| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>-<br>Correction Date: 7-23-21<br><br>The Iowa Department of Inspections and Appeals (DIA) in accordance with the Medicare Conditions of Participation set forth in 42 CFR 483, Subpart B-C, conducted this Medicare Recertification Survey and Investigation of complaints. The facility was found to be NOT IN COMPLIANCE.<br><br>Total residents: 37<br><br>Survey dates: 6/14/2021 - 6/23/2021<br><br>Complaint # reviewed:<br><br>#92293-C not substantiated<br>#94662-C not substantiated<br>#96240-C substantiated<br>#96419-C substantiated | F 000 | | |
| F 577 SS=C | -<br>Right to Survey Results/Advocate Agency Info<br>CFR(s): 483.10(g)(10)(11)<br><br>§483.10(g)(10) The resident has the right to-<br>(i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and<br>(ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.<br><br>§483.10(g)(11) The facility must-- | F 577 | | |

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

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 577 | Continued From page 1<br>(i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.<br>(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and<br>(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.<br>(iv) The facility shall not make available identifying information about complainants or residents.<br>This REQUIREMENT is not met as evidenced by:<br>-<br>Based on observation, policy review, resident group interview, and staff interview, the facility failed to place survey results in an accessible area for residents and family to examine. The facility reported a census of 37 residents.<br><br>Findings:<br><br>During an interview on 6/14/21 at 1:30 p.m., resident group members stated they did not know where the survey results were located and did not recall seeing them anywhere.<br><br>Observation 6/14/21, 6/15/21, and 6/16/21 revealed no survey results posted within either long-term care unit, Bluestem/Aster or Loden/Woodbine. Each unit required a code or keycard to exit through locked doors. Throughout the week, the survey binder was located outside the 2 units past the locked doors on the wall near the Director of Nursing's office. | F 577 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 577 | Continued From page 2<br><br>Review of the facility policy titled, "Resident Rights", revised 12/2019, stated the resident had the right to examine survey results and the results should be readily accessible to residents and families.<br><br>During an interview on 6/15/21 at 12:30 p.m., the DON stated the residents would not have any reason to leave the long-term care units to be out in the hallway (the location of the survey binder) unless they were with activities.<br><br>During interview and observation on 6/17/21 at 7:00 a.m., the surveyor toured both long-term care units with the DON and did not locate the survey results. The DON stated the survey results were not accessible since the residents could not get to the hallway outside the units without staff assistance. | F 577 | | |
| F 580 SS=E | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, | F 580 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 3<br>a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>-<br>Based on staff interview, clinical record review, and facility policy, the facility failed to notify the physician and/or resident representative of a fall | F 580 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 4 | F 580 | | |

for 3 of 3 residents reviewed for falls(Residents #85, #26, and #27), failed to notify the physician and/or resident representative of a weight change for 1 of 2 residents reviewed for nutrition(Resident #26), and failed to notify the physician and/or the resident representative of a skin concern for 1 of 1 residents reviewed for a skin condition(Resident #86) The facility reported a census of 37 residents.

Findings:

1. The MDS(Minimum Data Set) assessment tool, dated 1/20/21, listed diagnoses for Resident #85 as traumatic brain injury, history of falling, and muscle weakness. The MDS stated the resident required extensive assistance of 1 staff for bed mobility, transfers, walking, dressing, toilet use, personal hygiene, and bathing and listed her BIMS (Brief Interview for Mental Status) score as 15 out of 15, indicating intact cognition. The MDS stated the resident had 1 fall with no injury and 1 fall with a non-major injury during the review period.

Review of a 2/19/21 facility document titled "Unwitnessed", dated 2/19/21, stated staff found the resident lying on the floor between her recliner and the bed. The resident stated she slid down from the recliner as she was waiting for help to get her to the commode.

Review of a 2/23/21 Skin and Wound Evaluation document showed the resident had a bruise to her face 5.8 cm(centimeters) x 4.4 cm(length x width) and that the resident and staff stated the bruise was a result of a fall "on Friday".

Review of a 2/23/21 ARNP (Advanced Registered

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 5<br>Nurse Practitioner) progress note stated the resident's skin was warm and dry and did not note the resident had a bruise.<br><br>The facility lacked documentation of physician and family notification of the 2/19/21 fall and of the bruise.<br><br>The resident's current Care Plan did not address the resident's falls.<br><br>During an interview on 6/21/21 at 12:19 p.m., the DON (Director of Nursing) stated she did not locate any documentation of physician or family notification for Resident #85's 2/19/21 fall or subsequent bruise.<br><br>During an interview on 6/22/21 at 2:11 p.m., Staff D ARNP (Advanced Registered Nurse Practitioner) stated she had a virtual visit via the computer with the resident on 2/23/21. She stated she did not remember observing any bruises and did not remember the facility notifying her of a bruise but stated she would like them to.<br><br>2. The MDS assessment tool, dated 5/5/21, listed diagnoses for Resident #26 as cancer, cerebrovascular accident (stroke), and non-Alzheimer's dementia. The MDS stated the resident required extensive assistance of 1 staff for personal hygiene, extensive assistance of 2 staff for bed mobility, dressing, and toilet use, and depended completely on 2 staff for transfers. The MDS listed the resident's BIMS score as 4 out of 15, indicating severely impaired cognition.<br><br>Review of a facility report titled "Fall During Staff", dated 1/21/21, noted the resident transferred with staff assistance and was too weak to get all the | F 580 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 6<br>way to her destination and assisted to the ground by staff.<br><br>The facility lacked documentation of family notification of the event.<br><br>Review of the resident's Weights and Vitals report listed the following weights:<br>a. 1/12/21 164.6 lbs.<br>b. 5/25/21 194.2 lbs.<br>Showing the difference in weight calculated as 17.98%<br><br>The facility lacked documentation of physician notification of the resident's weight gain<br><br>Review of a Care Plan entry, dated 12/29/19, directed staff to weigh the resident per the facility policy.<br><br>During an interview on 6/16/21 at 2:40 p.m., the DON stated she did not locate family notification of Resident #26's 1/21/21 fall or physician notification of the resident's weight gain.<br><br>During an interview on 6/22/21 at 12:51 p.m., the DON stated if the resident had a significant weight gain; the facility should notify the physician.<br><br>3. The MDS assessment tool, dated 5/9/21, listed diagnoses for Resident #27 as cerebrovascular accident, non-Alzheimer's dementia, and depression. The MDS stated the resident required extensive assistance of 1 staff for bed mobility, transfers, walking, personal hygiene, and bathing, and depended completely on 1 staff for dressing and toilet use. The MDS | F 580 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 7<br>listed the resident's BIMS score as 3 out of 15, indicating severely impaired cognition.<br><br>Review of a 2/14/21 facility document titled "Unwitnessed", dated 2/14/21, stated staff found the resident on the floor leaning on the doorjamb. The resident stated she got out of bed and crawled to the door.<br><br>The facility lacked documentation of physician or family notification of the fall.<br><br>Review of a Care Plan entry, revised 4/6/21, stated the resident was at risk for falls.<br><br>During an interview on 6/17/21 at 10:00 a.m., the DON stated she could not locate documentation of physician or family notification of Resident #27's 2/14/21 fall.<br><br>4. The MDS assessment tool, dated 11/9/20 listed diagnoses for Resident #86 as heart failure, diabetes, and obesity. The MDS stated the resident required extensive assistance of 1 staff for bed mobility, walking, dressing, toilet use, personal hygiene, and bathing, and extensive assistance of 2 staff for transfers. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition.<br><br>Review of an 11/23/21 OT (Occupational Therapy) Discharge Instructions sheet stated the resident "now with sore area on bottom".<br><br>The facility lacked documentation of further assessments of the area, physician notification, and the initiation of a treatment. | F 580 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 8<br>Review of a Care Plan entry, dated 10/11/20, noted the resident was at risk for impaired skin integrity.<br><br>During an interview on 6/22/21 at 8:49 a.m., the DON stated she could not find any further documentation related to a skin area concern for Resident #86.<br><br>During an interview won 6/22/21 at 12:51 p.m., the DON stated therapists should notify nursing of skin concerns.<br><br>Review of the facility policy, "Change of Condition-Physician Notification", revised 7/2016, directed staff to notify the physician of all condition or health status changes.<br><br>Review of the facility policy "Change of Condition-Resident Family", revised 7/2016, directed staff to notify the family and responsible party of changes in the resident's condition or plan of care.<br><br>During an interview on 6/22/21 at 3:45 p.m., the DON stated it was typically the responsibility of the nurse on duty to notify the physician and the family of a fall. | F 580 | | |
| F 644 SS=D | Coordination of PASARR and Assessments<br>CFR(s): 483.20(e)(1)(2)<br><br>§483.20(e) Coordination.<br>A facility must coordinate assessments with the | F 644 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 644 | Continued From page 9<br>pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br>This REQUIREMENT is not met as evidenced by:<br>-<br>Based on clinical record review and staff interview, the facility failed to carry out PASRR (Preadmission Screening and Resident Review) requirements for 1 of 1 residents reviewed for PASRR (Resident #10). The facility reported a census of 37 residents.<br><br>Findings:<br><br>1. The Minimum Data Set (MDS) assessment tool, dated 1/8/20, listed diagnoses for Resident #10 as anxiety, depression, and major depressive disorder.<br><br>Review of a 12/30/19 PASRR evaluation stated the resident had a negative Level 1 screen (the resident did not have a major mental illness and did not require further evaluation). The evaluation stated the resident did not have major depression | F 644 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 644 | Continued From page 10<br>or another major mental illness.<br><br>The MDS assessment tool, dated 4/1/21, listed diagnoses for Resident #10 as anxiety disorder, depression, and PTSD (post-traumatic stress disorder).<br><br>Review of a 12/29/19 History and Physical listed the following diagnoses: anxiety, depression, and PTSD.<br><br>Review of a 4/7/20 untitled order sheet listed an order for psychotherapy for Major Depressive Disorder.<br><br>Review of a 6/30/20 untitled physical exam listed diagnoses of major depression and PTSD.<br><br>The facility lacked documentation of an additional PASRR evaluation submitted to reflect the resident's above diagnoses.<br><br>The resident's current Care Plan did not indicate the resident required a Level 2 PASRR or specialized services.<br><br>During an interview on 6/21/21 at 11:07 a.m., the Social Services Director stated if a resident's diagnoses changed, staff would need to submit a new PASRR evaluation.<br><br>During an interview on 6/21/21 at 12:06 p.m., the Social Services Director stated the resident did not have an updated PASRR and stated the resident admitted to the facility prior to her start date at the facility. She stated she would create a new evaluation "today".<br><br>During an interview on 6/22/21 at 3:45 p.m., the | F 644 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 644 | Continued From page 11<br>DON (Director of Nursing) stated the facility did not have a policy for PASRR procedures. | F 644 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>-<br>Based on observation, clinical record review, policy review, and staff interview, the facility failed to carry out professional standards for 1 of 6 residents observed by not correctly priming an insulin pen prior to use and not ensuring a resident consumed food in a timely manner after the administration of insulin(Resident #25). The facility reported a census of 37 residents.<br><br>Findings:<br><br>1. During a medication pass administration observation on 6/14/21 at 12:09 p.m., Staff B RN (Registered Nurse) dialed Resident #25's Novolog Flexpen to 1 unit and discarded the dose. She then dialed a dose of 7 units and injected it into the resident's lower left abdomen. The surveyor asked the resident and Staff B if she should come back after lunch to interview the resident and Staff B stated it would be a while before lunch arrived. When Staff B walked out of the resident's room, she informed the kitchen the | F 658 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 658 | Continued From page 12<br>resident was ready for lunch. The surveyor finished interviewing the resident and as of 12:28 p.m., staff had not delivered the resident's lunch. During an observation at 12:37 p.m., the resident put on a mask and walked out to the dining room. Staff C Cook served the resident's lunch at 12:43 p.m. and the resident began to eat.<br><br>Review of the resident's June 2021 Medication Administration Record(MAR) listed an order for Novolog Flexpen 6 units at noon and addition units per sliding scale.<br><br>Review of the Nursing 2021 Drug Handbook, utilized as a reference by the facility, directed staff to administer insulin "immediately"(5-10 minutes) before a meal.<br><br>Review of the facility policy "Insulin Pen", dated 07/2016, directed staff to prime the pen with 2 units of insulin to ensure accurate dosing.<br><br>During an interview on 6/15/21 at 1:00 p.m., the DON (Director of Nursing) stated staff should ensure resident's consumed food within 15 minutes of the administration of Novolog and stated staff should prime insulin pens with 2 units.<br>- | F 658 | | |
| F 688 SS=E | Increase/Prevent Decrease in ROM/Mobility<br>CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and | F 688 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 688 | Continued From page 13<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:<br>-<br>Based on clinical record review, policy review, and staff interview, the facility failed to carry out a restorative program in order to ensure residents maintained or improved their levels of function for 4 of 5 residents reviewed for restorative services (Residents #10, #23, #26, #27). The facility reported a census of 37 residents.<br><br>Findings:<br><br>1. The MDS (Minimum Data Set) assessment tool, dated 4/1/21, listed diagnoses for Resident #10 as cancer, anxiety disorder, and osteoarthritis (inflammation of the bone and joints). The MDS stated the resident required extensive assistance of 1 staff for bed mobility, transfers, walking, dressing, toilet use, personal hygiene, and bathing and listed the resident's BIMS(Brief Interview for Mental Status) score of 14 out of 15, indicating intact cognition.<br><br>Review of a Restorative Nursing plan for Resident #10, dated 12/28/20, showed the resident participated in bilateral LE exercises 3-5 times per week or LE exercise on the bike or | F 688 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 688 | Continued From page 14<br>walking up to 65 feet with walker and staff assistance.<br><br>Review of the resident's Documentation Survey Report v2 for the period of 1//1/21-6/17/21 documented the following number of days the resident received restorative services:<br>January 5 days<br>February 5 days<br>March 1 day<br>April 1 day<br>May 5 days<br>June 6 days<br><br>Many of the days on the report state "NA" and a key at the bottom stated this indicated "Not Applicable".<br><br>The resident's clinical record lacked documentation of additional days the resident received assistance with restorative services.<br><br>Review of Care Plan entries, dated 1/20/20 stated the resident participated in a restorative program including:<br>a. group exercises 2-3 times per week for the BUE(Bilateral Upper Extremities) and LE(Lower Extremities),<br>b. NuStep(stationary bike) 10 minutes per resident's tolerance,<br>c. walking 150-200 feet with walker up to 5 times per week.<br><br>During an interview on 6/21/21 at 4:07 p.m., the DON stated the initials "NA" in the restorative documentation meant staff did not complete the task. | F 688 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 688 | Continued From page 15<br><br>2. The MDS assessment tool, dated 3/9/21, listed diagnoses for Resident #23 as Alzheimer's disease, muscle weakness, and difficulty walking. The MDS stated the resident required extensive assistance of 2 staff for bed mobility, transfers, dressing, and toilet use, and extensive assistance of 1 staff for eating and personal hygiene and depended completely on 1 staff for bathing. The MDS listed the resident's cognition as severely impaired.<br><br>The MDS assessment tool, dated 5/6/21, stated the resident depended completely on 2 staff for transfers and toilet use.<br><br>Review of Restorative Nursing form, dated 3/5/21, for Resident #23 showed PT and OT recommendations, directed staff to assist the resident with upper and lower ROM, utilize the leg bike, and utilize the EZ Stand for standing tolerance 3-5 times per week.<br><br>Review of documentation of the resident's restorative documentation from the period of 3/5/21-6/17/21 revealed the resident participated in "exercise" on 6/8/21 and 6/13/21 according to the POC Response History for the period of 6/4/21-6/16/21. The document did not state what the exercise consisted of. The facility lacked further documentation showing the resident participated in restorative services during his period.<br><br>Review of a Care Plan entry, dated 6/16/21, noted the resident has a passive ROM program to all extremities 3-5 times a week as the resident tolerates and allows. | F 688 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 688 | Continued From page 16<br><br>3. The MDS assessment tool, dated 2/3/21, listed diagnoses for Resident #26 as non-Alzheimer's dementia, stiffness, and muscle weakness. The MDS stated the resident required extensive assistance of 1 staff for personal hygiene and bathing and extensive assistance of 2 staff for bed mobility, transfers, dressing, and toilet use. The MDS listed the resident's BIMS (Brief Interview for Mental Status) score as 3 out of 15, indicating severely impaired cognition.<br><br>The MDS assessment tool, dated 5/5/21, stated the resident depended completely on 2 staff for transfers.<br><br>Review of a Restorative Nursing form, dated 2/1/21, stated resident had a bilateral upper extremity ROM program as tolerated.<br><br>The facility lacked documentation showing the resident participated in a restorative program from 2/1/21-6/17/21.<br><br>Review of a Care Plan entry, dated 6/16/21, stated the resident participated in passive ROM to all extremities 3-5 times per week as the resident allowed.<br><br>4. The MDS assessment tool, dated 2/6/21, listed diagnoses for Resident #27 as cerebrovascular accident (stroke), non-Alzheimer's dementia, and arthritis. The MDS stated the resident required limited assistance of 1 staff for personal hygiene, extensive assistance of 1 staff for bed mobility, transfers, walking, dressing, toilet use, and bathing. The MDS listed the resident's cognition | F 688 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 688 | Continued From page 17<br>as severely impaired.<br><br>The MDS assessment tool, dated 5/9/21, stated the resident depended completely on 1 staff for dressing and toilet use. The MDS listed the resident's BIMS score as 3 out of 15, indicating severely impaired cognition.<br><br>Review of a Care Plan entry, initiated on 1/7/20 and revised on 6/17/21, stated the resident participated in an active ROM program to her bilateral lower extremities 3-5 times per week. A 6/17/21 entry stated the resident participated in n right upper extremity ROM 3-5 times per week<br><br>Review of a 3/10/21 Restorative Nursing document listed the following exercises: Seated lower extremity exercises per handout, 1 set of 10 and/or NuStep 10-15 minutes and walking with 4ww x 200 feet with 2 staff 3-5 times per week.<br><br>The facility lacked documentation of staff assisting the resident with the exercises during the period of 3/10/21- 6/21/21.<br><br>Review of the facility policy "Restorative Program Procedure", revised 11/2020, noted the facility would develop and implement a person-centered restorative program to maintain or improve the resident' ability to support independence as safely as possible by promoting improvement and minimizing a decline in function.<br><br>Request restorative documentation on 6/17/21, for Residents #10, #23, #26, and #27 for the time period of 1/1/21 to current. On 6/17/21 at approximately 12:00 p.m., the DON provided documentation for the resident's restorative | F 688 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 688 | Continued From page 18<br>participation and stated it was "not much".<br><br>During an interview on 6/21/21 at 4:07 p.m., the DON stated the staff member who was responsible for completing the restorative program was needed to work the floor and basic care came first. | F 688 | | |
| F 689 SS=D | -<br>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>-<br>Based on staff interview, clinical record review, and facility policy, the facility failed to create and implement fall interventions for 1 of 3 residents reviewed for falls (Resident #85). The facility reported a census of 37 residents.<br><br>Findings:<br><br>1. The MDS(Minimum Data Set) assessment tool, dated 1/20/21, listed diagnoses for Resident #85 as traumatic brain injury, history of falling, and muscle weakness. The MDS stated the resident required extensive assistance of 1 staff | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 19 | F 689 | | |

for bed mobility, transfers, walking, dressing, toilet use, personal hygiene, and bathing and listed her BIMS (Brief Interview for Mental Status) score as 15 out of 15, indicating intact cognition. The MDS stated the resident had 1 fall with no injury and 1 fall with a non-major injury during the review period.

Review of a facility document titled, "Unwitnessed", dated 1/14/21 stated staff observed the resident sitting on the floor with a 1 cm (centimeter) skin tear noted on the left hand.

Review of a facility document titled, "Unwitnessed", dated 1/17/21, stated staff heard a loud crash, and the resident was on her knees leaning her arms on the seat of the recliner. The report stated the resident was trying to reposition herself up further in bed and she rolled out of bed.

Review of a document titled, "Fall During Staff", dated 1/27/21, stated the resident was assisted to the floor when she lost her balance.

Review of a document titled, "Unwitnessed", dated 1/31/21 at 5:50 p.m. stated the resident slid out of her recliner onto the floor when attempting to raise the chair to eat. The report stated staff initiated neuro assessments.

Review of a document titled, "Unwitnessed", dated 1/31/21 at 5:45 p.m. stated staff entered the room to complete a neuro check and observed the resident lying on the floor on her left side in front of her wheelchair. The resident stated she slid out onto the floor.

Review of a document titled, "Unwitnessed",

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 20<br>dated 2/19/21 stated staff found the resident lying on the floor between her recliner and the bed. The resident stated she slid down from the recliner as she was waiting for help to get her to the commode.<br><br>Review of the Care Plan revealed it lacked documentation of interventions developed for the above falls for staff to implement in order to prevent further falls.<br><br>During an interview on 6/21/21 at 4:07 p.m., the DON (Director of Nursing) stated the facility should put as many things in place as possible with regard to fall interventions and that they should conduct a root cause analysis.<br><br>During an interview on 6/22/21 at 8:49 a.m., the DON stated she did not locate any additional fall interventions in the resident's clinical record.<br><br>During an interview on 6/23/21 at 10:00 a.m., the DON stated the facility did not have a policy related to falls and fall interventions.<br>- | F 689 | | |
| F 760 SS=D | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>-<br>Based on clinical record review, policy review, and staff interview, the facility failed to ensure residents were free of significant medication errors for 1 of 2 residents reviewed for insulin | F 760 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 760 | Continued From page 21<br>(Resident #25). The facility reported a census of 37 residents.<br><br>Findings:<br><br>1. The MDS (Minimum Data Set) assessment tool, dated 5/5/21, listed diagnoses for Resident # 25 as diabetes, Alzheimer's disease, and non-Alzheimer's dementia. The MDS listed the resident's BIMS (Brief Interview for Mental Status) score of 13 out of 15, indicating intact cognition.<br><br>Review of the June 2021 MAR (Medication Administration Record) listed the following orders:<br>a. Novolog (a type of insulin) FlexPen Inject 6 units at noon.<br>b. Novolog FlexPen Inject per sliding scale:<br>1-150(blood glucose levels in mg/dl-milligrams/deciliter) =0 units<br>151-200=1 unit<br>201-250=2 units<br>251-300=3 unit<br>301-350=4 units<br>351-400=5 units<br>401-450=6 units.<br>The MAR directed staff to notify the physician of blood glucose levels above 401.<br><br>Review of the entry on the MAR for 6/11/21 for both the noon scheduled Novolog and the sliding scale Novolog lacked staff initials to indicate the administration of the insulin.<br><br>Review of the Weights and Vitals Summary revealed the following blood glucose levels on 6/11/21:<br>11:12 a.m. 483 mg/dl<br>4:23 p.m. 477 mg/dl | F 760 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 760 | Continued From page 22<br>The facility lacked documentation of physician notification of the above blood glucose levels and lacked documentation of further timely assessments of the resident's blood glucose to ensure the levels returned to normal.<br><br>Review of the facility policy "Diabetes Management Protocol", revised 6/2020, directed staff to notify the physician of blood sugars over 400 mg/dl and to follow the physician's orders for sliding scale insulin.<br><br>Review of the facility policy, "Medication Administration", reviewed 6/2020, stated an outcome was to decrease the potential for medication errors, and directed staff to administer medications per the facility medication administration schedule or per physician orders.<br><br>During an interview on 6/15/21 at 2:55 p.m., the DON stated she was going to conduct more education with staff regarding insulin.<br><br>During an interview on 6/16/21 at 9:30 a.m., the DON (Director of Nursing) stated staff should notify the physician of blood sugars over 400 if the order directed them to do so.<br><br>During an interview on 6/1621 at 12:43 p.m., the DON stated she could not locate any documentation related to the resident not receiving her insulin on 6/11/21 or physician notification of the high blood sugar levels. She stated they called the physician to notify him/her of the error.<br><br>- | F 760 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary | F 812 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 812 | Continued From page 23<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>-<br>Based on observation, the 2017 Food Drug Administration (FDA) Food Code, and staff interview the facility staff failed to wear hairnets and failed to utilize proper handwashing technique to prevent contamination for 2 of 2 meal services. The facility reported a census of 37 residents.<br><br>Findings include:<br><br>Observations on 6/16/21 at 8:04 a.m., of the breakfast meal service in the Loden kitchenette revealed Staff A Homemaker Cook did not have a hair net in place while she fried an egg at the stove for a resident. Staff A proceeded to deliver | F 812 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 812 | Continued From page 24 | F 812 | | |

a breakfast tray she had prepared to the resident in room 206 at 8:13 a.m., and then returned to the kitchenette to prepare the next made to order breakfast. At 08:20 a.m., Staff A prepared and delivered a fried egg breakfast to a resident who sat at the dining room table. Staff A prepared and served 10 residents breakfast.

The 2017 FDA Food Code included the following: food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair that are designed and worn effectively to keep their hair from contacting exposed food.

Interview on 6/16/21 at 9:08 a.m., the Dietary Manager stated she would expect dietary staff to wear hairnets. The Dietary Manager stated extra hairnets are located on the counters of the kitchenettes for staff to utilize if needed. The Dietary Manager stated she was unaware of a facility policy or procedure related to use of hairnets.

Observations on 6/16/21 from 11:59 a.m. through 12:43 p.m. of the noon meal service in Loden kitchenette, Staff A Homemaker Cook washed her hands four times throughout the meal service. Staff A's hand washing process included: washed her hands with soap, turned off the water with her bare hands, and then proceeded to obtain paper towels to dry her hands. Staff A served 9 residents at the noon meal service.

Interview on 6/16/21 at 3:05 p.m., the Dietary Manager confirmed Staff A Homemaker Cook had turned off the water with her wet hands, prior to drying them off, throughout the meal service. The Dietary Manager stated she would expect

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165597 | A. BUILDING _____ B. WING _____ | C 06/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWATER, A WESLEYLIFE COMMUNITY | 9225 CASCADE AVENUE WEST DES MOINES, IA 50266 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 812 | Continued From page 25<br>staff to wash and dry her hands prior to turning the water off. The Dietary Manager stated she would educate staff. The Dietary Manager stated she was unaware of a facility policy or procedure related to handwashing technique.<br>- | F 812 | | |

F 000

This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet the regulations established by state and federal law.

F 577

1. In continued compliance with F 577 Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11). Edgewater immediately changed the location of the survey binder and placed a survey binder on the Aster/Bluestem household entrance wall and another on the Loden/Woodbine household entrance wall prior to the survey exit. All current residents will be notified by letter of their right to examine all survey results as well as to the location of the binder on each household on 7/16/21.

2. To ensure the problem does not recur; Edgewater Social Service Director and/ or designee will provide education to new residents on their right to examine all survey results as well as to the location of the survey binder.

3. As part of Edgewater's WesleyLife ongoing commitment to quality assurance, the Director of Nursing and/or designee will audit monthly for 3 months then randomly to monitor for compliance. Audit results with any identified concerns will be addressed immediately through the QAPI process.

4. This plan of correction constitutes the facility's credible allegation of compliance on 7/23/2021.

F 580

1. In continued compliance with F 580 Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) Edgewater immediately notified the responsible party on 7/12/21 with respect to Resident #26 of significant weight gain between 1/21 and 5/25/21 and of an incident without injury on 1/21/21. The physician and family were notified of the unwitnessed fall without injury on 2/14/21. Resident #85 was discharged from the community on 2/25/2021. Resident #86 was discharged from the community on 11/24/2020.

2. To ensure the problem does not recur; Edgewater Director of Nursing provided education to Charge Nurses on 7/12/21 to 7/16/21 regarding procedures for Change of condition which includes significant weight changes, falls and skin conditions , Physician and Resident/ family/ legally responsible party notification.

3. As part of Edgewater's WesleyLife ongoing commitment to quality assurance, the Director of Nursing and/or designee will audit weekly for 3 months then randomly to monitor for compliance. Audit results with any identified concerns will be addressed immediately through the QAPI process.

4. This plan of correction constitutes the facility's credible allegation of compliance on 7/23/2021.

F 644

1. In continued compliance with F 644 Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) Edgewater immediately corrected the deficiency with respect to Resident #10, PASSR was resubmitted on 6/21/21 to reflect change of condition with Major Depression Anxiety, and PTSD . No Level II evaluation was required.

2. To ensure the problem does not recur; Education was provided on PASSR requirements with condition changes to the Social Worker and MDS Coordinators on 6/21/21. Audits were completed on all residents PASSR to ensure any change of condition was updated and resubmitted any noted discrepancy between 6/21/21-6/25/21.

3. As part of Edgewater's ongoing commitment to quality assurance, the DON/ and or designee will complete audits on the PASSR at least quarterly. Audit results with any identified concerns will be addressed immediately through the QAPI process.

4. This plan of correction constitutes the facility's credible allegation of compliance on 7/23/2021.

F 658

1. In continued compliance with F 658 Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) Director of Nursing educated Staff B on 6/16/21 on the policy regarding how to prime an insulin pen with 2u prior to administration and instructed to assure residents are served a meal no greater than 10 minutes after administration of rapid-acting insulin.

2. To ensure the problem does not recur; Education was provided to all Charge Nurses on 7/16/21 on proper priming of insulin pen, guidance for using insulin products and the importance of serving resident's their meal no greater than 10 minutes after administration of rapid-acting insulin. All newly hired nurses will be educated on insulin procedures.

3. As part of Edgewater's ongoing commitment to quality assurance, the DON/ and or designee will complete audits weekly for one month then randomly to monitor for compliance. Audit results with any identified concerns will be addressed immediately through the QAPI process.

4. This plan of correction constitutes the facility's credible allegation of compliance. This deficiency was corrected on 6/16/2021.

F 688

1. In continued compliance with F 688 Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3). Edgewater immediately corrected the deficiency with respect to Residents #10, 23, 26 and 27, the restorative plans were reviewed and revised to meet individual levels of functioning and deficits on 7/14/21.

2. To ensure the problem does not recur; Education was provided on 6/28/21 to the MDS Coordinator on Restorative requirements to increase/ prevent decrease in ROM/Mobility with condition changes and evaluation of restorative programs. Audits were completed on 7/14/21 on all residents restorative program, reviewed and revised to meet individual levels of function. MDS Coordinator provided education to the Restorative Aide on 7/15/21 regarding the newly written programs. All CNAs will be educated on restorative programs, with review of documentation by 7/23/21. All residents are screened on a quarterly basis to assure appropriateness of current restorative and/or to identify needs for intervention.

3. As part of Edgewater's ongoing commitment to quality assurance, the DON/ and or designee will complete audits monthly for 3 months then randomly to monitor for compliance. Audit results with any identified concerns will be addressed immediately through the QAPI process.

4. This plan of correction constitutes the facility's credible allegation of compliance on 7/23/2021.

F 689

1. In continued compliance with F 689 Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) Resident #85 was discharged from the facility on 2/25/2021.

2. To ensure the problem does not recur; Education will be provided to the Charge Nurses regarding procedure for incident/accident procedure and care plan implementation at the time of the incident. Newly hired staff will be educated upon hire by the DON and/ or designee. An audit was completed on all active resident incident reports and were reviewed by the Risk management team and assured appropriate interventions have been implemented to prevent recurrence on 7/01/21.

3. As part of Edgewater's ongoing commitment to quality assurance, the DON/ and or designee will complete audits weekly for 3 months then randomly to monitor for compliance. Audit results with any identified concerns will be addressed immediatley through the QAPI process.

4. This plan of correction constitutes the facility's credible allegation of compliance effective 7/23/2021.

F 760

1. In continued compliance, F 760 Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2). Edgewater immediately corrected the deficiency with respect to Resident #25; the physician and legally responsible party were informed of the significant medication error on 6/11/2021.

2. To ensure the problem does not recur; Education was provided to the Charge Nurses on 6/16/21 regarding physician notification of blood sugar results outside the parameters of the sliding scale order or above or below the identified parameters ordered by the physician. An audit was completed by the ADON on all blood sugar records for diabetic residents on 7/2/21 to assure physician and family notifications have been completed as required. All newly hired licensed nurses will be educated upon hire by the DON and/ or designee regarding physician notification of blood sugar results outside the parameters of the sliding scale order or above or below the identified parameters ordered by the physician.

3. As part of Edgewater's ongoing commitment to quality assurance, the DON/ and or designee will complete audits weekly for 3 months then randomly to monitor for compliance. Audit results with any identified concerns will be addressed immediately through the QAPI process.

4. This plan of correction constitutes the facility's credible allegation of compliance as of 7/16/2021.

F 812

1. In continued compliance with F 812 Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i) (1) (2). Staff A was educated on 6/18/21 by the Dietary Service Manager on proper handwashing and wearing a hairnet per facility policy after the surveyor identified the concern.

2. To ensure the problem does not recur; The Dietary Service Manager educated each dietary team member on the handwashing and hairnet policy on a 1:1 basis on 6/18/21 and 7/16/21 and will educate new team members to the handwashing and hairnet policy upon hire.

3. As part of Edgewater's ongoing commitment to quality assurance, the Dietary Service Manager and or designee will complete audits monthly for 3 months then randomly to monitor for compliance. Audit results with any identified concerns will be addressed immediately through the QAPI process.

4. This plan of correction constitutes the facility's credible allegation of compliance effective 7/23/2021.