| 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 04/04/2024 |
|---|---|---|---|
| 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) |
|---|---|
| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50471<br><br>Based on clinical record review, staff interview, and policy review, the facility failed to provide discharge and medical information to the receiving health care institution at the time of discharge for one of four residents reviewed who transferred to the hospital (Resident #76). The facility reported a census of 82 residents.<br><br>Findings include:<br><br>1. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #76 readmitted to the facility from the hospital on 2/11/2024.<br><br>Review of the facility's electronic medical record Census List revealed Resident #76 had transferred to the hospital on 2/11/2024, and readmitted to the facility on [DATE].<br><br>The Progress Note dated 2/11/2024 at 05:00 AM., documented that Resident #76 transported to hospital for placement of G-tube.<br><br>The clinical record lacked documentation of information sent when the resident transferred to the hospital on 2/11/2024.<br><br>During an interview 04/03/2024 at 4:17 PM, the Director of Nursing (DON) reported no transfer form completed whenever a resident had transferred or discharged from the facility. The DON reported staff should've provided copies of the face sheet, Medication Administration Record (MAR), Physician Orders for Life-Sustaining Treatment (IPOST), progress Notes/Dr Notes. The DON reported she expected staff call the hospital to give a report of the condition of the resident. The staff did not document sending any of the transfer paperwork with the resident to the Emergency Department (ED), or about calling report to the ED staff on 2/11/2024. The DON stated she expected the nursing staff document a progress note when they had called report to the ED and the documents sent to the facility.<br><br>In an email on 4/4/2024 at 1:40 PM, the Administrator wrote no policy for resident transfers to the hospital. Copies of the face sheet, MAR, POS (physician's order summary), IPOST, and pertinent labs/tests sent, along with the reason for transfer. A verbal report is given and any information from that report is what would be sent. |

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 |
|---|---|---|

| 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 04/04/2024 |
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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50471<br><br>Based on record review, staff interview, and policy review the facility failed to notify the Long Term Care (LTC) Ombudsman of a resident transfer as required for 1 of 4 residents reviewed who were transferred from the facility (Residents #76). The facility reported a census of 82 residents.<br><br>Findings include:<br><br>The Quarterly7 MDS (Minimum Data Set) assessment dated [DATE] and the Census List for Resident #76 documented that the resident had transferred from the facility on 2/11/2024, and reentered the facility on 2/11/2024.<br><br>The clinical record lacked documentation of notification to the LTC Ombudsman that Resident #76 had transferred to the hospital as required by federal regulation.<br><br>During an interview 04/03/2024 at 2:47 PM the Administrator and Administrator's Assistant stated the facility did not report to the Ombudsman whenever residents had an Emergency Department (ED) visit<br><br>In an email on 04/03/2024 at 01:47 PM, the Administrator wrote no ombudsman policy, they followed the state/federal regulations. |

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| The Bridges at Ankeny | 3510 Northwest Abilene Road<br>Ankeny, IA 50023 |

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| F 0641<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817<br><br>Based on clinical record review, staff interview, and policy review, the facility failed to accurately complete a Minimum Data Set (MDS) assessment for one of eighteen resident's reviewed in the sample (Residents #19). The facility reported a census of 82 residents.<br><br>Findings include:<br><br>The Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 admitted to the facility on [DATE] and had diagnoses of non-Alzheimer's dementia, anxiety disorder, depression, and bipolar disorder. The MDS documented the resident not currently considered by the state level II PASRR (pre-admission screening and record review) process to have serious mental illness and/or intellectual disability or a related condition.<br><br>The Care Plan revised 2/15/24 revealed the resident had a diagnoses of bipolar disease and at risk for extreme mood swings, agitation, and paranoia. The resident had a PASRR completed and a Level II determined.<br><br>The PASRR dated 1/26/24 revealed a Level II outcome. The PASRR included the resident's diagnoses of major depressive disorder, anxiety , Bipolar disorder, traumatic brain injury, and dementia.<br><br>In an interview 4/4/24 at 9:59 AM, Staff C, Social Services (SW), reported PASRR's completed by the hospital prior to admission, but the SW's completed PASRR's if a resident came from the community. Staff C reported Resident #19 had a Level II PASRR. Staff C reported she was in the process of making a psychiatric referral.<br><br>In an interview 4/4/24 at 1:21 PM, the Director of Nursing reported Staff D, Assistant Director of Nursing (ADON), completed the MDS assessment before 3/2024.<br><br>In an interview 4/4/24 at 2:47 PM, Staff D, ADON, reported she completed the residents MDS assessments prior to 3/2024. Staff D reported she got information to complete MDS assessments and Care Plans from the admission information, AM daily interdisciplinary meetings, therapy communication, and forms the nurse/certified nurses assistants filled out regarding updates. The surveyor reviewed the MDS assessment dated [DATE] for Resident #19 with Staff D. Staff D stated she planned to update and resubmit the updated information to CMS.<br><br>In an email 4/4/24 at 1:40 PM, the Administrator wrote they didn't have a PASRR policy.<br><br>A Behavioral Assessment, Intervention, and Monitoring policy revised 3/2019 revealed the [NAME] II PASRR evaluation report used when conducting the resident assessment and care plan development. |

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F 0644

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817

Based on clinical record review, staff interview, and policy review, the facility failed to develop and update the comprehensive Care Plan with Preadmission Screening and Resident Review (PASRR) Level II service recommendations for one of one resident reviewed who had a PASRR Level II determination (Residents #19). The facility reported a census of 82 residents.

Findings include:

The Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 admitted to the facility on [DATE] and had diagnoses of non-Alzheimer's dementia, anxiety disorder, depression, and bipolar disorder.

The Care Plan revised 2/15/24 revealed the resident had a diagnoses of bipolar disease and at risk for extreme mood swings, agitation, and paranoia. The resident had a PASRR completed and a Level II determined. The Care Plan directed staff to follow any specialized services and specialized rehabilitation services recommended. The Care Plan lacked the PASRR recommended services.

The PASRR dated 1/26/24 revealed a Level II outcome. The PASRR included the resident's diagnoses of major depressive disorder, anxiety , Bipolar disorder, traumatic brain injury, and dementia. The PASRR revealed the services and supports required included (but not limited to) ongoing psychiatric medication management by a psychiatrist or psychiatric nurse practitioner, obtaining psychiatric records, rehabilitative services, and community placement supports.

In an interview 4/4/24 at 9:59 AM, Staff C, Social Services (SW), reported PASRR's completed by the hospital prior to admission, but the SW's completed PASRR's if a resident came from the community. Staff C reported Resident #19 had a Level II PASRR. Staff C reported she was in the process of making a psychiatric referral. Staff C stated Care Plan included the PASRR information and she normally completed this section on the Care Plan. Staff C stated she was unaware she needed to put PASRR recommendations on the Care Plan.

In an interview 4/4/24 at 1:21 PM, the Director of Nursing reported the SW updated the resident's care plan for behaviors and PASRR.

In an interview 4/4/24 at 2:47 PM, Staff D, Assistant Director of Nursing (ADON), reported PASRR related information should be on the Care Plan.

In an email 4/4/24 at 1:40 PM, the Administrator wrote they didn't have a PASRR policy.

A Behavioral Assessment, Intervention, and Monitoring policy revised 3/2019 revealed the [NAME] II PASRR evaluation report used when conducting the resident assessment and care plan development.

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A Comprehensive Person-Centered Care Plan policy revised 3/2022 revealed Care Plans included measurable objectives and timetables to meet the resident's psychosocial, physical and functional needs. The Care Plan described the services furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being included any specialized services to be provided as a result of PASRR recommendations and the professional services responsible for each element of care. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48886<br><br>Based on observation, record review, family and staff interview and policy review, the facility failed to develop and implement a comprehensive person-centered care plan for 3 of 18 residents reviewed for care plans (Resident #48, #55 and #76). The facility reported a census of 82 residents.<br><br>Findings include:<br><br>1. The Entry Minimum Data Set (MDS) for Resident #48, with a date of 12/27/23, documents the resident was admitted to the care facility on 12/27/23 from a skilled nursing facility.<br><br>Review of the electronic health record (EHR) for Resident #48 reveals a progress note on 12/27/23, titled admission summary, documenting the resident admitted to the nursing facility with lower dentures.<br><br>During an interview 4/2/24 at 10:02 AM, a family member advised there have been times while visiting Resident #48 the resident did not have her dentures in, the resident has a partial lower plate.<br><br>During an observation 4/2/24 at 12:55 PM, Resident #48 was not wearing her dentures. This was during lunch service.<br><br>The Care Plan for Resident #48, with an initiation date of 12/27/23 and a revision date of 3/25/24, lacked interventions with regard to dentures and oral care for the resident.<br><br>During an interview 4/2/24 at 1:00 PM, Staff G, LPN, advised Resident #48 often refuses to wear her dentures and will often remove them if she allows them to be placed. The resident will refuse the paste/adhesive and this causes the dentures to move in her mouth. Staff G advised oral care is completed daily with the resident.<br><br>During an interview 4/2/24 at 2:18 PM, Staff H, social worker, advised a care conference was held the previous day for Resident #48 where the family mentioned the resident's dentures were bothering her. Staff H acknowledged dentures and oral care were not on the comprehensive care plan for Resident #48 and stated she would expect dentures and oral care to be present in the Care Plan.<br><br>Review of the facility policy titled Care Plans, Comprehensive Person-Centered, with a revision date of March 2022, documents a comprehensive, person-centered care plan that includes measurable objective and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.<br><br>49698<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. The Minimum Data Set (MDS) dated [DATE] revealed Resident #55 had a Brief Interview for Mental Status (BIMS) of 3, which indicated severe cognitive impairment. The MDS documented the resident had diagnoses of Non-Alzheimer's dementia, impaired mobility due to fracture of left femur, muscle weakness, and difficulty walking. Resident fully dependent for mobility and transfers. The MDS further documented the resident had one fall without injury and one fall with injury since admission on 1/24/24.<br><br>The fall risk assessment dated [DATE], revealed Resident #55 scored 23, which indicated high risk for falls.<br><br>Review of Resident #55's progress notes indicated the following:<br><br>Fall on 1/27/24, resident found face down from wheelchair, resulting in a bruise to her forehead.<br><br>Fall on 3/5/24, found on the floor after falling from wheelchair. Transferred to the ER (emergency room ) for sutures to laceration on face.<br><br>Fall on 3/9/24, found on the floor after trying to get out of bed independently. No injuries noted.<br><br>Review of fall investigation worksheet indicated the following interventions:<br><br>Fall on 1/27/24, placement of wedge cushion in wheelchair<br><br>Fall on 3/5/24, wheelchair seat was dropped in the back Fall on 3/9/24, overlay placed on bed<br><br>The Care Plan dated 1/24/2024 failed to indicate Resident #55 had a fall risk, and documentation of previous falls and the interventions put in place for fall prevention.<br><br>During an interview on 4/4/24 at 2:47 PM, Staff D, Assistant Director of Nursing (ADON), reported she completed Resident #55's MDS assessments prior to 3/2024. After 3/2024, the facility's MDS assessments were completed by the new company taking over the facility. Staff D reported she got information to complete MDS assessments and care plans from the admission information, daily interdisciplinary team (IDT) meetings, therapy communication, and forms the nurse/ Certified Nurses Aid (CNA) filled out regarding updates. She also got information for Care Plans from the CNA documentation, risk management, Dr progress notes, and from residents and staff. She indicated the Care Plans are updated as frequently as possible but she tried to get updates on the Care Plan within 24 hours after she received the information. She thought Resident #55's falls were listed on the Care Plan, but when the new company took over, things may have gotten changed. After 3/2024, different staff were responsible for entering certain areas, so things were a little confusing as to who was entering what things on the Care Plan.<br><br>Review of facility's Comprehensive Person-Centered Care Plan Policy, revised March 2022, documented the comprehensive, person-centered Care Plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or significant Change in Status), and no more than 21 days after admission. Assessments of residents are ongoing and Care Plans are revised as information about the residents and the residents' conditions change.<br><br>(continued on next page) |

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| | 165616 | A. Building<br>B. Wing | 04/04/2024 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 50471<br><br>3. The Quarterly MDS assessment dated [DATE] revealed Resident #76 dependent on care from the staff and had impaired range of motion on one side. The resident's diagnosis included: hemiplegia (paralysis on one side) and hemiparesis (muscle weakness on one side) following a cerebral infarction affecting the left non-dominant side, and seizure. The MDS documented the resident had no restraints.<br><br>Review of the Care Plan dated 02/27/2024 lacked information pertaining to a scoop mattress.<br><br>During observation on 04/02/24 at 09:28 AM, Resident #76 lying on a scoop mattress in bed.<br><br>In an interview on 4/3/24 at 3:20 PM, the DON stated they do not get orders for scoop mattresses as they are normally used for comfort/positioning. They would get an order if it would be used as a restraint. The DON reported the facility is a restraint free facility.<br><br>In an interview on 04/03/24 at 02:40 PM, the Assistant Director of Nursing (ADON) reported she believed the resident's family highly requested side rails for the resident upon admission. The facility does not allow side rails as they are considered a restraint After consideration, staff was able to offer the scoop mattress and the family accepted. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48886<br><br>Based on record review, staff interview and policy review, the facility failed to review and revise a resident's Care Plan (Resident #26) to meet the resident's needs for catheter care for 1 of 18 residents reviewed for comprehensive care plans. The facility reported a census of 82 residents.<br><br>Findings include:<br><br>The Admission Minimum Data Set (MDS) dated [DATE] for Resident #26 documented the resident had a Brief Interview for Mental Status (BIMS) of 8, which indicated moderately impaired cognition. The MDS further documented diagnoses to include medically complex conditions, cancer, heart failure, cirrhosis, septicemia (blood poisoning by bacteria) and urinary tract infection (in the last 30 days). The MDS documented the resident admitted [DATE] from a short-term general hospital.<br><br>Progress Note BAA-SNF/Covid assessment dated [DATE] at 7:00 PM documented as follows; incontinent of bowel and bladder, pull ups, briefs, urinal used every two hours, and as needed. No urinary catheter noted.<br><br>BAA-Order Note dated 2/28/24 at 3:41 PM directed staff to insert 16 French 10 milliliter Catheter due to urinary retention.<br><br>The Care Plan for Resident #26, with an initiation date of 2/22/24 and a revision date of 3/7/24, lacks documentation for interventions, goals or problem with regard to a catheter. The Care Plan documented the resident was an assist of 1 with toileting and did not contain a revision for the catheter insertion.<br><br>During an interview 4/4/24 at 11:04 AM, Staff D, Licensed Practical Nurse (LPN) and Assistant Director of Nursing (ADON), advised the catheter should have been added to the Care Plan as a revision once the catheter was placed. Staff D stated an expectation that the Care Plan be revised within 24 hours after a catheter is placed. Staff D acknowledged the Care Plan was not revised for the resident and this should have occurred.<br><br>Review of facility policy titled Care Plan, Comprehensive Person-Centered, with a revision date of March 2022, documents assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817<br><br>Based on clinical record review, observation, staff interview, manufacturer instructions, and policy review, the facility failed to assure a medication error rate of less than 5%. During observation of medication administration, the facility had 2 errors out of 32 opportunities for error resulting in an error rate of 6.25% (Residents #11). The facility identified a census of 82 residents.<br><br>Findings include:<br><br>1. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had diagnoses of diabetes. The MDS documented the resident took insulin during the 7-day lookback period.<br><br>The Medication Administration Record (MAR) for Resident #11 listed Glargine insulin 30 units subcutaneously (SQ) and Humalog (lispro) insulin 2 units SQ administered by Staff B, Licensed Practical Nurse (LPN) on 4/2/24 during the AM for diabetes.<br><br>During observation on 4/2/24 at 8:20 AM, Staff B, Licensed Practical Nurse (LPN), prepared to administer insulin for Resident #11. Staff B reported Resident #11's blood sugar 249. Staff B dialed the Lantus flexpen to 30 (units), and the Humalog flexpen to 2 (units). Staff B administered the Lantus insulin to the resident's right abdomen, then removed the needle after 2-3 seconds. The flexpen had a liquid solution streaming from the needle after Staff B pulled the needle from the resident's skin. At the time, Resident #11 reported she felt something dripped on her. Staff B told the resident it's ok. Staff B then administered the Humalog insulin to the resident's left abdomen, and removed the needle after 2-3 seconds. Staff B did not check to ensure the dial showed zero, or hold the Lantus flexpen with the needle in the skin for a count of at least 10 seconds after the medication administered, or hold the Humalog flexpen with the needle in the skin for a count of at least 5 seconds. Staff D, Assistant Director of Nursing (ADON), stood in the room and observed the insulin medication administrations with the surveyor.<br><br>In an interview 4/2/24 at 4:30 PM, Staff D, Assistant Director of Nursing (ADON), reported staff needed to allow several seconds after the insulin pen button pushed and before the insulin pen removed to allow instillation of the insulin medication dose. Staff D stated she was uncertain if the facility had a policy for insulin pen administration.<br><br>In an interview 4/4/24 at 1:30 PM, the Director of Nursing (DON) reported whenever insulin administered via pen, staff needed to hold the insulin pen for at least 5-6 seconds after the click to ensure the full insulin dose administered.<br><br>In an interview 4/4/24 at 2:00 PM, the Corporate Nurse reported whenever insulin administered via a pen, she expected the nurse waited at least 5 seconds before the insulin pen removed.<br><br>The Lantus manufacturer instructions dated 2022 revealed the following procedural steps when gave an insulin injection:<br><br>a. Turn the dose selector to the number of units needed<br><br>(continued on next page) |

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|---|---|
| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | b. Insert the needle into the skin<br><br>c. Press the injection button all the way down until the dose counter shows O. Slowly count to 10 before removing the needle from the skin to ensure the full insulin dose administered.<br><br>The manufacturers insert aslo included the following information; Glargine insulin (onset 1.5 hours max effect in 5 hours).<br><br>The Humalog manufacturer instructions reviewed 7/2023 revealed the following procedural steps when gave an insulin injection:<br><br>a. Turn the dose knob to select the number of units.<br><br>b. Insert the needle into the skin.<br><br>c. Push the dose knob all of the way in and continue to hold the dose knob in, then slowly count to 5 before the needle removed from the skin.<br><br>The Humalog insert also included the follsoing infromation; Humalog (onset 15 minutes max effect 1 to 2 hours).<br><br>A facility policy for Insulin Administration revised 9/2014 revealed: depress the plunger and remove the needle after five seconds whenever insulin injected. |

| 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 04/04/2024 |
| --- | --- | --- | --- |
| 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.

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| --- | --- |
| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817<br><br>Based on clinical record review, observation, staff interview, manufacturer's instructions, and policy review, the facility failed to administer two of two insulin flexpens properly to ensure the proper amount of insulin administered during medication pass (Resident #11). The facility reported a census of 82 residents.<br><br>Findings include:<br><br>The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had diagnoses of diabetes. The MDS documented the resident took insulin during the 7-day lookback period.<br><br>The Medication Administration Record (MAR) for Resident #11 listed Glargine insulin 30 units subcutaneously (SQ) and Humalog insulin 2 units SQ administered on 4/2/24 during the AM for diabetes by Staff B, Licensed Practical Nurse (LPN).<br><br>During observation on 4/2/24 at 8:20 AM, Staff B, LPN, prepared to administer insulin for Resident #11. Staff B reported Resident #11's blood sugar 249. Staff B dialed the Lantus flexpen to 30 (units), and the Humalog flexpen to 2 (units). Staff B administered the Lantus insulin to the resident's right abdomen, then removed the needle after 2-3 seconds. The flexpen had a liquid solution streaming from the needle after Staff B pulled the needle from the resident's skin. At the time, Resident #11 reported she felt something dripped on her. Staff B told the resident it's ok. Staff B then administered the Humalog insulin to the resident's left abdomen, and removed the needle after 2-3 seconds. Staff B did not check to ensure the dial showed zero, or hold the Lantus flexpen with the needle in the skin for a count of at least 10 seconds after the medication administered, or hold the Humalog flexpen with the needle in the skin for a count of at least 5 seconds. Staff D, Assistant Director of Nursing (ADON), stood in the room and observed the insulin medication administrations with the surveyor.<br><br>In an interview 4/2/24 at 4:30 PM, Staff D, ADON, reported staff needed to allow several seconds after the insulin pen button pushed and before the insulin pen removed to allow instillation of the insulin medication dose. Staff D stated she was uncertain if the facility had a policy for insulin pen administration.<br><br>In an interview 4/4/24 at 1:30 PM, the Director of Nursing (DON) reported whenever insulin administered via pen, staff needed to hold the insulin pen for at least 5-6 seconds after the click to ensure the full insulin dose administered.<br><br>In an interview 4/4/24 at 2:00 PM, the Corporate Nurse reported whenever insulin administered via a pen, she expected the nurse waited at least 5 seconds before the insulin pen removed.<br><br>The Lantus manufacturer instructions dated 2022 revealed the following procedural steps when gave an insulin injection:<br><br>a. Turn the dose selector to the number of units needed<br><br>(continued on next page) |

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| 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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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | b. Insert the needle into the skin<br><br>c. Press the injection button all the way down until the dose counter shows O. Slowly count to 10 before removing the needle from the skin to ensure the full insulin dose administered.<br><br>The Humalog manufacturer instructions reviewed 7/2023 revealed the following procedural steps when gave an insulin injection:<br><br>a. Turn the dose knob to select the number of units.<br><br>b. Insert the needle into the skin.<br><br>c. Push the dose knob all of the way in and continue to hold the dose knob in, then slowly count to 5 before the needle removed from the skin.<br><br>A facility policy for Insulin Administration revised 9/2014 revealed: depress the plunger and remove the needle after five seconds whenever insulin injected. |

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|---|---|---|---|
| | 165616 | A. Building<br>B. Wing | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Bridges at Ankeny | 3510 Northwest Abilene Road<br>Ankeny, IA 50023 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817<br><br>Based on record review, observations, staff interview, and policy review, the facility failed to ensure staff followed infection control practices to protect against cross contamination and potential spread of infection. The staff failed to utilize a barrier and disinfect contaminated equipment and surfaces after use for 1 of 6 units observed. The facility staff also failed to remove Personal Protective Equipment (PPE) prior to exit from an enhanced barrier precautions room for 1 of 6 units observed. The facility also failed to provide peri-care in a manner to prevent cross-contamination and infection for 1 of 3 residents observed for peri-care (Resident#11).The facility identified a census of 82 residents.<br><br>Findings include:<br><br>1. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had a Stage 2 pressure ulcer present.<br><br>The Care Plan revised 2/28/24 revealed Resident #11 had Stage 2 pressure ulcer to the left buttock and an acute infection.<br><br>Observations revealed the following:<br><br>a. On 4/1/24 at 11:26 AM, an Enhanced Barrier Precautions (EBP) sign posted on Resident #11's wall inside her room, and a 3-drawer bin with personal protective equipment (containing gown, gloves) sat on the floor near the door in the resident's room.<br><br>b. On 4/3/24 at 9:57 AM, Staff A, Certified Nursing Assistant (CNA), donned a yellow isolation gown and gloves prior to assisting Resident #11 to transfer from the wheelchair to the toilet. Staff A provided peri-care after the resident toileted. At 10:07 AM, Staff A transferred the resident from the toilet to a wheelchair using a gait belt after Staff I, Registered Nurse (RN), performed a treatment to the wound on Resident #11's bottom. At 10:15 AM, Staff A removed the gait belt around the resident, rolled the gait belt up, and placed the gait belt in her scrub pant pocket. Staff F, Assistant Director of Nursing (ADON) stood in the room and observed staff with the surveyor while cares performed.<br><br>During an interview 4/3/24 at 10:25 AM, Staff A, CNA, reported residents who had a wound are placed in EBP. PPE such as gown and gloves worn whenever performed cares and physically touched the resident.<br><br>During an interview 4/4/24 at 1:20 PM, the Director of Nursing (DON) reported she expected resident care equipment such as a gait belt left in the resident's room and used for that resident whenever a resident is in isolation /EBP.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. On 4/2/24 at 7:40 AM, Staff B, Licensed Practical Nurse (LPN), placed nasal spray, an inhaler, and eye drop medications/boxes into a plastic basin. Staff B took the plastic bin with the medications inside to Resident #11's room. Staff B placed the plastic bin on the resident's bed. After Staff B administered the medications, she placed the medications back into the medication boxes and then placed them back into the plastic bin. At 7:52 AM, Staff B took the plastic bin and sat it on the medication cart, then placed the eye drop, inhaler, and nasal spray medication boxes back into the medication cart. Staff B then placed the plastic bin on the counter by the nurse's station. Staff B did not disinfect the plastic bin. Staff D, ADON, observed Staff B with the surveyor.<br><br>During an interview 4/2/24 at 4:30 PM, Staff D, ADON, reported she expected staff used a barrier when placed equipment or supplies on surfaces such as an overbed table or the bed. Staff D reported she expected staff to disinfect the plastic bin after use, using disinfect wipes.<br><br>3. On 4/4/24 at 7:16 AM, Staff E, certified medical assistant, walked out of a resident room down the 400 hall and wore a blue isolation gown and gloves. Upon arrival to the medication cart, Staff E removed the gown, rolled the gown into a ball, walked across the hall toward the nurse's station and placed the gown into a trashcan. Staff E removed her gloves, opened the cupboard door, and obtained disinfectant wipes from the cupboard.<br><br>During an interview 4/4/24 at 1:20 PM, the DON reported she expected staff removed isolation gown and gloves before they left the resident's room.<br><br>An Enhanced Barrier Precautions Policy dated 3/25/24 revealed EBP's utilized to prevent or reduce the spread of multi-drug resistant organisms (MDROs) to residents.<br><br>An Isolation-Transmission Based Precautions policy revised 9/2022 revealed isolation gown and gloves removed before leaving the room. Precautions are additional measures that protect staff, visitors, and other residents from becoming infected. When precautions are in effect, non-critical resident care equipment such as a stethoscope, blood pressure monitor or other equipment dedicated to a single resident. If re-use of items is necessary then the equipment is cleaned and disinfected according to current guidelines before used on another resident.<br><br>48886<br><br>4. The Minimum Data Set (MDS) for Resident #9, dated 3/15/24, documents the resident is always incontinent of urine and frequently incontinent of bowel. The MDS further documents diagnoses to include debility, cardiorespiratory conditions, coronary artery disease, heart failure and renal insufficiency.<br><br>The Care Plan for Resident #9, with an initiation date of 4/2/24, documents under the problem section the resident is incontinent of bowel and bladder and instructs staff under the interventions section to clean peri-area with each incontinence episode.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation 4/2/24 at 2:34 PM, Staff J, Certified Nursing Assistant (CNA), began to perform peri care to Resident #9 after an episode of bowel incontinence, with Staff K, Assistant Director of Nursing (ADON), present. Staff J did not wash her hands prior to placing gloves on her hands to begin the peri care, and with a wipe cleaned back to front for the first swipe of peri care. The remaining wipes were performed front to back. The mechanical sling was left under the resident during the entirety of the peri care without a barrier placed between the sling and the resident.<br><br>During an interview 4/3/24 at 2:50 PM, Staff K, ADON, acknowledged a concern for infection control when Staff J wiped back to front during the peri care of Resident #9, and with the sling being present during the care without a barrier placed. Staff K advised there should have been a barrier between the sling and the skin for infection control.<br><br>Review of facility policy titled Perineal Care, with a revision date of February 2018, documents under the steps in the procedure section to wash and dry hands thoroughly, put on gloves, and wipe from front to back. |