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	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Bridges at Ankeny	3510 Northwest Ablilene 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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and documentation review, the facility failed to provide grooming for 1 of 3 residents reviewed (Resident #7). Resident #7 was noted to have caked dried on food in his mustache and beard on 2 separate days. Refusals of care were not documented. The facility reported a census of 96. Findings include:A Minimum Data Set (MDS) dated [DATE], documented diagnoses for Resident #7 included stroke, hemiplegia (loss of strength/movement on one side of the body), and non-Alzheimer's dementia. A Brief Interview for Mental Status (BIMS), documented this resident had a score of 3 out of 15, indicating that this resident had a sever cognitive deficit. Resident #7 required substantial to maximal assistance for personal hygiene, bathing, and transfers. On 6/8/26 at 3:45 p.m., Resident #7 was lying in bed. His beard and facial hair were crusted all around mouth with reddish dried on matter (food). This Resident did not answer when asked if staff help him with cleaning his beard. He looked away. On 6/9/26 at 10:20 a.m., this Resident was lying in bed. Lights were off in room. Had a container of scrambled eggs and toast on his tray table next to his bed. Resident appeared to have food/matter still dried on to his beard and facial hair. Resident would not answer questions and looked the other way. On 6/9/26 at 1:15 p.m., Resident #7 was lying in bed. Food was noted to be on his facial hair. On 6/9/26 at 2:05 p.m., this resident was lying in bed. The food remained on his beard and facial hair. On 6/9/26 at 3:31 p.m., The Lead Housekeeper was outside of his room. She stated she planned to clean his room next. She stated normally she has a male housekeeper clean his room because the resident can be so inappropriate. She said it's not the things he says, she said she can deal with that. She says it's what he does that is so inappropriate. Resident lying in bed. Food remained caked on his facial hair.On 6/9/26 at 3:45 p.m., The above observations were shared with the Director of Nursing (DON). She stated that this resident refuses cares all the time. This DON will look for documentation of the refusals. The DON asked Staff A, Licensed Practical Nurse (LPN), to go in to this resident's room with her for cares in pairs. This LPN responded he refuses all the time. The LPN was asked if this was documented and the LPN repeated that this resident refuses care all the time. Upon entrance to this resident, the DON asked Resident #7 if she could wash off his mustache and beard. DON started to wash the food of his beard. She stated It (the food) is stuck on there pretty good. The resident did not resist but stuck his hand underneath the covers and appeared to be pleasuring himself. This resident propositioned the DON sexually while she was washing his face. She was able to wash his mustache and beard with soap and water and then rinse with water using wash cloths. She asked if she could dry and he pushed her hand away and said no. She asked if there was anything else she could do for him before she left the room. Following the above observation the DON acknowledged that this resident's refusals to have his face washed had not been documented.On 6/29/26 at 10:18 a.m., Administrator and DON acknowledged that this resident had food dried on his beard and mustache after meals, which was not cleaned off. On 6/10/26 at 11:58 a.m., Staff B, Certified Nurse Aide (CNA), stated that yesterday morning, he had tried to wash Resident #7's face off. He stated he tried to wash his face off right before breakfast. He said that there had been debris in his beard for a long time. Staff B had tried to use a wash cloth to try and moisten it (the day before), but it was so hard that he couldn't get the debris off. He stated (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that later on he had tried to use wipes and tried using soapy water and the resident started pushing Staff B away. Staff B stated he tries to do as much for Resident #7 as he can because Resident #7 has behaviors toward women. Staff B stated that this resident doesn't have the sexual behavior toward men. Staff B stated that multiple female staff have asked Staff B to care for Resident #7 as they don't feel comfortable with him. On 6/10/26 at 12:30 p.m., the Administrator stated they know they need to document refusals and they are going to follow up with more education regarding how to care for Resident #7.An Activities of Daily Living policy copyright date of 2025, directed the following: Policy:The facility will, based on the resident's comprehensive assessment and consistent with the resident'sneeds and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration isunavoidable.Care and services will be provided for the following activities of daily living:1. Bathing, dressing, grooming and oral care;2. Transfer and ambulation;3. Toileting;4. Eating to include meals and snacks; and5. Using speech, language or other functional communication systems.Policy Explanation and Compliance Guidelines:1. Conditions which may demonstrate unavoidable decline in ADLs include:a. Natural progression of the resident's disease state with known functional decline.b. Deterioration of the resident's physical condition associated with the onset of an acutephysical or mental disability while receiving care to restore or maintain functional abilities.c. Refusal of care and treatment by the resident or his/her representative to maintain functionalabilities after efforts by the facility to inform and educate about the benefits/risks of theproposed care and treatment; counsel and/or offer alternatives to the resident or representative.2. The facility will provide a maintenance and restorative program to assist the resident in achieving andmaintaining the highest practicable outcome based on the comprehensive assessment.3. A resident who is unable to carry out activities of daily living will receive the necessary services tomaintain good nutrition, grooming, and personal and oral hygiene.4. The facility will identify resident triggers through the Care Area Assessment (CAA) process to assesscausal factors for decline, potential decline or lack of improvement.5. The facility will maintain individual objectives of the care plan and periodic review and evaluation.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview and policy review, the facility failed to notify a qualified staff member of an intravenous (IV) pump that was not working properly resulting in a delay of the resident's continuous IV medication for 1 of 5 residents reviewed for medication administration (Resident #12). The facility reported a census of 96 residents. The facility corrected the noncompliance prior to the beginning of the survey on 6/9/26 by doing the following; a. The scheduler was immediately educated on the need to ensure a registered nurse (RN) or licensed practical nurse (LPN) with IV certification was on the schedule at all times while an IV is in the building. b. The master schedule was reviewed to identify and areas of concern that may not have IV staff. c. Staff education to LPN's who are not certified included the purpose as follows; to ensure safe resident care and prevent delays in treatment, all nursing staff must understand expectations for IV-related issues when and IV-certified nurse is not immediately available. d. The scheduler will review daily schedules to ensure there are no gaps. e. In addition RN staffing and regulations were reviewed. Findings include: The Minimum Data Set (MDS) dated [DATE] revealed Resident #12 had a Brief Interview for Mental Status (BIMS) of 15 indicating intact cognition. The MDS further revealed the resident had diagnoses of sepsis (life threatening response to an infection) and osteomyelitis (infection of the bone). Review of the June Medication Administration Record (MAR) for Resident #12 revealed an order for continuous Nafcillin (antibiotic) sodium IV solution reconstituted with a start date of 5/6/26. Review of the Care Plan initiated 5/1/26 for Resident #12 revealed the resident had an acute infection of osteomyelitis of the thoracic vertebrae (middle spine) with sepsis and directed staff to administer antibiotics as ordered. During an interview 6/10/26 at 9:45 AM, Resident #12 revealed on 6/9/26 at approximately 4:00 AM he had utilized his call light to alert staff that the IV pump had an error code and was not operating. A staff member responded and stated they would notify the nurse however no one arrived for approximately 30 minutes. The resident stated he then walked to the nurse's station to notify staff of the IV pump not working and was told he would have to wait until shift change because there was currently no one at the facility that was IV certified. The resident stated he then waited until approximately 6:30 AM following the 6:00 AM shift change report to notify staff of the malfunctioning IV pump and a Registered Nurse (RN) adjusted the IV pump so that it was in working order. Review of the facility incident report dated 6/9/26 at 6:00 AM, Resident #12 reported the IV malfunctioned at approximately 4:00 AM the IV started to beep indicating it needed to be reset and the nurse was not able to reset the IV. This resulted in the resident missing 2 hours of the antibiotic. On 6/10/26 at 10:25 AM, the Administrator confirmed that Resident #12 did not receive his IV antibiotic as ordered on the morning of 6/9/26. The Administrator revealed a RN that usually covered the shift had been on leave at the time. The Administrator further revealed the Assistant Director of Nursing (ADON) had been on-call and covered 6/9/26 however the ADON left the facility around 3:30 AM. On 6/10/26 at 2:15 PM, the Administrator clarified that a Licensed Practical Nurse (LPN) with IV therapy certification had been on duty during the time Resident #12's IV pump malfunctioned on 6/9/26. However, the Administrator confirmed that facility personnel failed to notify the certified LPN of the malfunctioning IV pump after being alerted by the resident.Review of facility policy titled, Nursing Services and Sufficient Staff, dated 2025 revealed it is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.