Tramadol. Staff L reported she made a lot of changes in the resident's medications, including changes from PRN to scheduled pain medication.

In an interview on 3/12/26 at 10:57 AM, Staff M, RN, reported Resident #102 had colon cancer and a colostomy. She had a lot of pain. The wound to her rectum dehisced and the nurses packed the wound. The resident originally was not honest about the pain. It was like she was always in pain and just dealt with it. Staff M reported she was aware there had been some mix up with the Tramadol. Resident #102 was started on one dose and changed to another dose to help with the pain. They eventually got her pain manageable. Staff M reported new orders entered by the ADON but the nurses also entered the physician's orders. Another nurse had to double check and note the orders. In an interview on 3/12/26 at 12:37 PM, Staff K, ADON, reported Resident #102's daughter came to her and said her mom felt like the pain medications were not working. Staff K reported she called the on-call Dr. The daughter wanted staff to give scheduled medication not PRN. Staff K got an order for the pain medication to be on scheduled times and an order to increase the Tramadol to 100 mg every 6 hours. The pharmacy had to call the on-call doctor because they wanted verbal verification on the dose because they thought the dose of 100 mg was kind of high on the Tramadol. Pharmacy wanted to make sure that the dose is what the provider wanted. At that time, Staff L, NP, said to go ahead and send the Tramadol but to make it into 50 mg tablets. The pharmacy sent the 100 mg tablets but cut the pill in half and placed the pills into the bubble pack. Staff K reported she told the nurses and CMA's to go by what the computer order showed not what the bubble pack says to do but the nurses followed the bubble pack directions not the order in the computer. Staff K reported she had called the doctor on a Friday to get orders for pain medication. The resident got 50 mg instead of 100 mg dose over the weekend. She got a 1/2 tab of the 100 (which was 50 mg) but the resident should have gotten 2 tablets of the 1/2 tab to make the 100 mg. Staff K reported the order was correct but the label on the bubble pack from pharmacy was different. The person who got the bubble pack from pharmacy should have put an alert such as check the MAR on the bubble pack. The nurses thought the tablets in the bubble pack was a full tablet not 1/2 tablet of the 100 mg tablet. Staff K reported the pharmacy delivered the medication. The nurse received the medication and signed off on the phone that the medication was received. Staff K stated she provided education to staff to make sure the order matched the computer and the bubble pack. If the bubble pack did not match the order in the computer, then a note or alert shall be placed on the bubble pack.

During an interview on 3/17/26 at 3:21 PM, the Administrator reported the QA team had worked on a Performance Improvement Projects (PIP) related to medication errors. The PIP included the staff education completed with all of the nurses and CMA's that passed medication, audits by the unit nurse manager of staff during medication pass ensuing the 6 Rights were followed, and staff education about communication amongst the nurses and CMA's. Two weeks prior to an incident with
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F 0760 Level of Harm - Actual harm Residents Affected - Few	a medication error, the facility began to schedule 1 nurse, 1 CMA, and 1 CNA on the skilled units. Before that time, they staffed 1 nurse and 2 CNA's on the unit but the nurses had difficulty getting assessments and the things that needed to be done. A CMA was added to help take the load off of the nurse. When they switched to 1 nurse and 1 CMA, they continued to use 1 medication cart for the nurse/ CMA to run off. After an medication error incident, a second cart was obtained and added on the unit. In addition to the Medication Error PIP, an audit on medication carts was done to ensure that the resident's medications were put in the correct place behind the room placard (in the medication cart). A medication error incident happened when the placard for 114 was placed in 115. Staff needed to make sure the placard was kept in the correct location in the medication cart. A room checklist was also implemented and included for staff to make sure the resident's picture was updated, and the room label had an updated resident's name. The facility also provided training on where staff can access policies. An undated Medication Administration policy revealed medication are administered as ordered by the physician in accordance with professional standards of practice. The following steps should be followed whenever a medication administered: 1.Review MAR to identify medication to be administered.2.Compare medication source (bubble pack, vial, etc.) with MAR to verify the resident's name, medication name, form, dose, route, and time.3. Ensure that the six rights of medication administration are followed:a. Right residentb. Right drugc. Right dosaged. Right routee. Right timef. Right documentation