

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 The Bridges at Ankeny		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**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.</p> <p>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.</p> <p>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, Ezetimibe (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)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The Order Summary Report dated 1/14/26 revealed Tramadol 100 milligrams (mg) by mouth (PO) (continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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 dehiscd 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.</p> <p>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 (continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure sanitary and safe conditions in the three kitchenettes and six service areas in the facility maintained for food services. These failures posed the risk of food borne illness to the residents receiving food from the kitchenettes and service areas. Maintain best practices in accordance with professional standards of food service safety. The deficient practice has the potential to result in food borne illness among the residents that consumed food from the kitchen. The facility reported a resident census of 90. Findings include:</p> <p>Observation on 3/10/2026 at 12:35 p.m. of the 100 hall and 200 hall kitchenette revealed a stainless steel prep counter that had a coffee maker and toaster placed on it with crumbs on top of the toaster and a white dried substance on the counter with debris on the counter and the stainless steel shelf above the counter with debris on it.</p> <p>Observation and interview on 3/10/2026 at 2:15 p.m. of the 300 hall and 400 hall kitchenette revealed the reach-in freezer with dried juice on the bottom, and the steam table with dried calcium deposits on the front and its lower shelf with calcium deposit buildup. Staff O, Dietary Aide and Cook, stated she had worked at the facility for two years and when asked regarding cleaning schedules, she was not aware of any posted cleaning schedules.</p> <p>Observation on 3/10/2026 at 2:53 p.m. of the 500 hall and 600 hall kitchenette revealed a fan on the floor with debris on the front guard of the fan. The lower shelf of the center island was covered with a whitish residue, and contained a cardboard box with a garbage liner and used meal slips inside, serving trays had been placed to the side of the box. Above the shelf there were dried drips of residue on the front of the stainless steel drawer beneath the counter of the center island.</p> <p>During an interview on 3/11/2026 at 9:50 a.m. with the Dietary Director revealed she had no cleaning schedules for the facility's kitchenettes and stated They [the dietary staff] are pretty good about cleaning up.</p> <p>Observation on 3/11/2026 in the 500 hall and 600 hall kitchenette of the noon meal service with Staff O, Dietary Aide/Cook revealed at:</p> <p>12:27 p.m., Staff O, put on a pair of disposable gloves and took 12 plates from a warmer and the meal slips and placed them on the steam table's counter and began plating the food for the noon meal with the same pair of gloves. With that pair of gloves on, she touched a spatula to serve the lasagna, a pair of tongs to place pieces of garlic bread, the sides of a salad bowl, and the individual resident's meal slip to place on a tray for serving. She then opened the fridge and took out a tray of individual salad dressings, placed the tray on the kitchenette's center island, and took one of the individual salad dressings and placed it on the resident's tray.</p> <p>12:30 p.m., she took off both of her gloves and put on another pair of gloves. She had not sanitized her hands after removing the gloves, or prior to putting on the clean pair of gloves. With those gloves on she served several meals, touching the plate, the handle of a spatula or a scoop to plate the lasagna, the tongs for the garlic bread, the resident's meal slip, and the sides of the salad bowl for each meal served.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>12:33 p.m., she removed that pair of gloves to review the meal slips and used a pair of scissors to cut some of the meal slips and placed one of the meal slips on the tray with the meal to be served. She then put on a clean pair of gloves, without sanitizing her hands, and plated several more resident meals for serving.</p> <p>12:36 p.m., she removed the pair of gloves, reviewed the meal slips and used the scissors to cut one of the meal slips and placed it on the tray with the meal to be served.</p> <p>12:37 p.m., she put on a clean pair of gloves, without sanitizing her hands, and plated more resident meals for serving.</p> <p>12:49 p.m., she took off her gloves, washed her hands in the kitchenette's hand sink rubbing her hands with antibacterial soap for approximately five seconds before rinsing off the soap and drying her hand and then put on a clean pair of gloves. With those same gloves on she touched a meal slip, a plate, the handle of the scoop to plate lasagna, the tongs to plate a piece of garlic bread, the sides of the lettuce bowl, and placed the plate on a tray for serving. She then touched the handles of the cart to reposition it in the doorway. She then continued to plate another meal with those same gloves on. She handled another plate, meal slip, scoop for the lasagna, tongs for the garlic bread, the sides of the lettuce bowl and placed the prepared plate and meal slip on a tray. With the same pair of gloves on, she prepared another plate, touching the plate, meal slip, scoop for lasagna, tongs for garlic bread, and lettuce bowl. She then, with the same pair of gloves on, unwrapped a package of hot dog buns and handled a ready-to-eat hot dog bun, removing the bun from the package and placed it on a plate and open the bun with those same gloved hands and used a scoop to place ground hot dog on the bun, and placed garlic bread on the plate and placed the plate on a tray to be served. She then continued to plate other resident meals for serving with the same gloved hands.</p> <p>12:56 p.m., she removed the pair of gloves, but failed to sanitize her hands.</p> <p>During an interview on 3/11/2026 at 1:02 p.m. with Staff O, Dietary Aide/Cook, the observations of her glove use were reviewed including her failure to wash her hands thoroughly after taking off a pair of gloves, and before putting on a clean pair of gloves, touching multiple surfaces that contaminated the gloves before handling the ready-to-eat hot dog bun, and not limiting glove use to only one task. Staff O, Dietary Aide/Cook, stated that she had been trained to wear gloves while she was plating resident meals for meal service, and agreed that she had touched multiple surfaces prior to handling the hot dog bun.</p> <p>During an interview on 3/11/2026 at 1:06 p.m. with the Dietary Director revealed she stated she encouraged dietary staff not to wear gloves when preparing and serving resident meals.</p> <p>Review of Staff O, Dietary Aide/Cook's Employee Personnel File revealed she had been hired on 7/9/2024 and had signed the facility's Ready to Eat (RTE) Foods and Glove Use policy on 6/27/2024 that stated The FDA Food Code prohibits handling of RTE foods with bare hands. This applies during food preparation. A glove may be used to handle RTC foods if absolutely necessary. The following steps must be taken with GLOVE USE:</p> <ol style="list-style-type: none"> 1. You MUST wash your hands thoroughly before putting on the glove(s): this is a Food Code Rule!!! 2. A glove must be limited to one task only- thus the term Single Use. Once you don the glove(s) and leave the task to open a refrigerator, oven , box, bag, etc., the glove(s) is contaminated and must be (continued on next page) 		

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NAME OF PROVIDER OR SUPPLIER The Bridges at Ankeny		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>removed/replaced before returning to handling the RTE food item(s). Wash hands again before donning a new glove.</p> <p>I have read and understand that I cannot touch any ready to eat (RTE) foods with my bare hands and must follow the above procedures for glove usage.</p> <p>&emsp;</p> <p>Observation on 3/12/2026 at 11:38 a.m. of the 500 hall Dining Room Serving Area revealed the microwave with food debris in it and the ice scoop's plastic holder affixed to a wall was dirty.</p> <p>During an interview on 3/12/2026 at 11:54 a.m. with the Dietary Director, the lack of cleanliness of the facility's kitchenettes and dining room serving areas, including dried juice spills on the bottom of fridges in the serving area, debris in the microwaves, shelves noted to have dried substances and debris, ice machines with dried substances was discussed. She stated that she had scheduled a staff person to work every other week on a cleaning list she compiled.</p> <p>During an interview on 3/12/2026 at 1:10 p.m. with the Administrator revealed her expectation that the dietary staff should have, and follow cleaning schedules. She agreed that dietary staff should use a clean pair of one-use gloves prior to handling a ready-to-eat food items.</p> <p>Review of the facility policy Sanitization, revised November 2022 revealed The food service area is maintained in a clean and sanitary manner:</p> <p>All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris,.</p> <p>All. counters, shelves and equipment are kept clean.</p> <p>2. A direct, continuous observation of the 600 hall dining room on 03/10/2026 beginning at 12:06 PM and ending at 12:55 PM revealed the following:At 12:06 PM Staff P, CNA, was observed touching various unsanitary surfaces including the wheels of a wheel chair and then, without hand hygiene, serving food to residents. At 12:12 PM Staff P continuously served meals to residents with her thumb on the eating surfaces of a residents dishware as she served food to residents. Again no hand hygiene was observed. At 12:17 PM Staff P was observed direct bare-skin contact with what was later identified as a Turkey Rueben Sandwich, this was served to the resident and consumed.</p> <p>A direct, continuous observation of the 600 hall dining room on 03/11/2026 beginning at 12:08 PM and ending at 12:34 PM revealed the following:At 12:32 PM Staff Q, CNA, was observed to be making direct bare-skin contact with a residents garlic bread, it was then served to the resident and consumed. At 12:33 PM Staff P was observed to be again making direct bare-skin contact with a residents food, it was then served to the resident. In an interview on 03/12/2026 at 11:28 AM with Staff D, CNA, she stated facility staff are not allowed to touch a resident's food, and staff should wash their hands in between each resident. In an interview on 03/12/2026 at 11:45 AM with Staff H, CNA, she stated staff should not touch food when serving it to residents. She stated staff should also keep their fingers and thumb away from the top of the dish so as to avoid the serving areas of the plates and bowls. In an interview on 03/12/2026 at 11:34 AM with Staff I, Licensed Practical Nurse (LPN), she stated staff members cannot touch a residents food with their bare hands. She added staff should also avoid touching the tops of a residents plate to avoid cross contamination. (continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 03/12/2026 at 11:12 AM with Staff J, RN, she stated staff members should avoid touching a resident's food when serving them. Review of a facility provided document titled Food Preparation and Service, with a last revised date of November 2022, stated in the section labeled General Guidelines Cross-contamination can occur when harmful substances, ie chemicals or disease-causing microorganisms are transferred to food by hands. In the section labeled Food Distribution and Service it documents Bare hand contact with food is prohibited.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff interviews and policy review, the facility failed to implement Transmission Based Precautions (TBP) for 1 of 2 residents reviewed for TBP (Resident #5). The facility also failed to demonstrate proper mechanical lift sanitation practices and Personal Protective Equipment (PPE) use to prevent cross contamination for 3 of 6 units reviewed for infection control (Units #100, #500 and #600). The facility failed to provide filter changes/cleaning to a non-invasive device (BiPAP) machine for 1 of 1 residents reviewed for BiPAP use (Resident#1). The facility reported a census of 90. Findings include: 1. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had diagnoses of pneumonia, sepsis and obstructive sleep apnea. It also indicated that she did not have a BiPAP or had used it in the last 14 days. She had a Brief Interview for Mental Status (BIMS) score of 15.</p> <p>The Care Plan initiated on 2/27/26 indicated that Resident #1 had an altered respiratory status and diagnoses of pneumonia and obstructive sleep apnea. It lacked documentation of BiPAP use.</p> <p>The Nursing Admission/readmission assessment dated [DATE] indicated under the respiratory assessment that Resident #1 used a BiPAP and had a diagnoses of sepsis, pneumonia and obstructive sleep apnea.</p> <p>During an observation on 3/09/26 at 2:37 PM Resident #1 had a BiPAP device on her face and the machine was running when the surveyor entered the room. She removed the device to talk with the surveyor.</p> <p>During an observation on 3/11/26 at 1:20 PM Resident #1 had a BiPAP machine in her room on the bedside table.</p> <p>In an interview on 3/11/26 at 1:20 PM Resident #1 stated she was on a BiPAP that she takes care of. The staff only fills the water tank for it. She added that the facility ordered a tubing replacement for her.</p> <p>In an interview on 3/11/26 at 2:15 PM Staff F, Registered Nurse (RN) stated that a resident on a BiPAP should have an order for it that would include washing the mask and refilling the water reservoir. There should also be a place to document when the BiPAP is on and off as well.</p> <p>In an interview on 3/11/26 at 2:45 PM with the Assistant Director of Nursing (ADON), Administrator and the Regional Director of Clinical Services, the Regional Director of Clinical Services stated that Resident #1 was not using her BiPAP. The ADON agreed. The surveyor informed them of an observation of her using her BiPAP as well as Resident #1 stating that staff fill the water for her BiPAP. All stated they were unaware she was using her BiPAP.</p> <p>In an interview on 3/12/26 at 12:10 PM the ADON stated that Resident #1 should have had orders for her BiPAP but she was not aware she had one as the family brought in over the weekend. She stated that she has an order template that she uses that says to obtain in home settings and to assist with water in the reservoir. She spoke with Resident #1 and saw her BiPAP. Resident #1 told her that the staff were filling her water reservoir.</p> <p>A policy titled Noninvasive Ventilation (CPAP, BiPAP, AVAPS, Trilogy&trade;) dated 2025 indicated (continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>that the facility will obtain an order for the use of a CPAP, BiPAP, AVAPS or Trilogy® device and settings from the practitioner. It also indicated that:</p> <p>a. A personal CPAP/BiPAP/AVAPS/Trilogy® device may/may not be brought into the facility for the resident's use. If brought in, the nurse/respiratory therapist will verify the settings on the machine prior to use.</p> <p>b. The facility will follow the manufacturer's instructions for use of the machine.</p> <p>c. Nursing will assess the skin integrity around the mask site daily to ensure there is no impairments to the skin. Treat as per physician's orders if noted.</p> <p>d. Document use of the machine, resident's tolerance, any skin, respiratory or other changes and response(s).</p> <p>e. Follow manufacturer instructions for the frequency of cleaning/replacing filters and servicing the machine. Only the supplier may service the machine.</p> <p>f. Replace equipment immediately when it is broken or malfunctions, or if visible soiling remains after cleaning.</p> <p>The residents clinical record lacked documentation of cleaning/replacement of filters to the BiPAP machine for Resident#1.</p> <p>2. Resident #19's Electronic Health Record revealed: Clinical Orders for a respiratory panel and a portable chest x-ray for cough, shortness of breath and wheezing ordered on 3/2/26. Droplet isolation precautions started on 3/3/26. This order was revised on 3/11/26 to include Contact/Droplet isolation (Airborne N-95 use required) due to highly contagious pathogen COVID-19).</p> <p>Progress Notes for Resident #19 revealed: a. On 3/2/26 at 2:50 PM, the resident had a cough and expiratory wheezes bilaterally, and complained of a headache. b. On 3/3/26 at 12:04 PM, the resident was positive for COVID and in droplet precautions.</p> <p>The Care Plan initiated on 3/3/26 revealed Resident #19 tested positive for COVID-19 and was placed on droplet isolation. The Care Plan directed staff to follow Center for Disease Control (CDC) recommendations and the facility's protocol.</p> <p>Observations revealed the following: a. On 3/9/26 at 12:16 PM, a Droplet Precautions sign hung on the wall by the resident's door. A date of 3/13/26 indicated the end date of the isolation. A plastic bin with drawers was by the door outside the room and contained face shields, gloves, and masks.b. On 3/9/26 at 12:18 PM, a female staff member donned a yellow gown, donned a N95 mask over the surgical mask she already had on her face, and donned a pair of gloves. The staff member entered the room. At 12:21 PM, the female staff member exited the resident's room without the N95 mask, gown and gloves but continued to wear the surgical mask and walked down the hall.</p> <p>In an interview on 3/12/26 at 10:06 AM, Staff C, IP, stated that staff should not be wearing a surgical mask under an N95 mask.</p> <p>A COVID-19 Policy Guidelines revealed the facility had established protocol for the prevention and (continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>spread of COVID-19 in accordance with the CDC, CMS and State agencies.</p> <p>A Donning and Doffing PPE sign on the wall by the resident's room revealed: To [NAME] (put on the gear) -a. Perform hand hygiene.b. [NAME] isolation gown.c. Put on N95 facepiece. Do not wear facemask under your chin or store in pocket between residents. d. [NAME] a face shield or goggles. e. Put on gloves. f. Enter the resident's room.</p> <p>To Doff (take off the gear) - a. Remove gloves and gown.b. Exit the room.c. Perform hand hygiene.d. Remove face shield.e. Remove respirator / face mask.f. Perform hand hygiene.</p> <p>3. During a direct observation on 03/10/2026 at 01:46 PM an unknown staff member was observed taking a mechanical lift from room [ROOM NUMBER] and moving to it room [ROOM NUMBER] without sanitation.</p> <p>During a direct observation on 03/11/2026 at 11:38 AM, a mechanical lift was removed from room [ROOM NUMBER]. Without sanitation it was carried down the hallway by Staff Q, Certified Nurses Aide (CNA), to room [ROOM NUMBER] and used to transfer the resident.</p> <p>In an interview on 03/12/2026 at 11:45 AM with Staff H, CNA, she stated you have to wipe down mechanical lifts after leaving a residents room and before entering the residents room. During the interview her coworker, Staff R, CNA, took the mechanical lift from room [ROOM NUMBER] and without sanitizing it took it into room [ROOM NUMBER] to transfer the resident. In an interview on 03/12/2026 at 11:28 AM with Staff D, CNA, she stated mechanical lifts have to be cleaned before and after transferring each resident. In an interview on 03/12/2026 at 11:34 AM with Staff I, Licensed Practical Nurse (LPN), she stated mechanical lifts have to be sanitized before use with either purple top cleaning wipes or a spray that is maintained by the facility. In an interview on 03/12/2026 at 11:12 AM with Staff J, Registered Nurse (RN), she stated mechanical lifts should be cleaned in between each resident with cleaning supplies stored at all of the nurses stations. In a interview on 3/12/26 at 10:06 AM Staff C, Infection Preventionist (IP) stated that mechanical lifts should be cleaned between different residents. Purple top wipes are available at each nurse's station. Review of a facility provided document titled Cleaning and Disinfection of Resident-Care Equipment, with a copyright date of 2025, documented the following: Staff shall follow established infection control principles for cleaning and disinfecting reusable, noncritical equipment. General guidelines include: a. Verify whether the equipment is single-use or reusable. Discard single-use items after use. b. Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident. c. Direct care staff are responsible for cleaning single-resident equipment when visibly soiled, and according to routine schedule (where applicable). d. Multiple-resident use equipment shall be cleaned and disinfected after each use</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff interviews, and policy review, the facility failed to obtain orders and accurate settings for a Bilevel Positive Airway Pressure (BiPAP) to ensure safe and accurate delivery of respiratory therapy for 1 of 2 resident reviewed for respiratory care (Resident #1). The facility reported a census of 90 residents. Findings include: The Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had diagnoses of pneumonia, sepsis and obstructive sleep apnea. It also indicated that she did not have a non-invasive mechanical ventilator (BiPAP) or had used it in the last 14 days. She had a Brief Interview for Mental Status (BIMS) score of 15. The Care Plan initiated on 2/27/26 indicated that Resident #1 had an altered respiratory status and diagnoses of pneumonia and obstructive sleep apnea. It lacked documentation of BiPAP use. The Nursing Admission/readmission assessment dated [DATE] indicated under the respiratory assessment that Resident #1 used a BiPAP and had a diagnoses of sepsis, pneumonia and obstructive sleep apnea. During an observation on 3/09/26 at 2:37 PM Resident #1 had a BiPAP device on her face and the machine was running when the surveyor entered the room. She removed the device to talk with the surveyor. During an observation on 3/11/26 at 1:20 PM Resident #1 had a BiPAP machine in her room on the bedside table. In an interview on 3/11/26 at 1:20 PM Resident #1 stated she was on a BiPAP that she takes care of. The staff only fills the water tank for it. She added that the facility ordered a tubing replacement for her. In an interview on 3/11/26 at 2:15 PM Staff F, Registered Nurse (RN) stated that a resident on a BiPAP should have an order for it that would include washing the mask and refilling the water reservoir. There should also be a place to document when the BiPAP is on and off as well. In an interview on 3/11/26 at 2:45 PM with the Assistant Director of Nursing (ADON), Administrator and the Regional Director of Clinical Services, the Regional Director of Clinical Services stated that Resident #1 was not using her BiPAP. The ADON agreed. The surveyor informed them of an observation of her using her BiPAP as well as Resident #1 stating that staff fill the water for her BiPAP. All stated they were unaware she was using her BiPAP. In an interview on 3/12/26 at 12:10 PM the ADON stated that Resident #1 should have had orders for her BiPAP but she was not aware she had one as the family brought in over the weekend. She stated that she has an order template that she uses that says to obtain in home settings and to assist with water in the reservoir. She spoke with Resident #1 and saw her BiPAP. Resident #1 told her that the staff were filling her water reservoir. A policy titled Noninvasive Ventilation (CPAP, BiPAP, AVAPS, Trilogy?) dated 2025 indicated that the facility will obtain an order for the use of a CPAP, BiPAP, AVAPS or Trilogy? device and settings from the practitioner. It also indicated that: a. A personal CPAP/BiPAP/AVAPS/Trilogy? device may/may not be brought into the facility for the resident's use. If brought in, the nurse/respiratory therapist will verify the settings on the machine prior to use. b. The facility will follow the manufacturer's instructions for use of the machine. c. Nursing will assess the skin integrity around the mask site daily to ensure there is no impairments to the skin. Treat as per physician's orders if noted. d. Document use of the machine, resident's tolerance, any skin, respiratory or other changes and response(s). e. Follow manufacturer instructions for the frequency of cleaning/replacing filters and servicing the machine. Only the supplier may service the machine. f. Replace equipment immediately when it is broken or malfunctions, or if visible soiling remains after cleaning.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Post nurse staffing information every day.</p> <p>Based on observations, staff interviews, and facility policy review, the facility failed to ensure the daily nurse staffing information was posted for 18 days of the 31 days reviewed (February 10 to March 12, 2026). This failed practice had the potential to affect all residents residing in the facility and their representatives, visitors, and others who wanted to review the facility's current staffing levels. The facility reported a census of 90 residents. Findings include: Observation on 3/10/2026 at 1:43 p.m. revealed the daily staff posting, located at the front of the building, to the right of the administrator's office was dated 2/28/2026. Previous postings were behind the 2/28/2026 form and included postings for February 10th, 12th through 19th, 24th through 26th, and 28th. There were no postings found for February 11th, 20th, 21st, 22nd, 23rd, 27th and after the February 28th posting. Observation on 3/11/2026 at 7:20 a.m. revealed the daily staff posting by the administrator's office remained the 2/28/2026 posted form. Observation on 3/12/2026 at 7:35 a.m. revealed the daily staff posting by the administrator's office remained the 2/28/2026 posted form. During an interview on 3/12/2026 at 12:34 p.m., Staff N, Staffing Coordinator, stated she had worked at the facility since September 2025 and was responsible for posting the daily nurse staffing information which she posted beside the administrator's office. Staff N stated the payroll system she had used gave her the option to print a computerized Daily Nurse Staffing form that she posted. She stated she worked Monday through Friday and on Friday she would print the Daily Nurse Staffing forms for Friday, Saturday, Sunday, and Monday. She would then post those forms with the Friday form facing out. She stated that occasionally she noticed on Tuesday morning that the Friday posting from the prior week was still posted and had not been changed daily by the staff. She was not aware of who was responsible to change the form on the weekends. Staff N revealed that a new payroll system had been implemented by the facility on March 1st, 2026 and she was not sure how to post the required Daily Nurse Staffing form. She stated the new payroll system did not have option to print a Daily Nurse Staffing form. During an interview on 3/12/2026 at 1:05 p.m. with the Administrator regarding the required posting of the Daily Nurse Staffing report, she was not aware the Daily Nurse Staffing Report had not been posted daily since March 1, 2026 and was unaware that the new payroll system had no option to print the report. After reviewing the postings by her office, she agreed that the Daily Nurse Staffing had not been posted since February 28, 2026. Review of the facility's policy Posting Direct Care Daily Staffing Numbers, revised July 2016 revealed Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. The daily posting would be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. The form must be legible so that staffing data can be easily seen and read by residents, staff, visitors or others who are interested in our facility's daily staffing information.</p>		