STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165790	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Ridge Village	8950 Coachlight Drive West Des Moines, IA 50266

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on clinical record review, staff interview, and facility policy review, the facility failed to provide the required beneficiary notifications to residents upon discharge for 1 of 3 residents sampled (Resident #50). The facility reported a census of 38. Findings include: The discharge Minimum Data Set (MDS) for Resident #50, completed 06/05/2025, documented the resident entered the facility on 05/20/2025 and discharged from the facility on 06/05/2025. An email from the Social Services coordinator, received on 08/05/2025 at 03:36 PM, contained the Beneficiary Notifications for two residents as requested by the surveyor, but did not contain the Beneficiary Notifications for Resident #50. In an interview on 08/05/2025 at 03:37 PM with the Social Services Coordinator, she stated she had been hired by the facility in June of 2025. When she was hired she was asked to begin auditing the work of her predecessor and discovered that for some residents, the Advanced Beneficiary Notification (ABN) and Notice of Medicare Non-Coverage (NOMNC), had not been provided to residents discharging from the facility as required by Federal regulation. As a result, she had initiated a performance improvement plan to ensure this did not happen again. She acknowledged the notifications are required. In an interview on 08/07/2025 at 02:35 PM with the Director of Nursing (DON), he acknowledged he knew that several required notifications had not been provided to residents as they discharged from the facility. He stated his expectation is for notifications to be granted in accordance with Federal regulation, but also acknowledged that he does not oversee this process as it is outside of his job responsibilities. A facility policy regarding ABN/NOMNCs was requested, but in an email received on 08/07/2025 at 10:42 AM from the facility Administrator, she stated there was no policy but the facility follows the Centers for Medicare/Medicaid Services (CMS) guidelines.

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

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review the facility failed to ensure staff documented non-pharmacological interventions attempted prior to the administration of anti-anxiety medication (AA) for one of five residents reviewed for unnecessary medications (Resident #35). The facility reported a census of 38 residents. Findings Include: The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 admitted to the facility on [DATE] and had diagnosis of anxiety disorder. The MDS revealed the resident took an antianxiety (AA) medication during the seven day look-back period. The MDS recorded the resident had no behaviors. The Care Plan revised 4/23/25 lacked information related to Resident #35 taking an AA medication and the non-pharmacological interventions used or attempted prior to administration of the AA medication. The Order Summary revealed clonazepam (an AA medication) 0.5 milligrams (mg) by mouth every 8 hours as needed (PRN) started on 6/27/25. The Medication Administration Record (MAR) revealed clonazepam 0.5 mg by mouth every 8 hours as PRN administered the following: 6/1/25 to 6/30/25: 21 times7/1/25 to 7/31/25: 25 times. The record lacked non-pharmacological interventions attempted prior to administration of clonazepam medication. In an interview on 8/6/25 at 7:50 AM, Staff G, Registered Nurse (RN), reported she documented on the MAR whenever a PRN AA medication administered. The computer system prompted her to document a note about the non-pharmacological interventions attempted. This note then showed up in the progress notes. In an interview on 8/7/25 at 12:18 PM, the MDS Coordinator reported the process for documentation of PRN medication and the nonpharmacological interventions had been updated in the past 2 weeks. The non-pharmacological interventions added on the electronic MAR whenever a PRN medication administered. After clicking on the PRN medication displayed on the EMAR, click on supplemental documentation, and pick the interventions that were tried. The system prompted staff to choose the interventions that were used. Prior to a couple of weeks ago, nothing was in place for documenting the non-pharmacological interventions attempted. She worked with the Director of Nursing (DON) and the Corporate staff to get the interventions added to the system. At the time, the MDS Coordinator checked the MAR for Resident #35 and reported a y was indicated for interventions but did not document the specific interventions tried. In an interview 8/7/25 at 12:43 PM, the DON reported they did not have a policy for psychotropic medication and the use of nonpharmacological interventions.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy review, the facility failed to ensure that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for 2 of 5 residents investigated for unnecessary medications (Resident #21 and #35). The facility reported a census of 38.Findings include:1. The Care Plan initiated on 7/15/24 lacked documentation indicating Resident #21 was on an antidepressant and directives for staff related to monitoring side effects of medication. The Physician’s Orders indicated that Resident #21 was started on Lexapro 10 milligram (mg) daily for depression on 7/9/25. During an interview on 8/7/25 at 12:18 PM, Minimum Data Set (MDS) coordinator stated she has worked at this facility in the MDS role since 1/27/25. States she updates care plans whenever any medication changes or assistive level of care changes, and with admission or discharges. Stated she usually adds things to the care plan within 24 hours. States she looks at the dashboard on Point Click Care (PCC) to see if any new medications are prescribed. Stated that for Resident #21, she was not on an antidepressant when she came back from the hospital but then it was added. Stated she did not get it back on the care plan. 2. The admission MDS assessment dated [DATE] revealed Resident #35 had diagnoses of anxiety disorder and depression. The MDS revealed the resident took an antianxiety (AA) medication and an antidepressant medication during the seven-day look-back period. The Care Plan revised 4/23/25 revealed Resident #35 took an antidepressant medication. The Care Plan lacked information related to taking an AA medication and the non-pharmacological interventions used or attempted prior to administration of an AA medication. The Care Plan also lacked information about medication side effects, and the signs and symptoms to monitor related to taking an AA medication. The Order Summary revealed an order for clonazepam (AA medication) 0.5 milligrams (mg) every 8 hours as needed (PRN) for anxiety started on 6/27/25. In an interview on 8/7/25 at 12:18 PM, the MDS Coordinator reported she updated the residents' care plans whenever a resident had a medication change or changes in their assistive level of care. New information was added to the care plans typically within 24 hours, unless it was over the weekend. The MDS Coordinator reported she looked at the dashboard on the computer to see if a resident had a new medication such as an AA or an antibiotic medications. At the time, the MDS Coordinator confirmed AA medication not listed on Resident #35’s care plan. The MDS Coordinator stated she would add the information to the resident’s care plan. The facility policy titled, A Comprehensive Person-Centered Care Plan, revised 7/2024 revealed a comprehensive person-centered care plan developed and implemented for each resident. The care plan was derived from a thorough analysis of information gathered as part of the comprehensive assessment, and revised as information about the resident and any condition changes.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, resident interview, staff interviews, and policy review, the facility failed to ensure staff appropriately completed a resident assessment and provide timely intervention for one resident with Lower Extremity Edema ([NAME]) for 1 of 1 resident reviewed for edema (Resident #21) and 1 of 4 residents sampled for skin conditions (Resident #1). The facility reported a census of 38.Findings include:1. The Minimum Data Set (MDS) dated [DATE] revealed that Resident #21 had diagnoses of coronary artery disease, hypertension, heart failure, localized edema and acute respiratory failure with hypoxia. The Care Plan initiated on 7/15/24 lacked documentation of [NAME] hose use for [NAME]. The Electronic Health Record (EHR) indicated that Resident #21 is having significant weight gain and [NAME] despite elevation and compression hose. It further indicated that Resident #21 is wearing [NAME] hose daily from 6/30/25 through 7/28/25 despite being discontinued on 6/30/25. The Electronic Medication Administration Record (EMAR) indicated that Resident #21 refused [NAME] hose 3 times in June of 2025 and none in May 2025. The Physician’s Orders indicated [NAME] hose on in the morning and off and bedtime that was initiated on 4/25/25 and discontinued on 6/30/25. Observations revealed the following: a. On 8/4/25 at 3:11 PM, Resident #21 was noted to have [NAME] and wearing regular socks. b. On 8/5/25 at 1:16 PM, Resident #21 was noted to have [NAME] and wearing regular socks. c. On 8/5/25 at 1:20 PM, Staff A, CNA found [NAME] hose on the table next to Resident #21’s chair and put on her bilateral lower extremities. d. On 8/5/25 at 4:00 PM, Resident #21 was noted to have [NAME] hose on bilateral lower extremities. e. On 8/6/25 at 2:00 PM, Resident #21 was resting in her chair with legs elevated and [NAME] hose on bilateral lower extremities. During an interview on 8/5/25 at 1:18 PM, Resident #21 stated she usually has socks on up to her knees but had regular socks on currently. During an interview on 8/5/25 at 1:20 PM, Staff A, CNA stated she was not sure if Resident #21 has compression socks or ted hose. She then said that she was pretty sure that she does wear [NAME] hose and found them on the table next to her chair. During and interview on 8/5/25 at 1:50 PM, Staff C, LPN stated that CNA's know how to care for residents by looking at the Kardex on their iPads. The nurse stated Resident #21 used to have [NAME] hose continuously but she refused often and now only has them on if she tolerates them. When informed the CNA put the hose on Resident #21 she stated that it was good she let them be put on. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/5/25 at 4:08 PM, Staff B, RN stated [NAME] hose on Resident #21 were discontinued as she refused them frequently. Stated refusals were documented in the Electronic Medication Administration Record (EMAR). Showed this surveyor that she no longer has them as there was no order. When questioned why they were currently on Resident #21, she stated that maybe the CNA's are documenting on her. Checked the CNA charting and noted that they are not charting on it. In an interview on 8/6/25 at 8:25 AM, Staff H, LPN stated that Resident #21 does wear [NAME] hose and currently has them on. Stated she does not refuse often but does sometimes remove them by herself. Stated family concerned about her edema. Stated CNAs do not chart on [NAME] hose but the nurse does in the EMAR. She noted that it does not appear to be in the EMAR when checked. After questioning about discontinuation on 6/30/25, stated that this surveyor was correct that they had been discontinued. In an interview on 8/7/25 at 1:30 PM, the DON stated that [NAME] hose use does require an order and would be on the Care Plan. Stated Resident #21 came back from the hospital with no mention of [NAME] hose so they were discontinued. Stated reached out to Hospice yesterday to obtain an order for [NAME] hose. Stated should not have had [NAME] hose after the discontinuation of the order. Stated not sure if has been getting [NAME] hose despite assessments because after the first assessment, the subsequent assessments have data carried over and must be unchecked if no longer correct. They have had a recent education on this topic. 2. The MDS for Resident #1, dated 07/14/2025, revealed the following relevant diagnoses: Atrial Fibrillation (A-Fib), coronary artery disease (heart disease impacting the coronary artery), heart failure, hypertension, myocardial infarction type 2 (heart attack), ischemic cardiomyopathy (reduced heart function due to loss of blood flow), and long term use of anti-coagulants. It failed to document the presence of purpura (minor bleeding under the skin) or other skin conditions resulting from the cardiac conditions and use of anti-coagulation therapies. The Care Plan for Resident #1, last revised on 07/10/2025, failed to document lasting bruises on the residents forearms and hands, but instructed staff members to monitor the resident for bruises due to his long term use of anti-coagulant therapy. The Medication Administration Record (MAR), for July 2025, documented the use of apixaban (generic for Eliquis) oral tablet, 5mg, twice a day and warned staff the resident was using anti-coagulant therapy and instructed staff members to document side effects such as bruising on the MAR. The MAR for June and August 2025 lacked any documentation of bruising or other side effects. Review of the Nursing Progress Notes dated from 07/10/2025 to 08/07/2025 documented only scattered bruising on the arms on 07/10/2025 with no further documentation of bruising. In an interview on 08/04/2025 at 01:23 PM with Resident #1, he stated the bruising on his forearms and hands had been there for years, since he started his anti-coagulant therapy. He was unsure if the facility was monitoring the bruising. In an interview on 08/07/2025 at 10:24 AM with Staff I, CNA, she stated she was aware Resident #1 had significant bruising to his forearms and the tops of his hands, and they had been present upon admission. She stated she does not track the bruises as she is a CNA, but believes nursing staff track the bruising. She stated things like bruising and special precautions were tracked on a resident's plan of care. In an interview on 08/07/2025 at 10:50 AM with Staff A, CNA, she stated she was unsure if Resident #1 had arm bruising, but noted the facility keeps a care plan book at the nurses station in addition to a pocket care plan that makes staff aware of all special precautions such as monitoring that needs to be done. She stated she was unaware of any special precautions Resident #1 required. In an interview on 08/07/2025 at 11:03 AM with Staff G, RN, she stated she was aware of the purple bruise-like coloration on Resident #1's forearms and hands, but noted there was no task to track it, so she had been excluding it from skin assessments as it was not flagged as a problem and was present on admission. In an interview on 08/07/2025 at 11:24 AM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the MDS Coordinator, RN, she acknowledged she is responsible for creating care plans, tasks related to care plans, and for completing MDS for each resident. She gathers her data and adds it to the care plan, including tracking tasks, based on the initial resident assessment. These initial assessments flag the creation of tracking tasks in her system to monitor localized bruising over time. She noted Resident #1's initial assessment lacked the location of bruising and did not note the purple coloration of his forearms and hands, which would have prompted a task to track the progress of the coloration. In an interview on 08/07/2025 at 02:17 PM with the Social Services Coordinator, RN, she confirmed she was the person who performed the initial intake assessment for Resident #1. She acknowledged she had missed the purple discoloration on Resident #1's skin during the initial assessment, and marked only scattered bruising on the initial assessment. She acknowledges that as a result of this the purple coloration on his arms were not tracked. In an interview on 08/07/2025 at 02:35 PM with the Director of Nursing (DON), he stated his expectation is for all potential issues to be noted on the initial intake assessment and for issues such as potential bruising to be tracked by staff members. He acknowledged that without a proper initial assessment, it is much harder to track things like worsening arm bruising. A policy regarding skin assessments or initial skilled assessments was requested but was not provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on direct observation, clinical record review, staff interview, and facility policy review, the facility failed to follow care planned interventions to prevent and mitigate falls for 1 of 3 residents sampled (Resident #6). The facility reported a census of 38. Findings include: The Significant Change Minimum Data Set (MDS) for Resident #6, dated 07/21/2025, documented the residents Brief Interview for Mental Status score (BIMS) as 9, indicating moderately impaired cognition. It documented the following relevant diagnoses: Atrial Fibrillation (A fib), Cerebrovascular Accident (Stroke), displaced fracture of the neck of the right femur (broken femur), and senile degeneration of the brain (lost of cognitive ability due to age). It further documented her as dependent on staff for mobility and documented her as unable to walk. The significant change MDS, dated [DATE], documented the resident as ambulatory and only requiring supervision while ambulating. The Care Plan for Resident #6, last revised on 07/15/2025, documented she has a history of falls. It documented the following interventions: Non-skid rubber soled footwear on at all times, utilizes a wheelchair when off unit, ensuring the call light is within reach at all times, ensuring her room is free from clutter, her bed to be in the lowest position while the resident is in bed, and for fall mats to be on both sides of the bed while the resident was in bed. It noted the fall mats and bed in the lowest position were put into place on 07/15/2025 after the resident had fallen and fractured her femur. The visual/Bedside Kardex Report, printed on 08/07/2025, documented a requirement to have fall mats in place while Resident #6 is in bed. A direct observation on 08/04/2025 at 01:18 PM in which Resident #6 was in her bed. Her footwear could not be assessed, but her bed was noted to be in the lowest position. Fall mats were not seen during this observation. During an observation of medication administration on 08/06/2025 at 11:23 AM, the resident was again observed in her bed without fall mats present. Staff G, Registered Nurse (RN), did not intervene or place mats upon noting they were not present. A direct observation on 08/07/2025 at 08:10 AM again revealed Resident #6 to be laying in her bed without bed mats in place, a picture was taken at this time and the Director of Nursing (DON) was notified. When asked if Resident #6 required bed mats he confirmed she did, and proceeded to place them in her room on both sides of her bed. In an interview on 08/07/2025 at 10:24 AM with Staff I, Certified Nurse Aide (CNA), She stated she did not believe that Resident #6 required any special cares such as fall mats. She stated the care plan informs CNA's and other staff members of the precautions that need to be taken to ensure a resident is receiving appropriate cares, and requires those providing those cares to sign off on them in the electronic health record (EHR) pocket care plan/Kardex. She stated in addition to the EHR, the care plans for every resident is located in a binder at the nurses station. In an interview on 08/07/2025 at 10:50 AM with Staff A, CNA, she stated Resident #6 requires a number of special precautions, including fall mats and for her bed to be placed in the lowest position. She confirmed the EHR requires them to document the precautions were put into place. In an interview on 08/07/2025 at 11:24 AM with the MDS Coordinator/RN, she showed the surveyor the care plan requires several different fall precautions for Resident #6 including fall mats, she stated CNAs are responsible for putting that intervention into place. In an interview on 08/07/2025 at 02:35 PM with the Director of Nursing (DON), he acknowledged the care plan for Resident #6 was not being followed when he observed her earlier in the day. He stated his expectation is for staff members to put care planned interventions into place to prevent harm, and noted that it was frustrating to see her care plan had not been followed. He stated not following the care plan could result in harm to residents, and noted she already had a broken femur. Review of a facility provided document titled Fall Prevention (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Program, with a creation day of July 2024, states that the nursing team will convene to discuss interventions that will be beneficial to reduce falls and mitigate fall damage and communicate with the team what interventions to put into place for all residents who have had actual falls.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **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 ensure safe and accurate delivery of oxygen therapy for one of two residents reviewed for respiratory care (Resident #21). The facility reported a census of 38 residents. Findings include:1. The Minimum Data Set (MDS) dated [DATE] revealed that Resident #21 had diagnoses of coronary artery disease, hypertension, heart failure, localized edema and acute respiratory failure with hypoxia. The Care Plan initiated on 7/15/24 indicated that Resident #21 has altered cardiovascular status, difficulty breathing and altered respiratory status requiring oxygen at 2-3 liters via nasal cannula (NC) to keep oxygen saturation greater than 88%. The Physician's Orders included an order oxygen continuous at 2-3 liters via NC to keep oxygen saturation greater than 88%. Observations revealed the following:a. On 8/4/25 at 3:11 PM Resident #21 had her oxygen concentrator set at 1 1/2 liters via NC. b. On 8/5/25 at 9:09 AM Resident #21 had her oxygen concentrator set at 1 3/4 liters via NC. c. On 8/5/25 at 1:16 PM Resident #21 was sitting in her recliner without oxygen on. Her oxygen concentrator was off with the tubing wrapped up and stuck under the handle on top. The oxygen tank that was on the back of her wheel chair was also noted to be off. Resident #21 put on her call light for staff to put oxygen on. d. On 8/5/25 at 1:25 PM Staff A, Certified Nursing Assistant (CNA) turned on Resident #21's oxygen concentrator and applied oxygen via nasal cannula to her. e. On 8/5/25 at 4:00 PM Resident #21 noted to have her oxygen on with the oxygen concentrator set at 1 3/4 liters. During and interview on 8/5/25 at 1:20 PM Staff A, CNA stated that this surveyor should check with the nurse to find out if Resident #21's oxygen was supposed to be continuous. She also stated that she does not adjust the dial on the oxygen concentrator she just turns it on or off. During an interview on 8/5/25 at 4:08 PM, Staff B, Registered Nurse (RN) stated she checks oxygen setting on Resident #21 at the beginning of her shift. Stated she just checked and it is on 2 liters. Staff B, RN showed this surveyor the reading of 2 liters on the oxygen concentrator. She was standing above and slightly to the side. After looking straight at the concentrator directly in front of it, she stated that it was on 1 3/4 liters and turned it up to 2 liters.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, staff interviews, and policy review, the facility failed to utilize enhanced barrier precautions (EBP's) and infection control practices for 1 of 4 residents sampled on EBP's (Resident #34). The facility also failed to ensure staff followed infection control practices to protect against cross-contamination and potential spread of infection for a resident on droplet precautions for 1 of 4 residents on droplet/contact precautions (Resident #4). The facility reported a census of 38 residents. Findings include: 1.The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #34 had a diagnosis of obstructive uropathy. The MDS indicated the resident had an indwelling catheter. The Care Plan revised 6/30/25 revealed the resident had a catheter due to urinary retention. The Care Plan directed staff to use EBP’s per facility guidelines. During observation on 8/6/25 at 1:50 PM, Staff E, certified nursing assistant (CNA) stood in the bathroom as Resident #34 sat on the toilet. The resident had a catheter that was attached to a leg bag. The leg bag was strapped to the resident's right thigh. An EBP sign was posted on the wall in the bathroom and a plastic bin with drawers had a supply of gowns and gloves inside. The plastic bin was just beneath the EBP’s signage. Staff E washed her hands and donned a pair of gloves. Staff E placed a graduate container on a paper towel on the floor, opened the drain port on the leg bag and drained the urine contents into the graduate container. Staff E placed the graduate on a paper towel on the floor. A small amount of urine dripped from the drain port onto the floor before Staff E closed the drain port on the leg bag. Staff E took an alcohol swab and cleansed the end of the port. Staff E had the resident stand up by the toilet, then Staff E emptied the graduate into the toilet. Staff E assisted the resident to pull her brief and pants up. Staff E removed her gloves and washed her hands. At 1:55 PM, Staff E donned a pair of gloves, took a paper towel and wiped up the floor by the toilet, then bagged up the trash and removed her gloves. Staff E took the bag of trash to the soiled utility room down the hall from the resident’s room and washed her hands. In an interview 8/6/25 at 2:00 PM, Staff E reported EBP used whenever a resident had influenza, COVID, or c-diff (clostridium difficile) (bacteria that caused diarrhea), or someone had been exposed to influenza (flu) or COVID. Staff E stated she would wear a gown, mask and gloves whenever a resident was on EBP’s. In an interview 8/6/25 at 2:40 PM, Staff F, CNA, reported EBP’s used if there was an EBP sign posted in the resident’s room. She used PPE depending on the type of isolation a resident was in. Staff F reported she would use a gown and gloves whenever she handled or took care of a resident with a catheter. In an interview on 8/6/25 at 2:53 PM, the Infection Preventionist reported she expected staff wear a gown and gloves whenever they handled a resident’s catheter. The Infection Preventionist stated the floor should be disinfected with a purple top wipe or germicidal surface wipes, or staff should call housekeeping to clean and disinfect the contaminated area because there could be bacteria present. The Infection Preventionist reported the contact time to properly disinfect the area was 2 minutes. Wiping the contaminated surface with a paper towel would not effectively disinfect the surface. The facility’s “EBP’s” policy dated 3/27/24 revealed EBP’s designed to reduce the transmission of multidrug-resistant organisms (MDRO). Gown and gloves used during high contact resident care activities that provide opportunities for transfer of MDRO’s to staff (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165790	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Ridge Village	8950 Coachlight Drive West Des Moines, IA 50266

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hands and clothing. EBP’s are indicated whenever staff provided cares for residents with an indwelling medical devices 2. The Care Plan initiated 8/22/22 lacked documentation that Resident #4 was having symptoms of respiratory illness or was in Transmission Based Precautions. The Care Plan was updated on 8/5/25 to indicate that Resident #4 had a diagnosis of Parainfluenza Type 2 and was placed in Droplet precautions per facility guidelines. The Electronic Health Record (EHR) indicated: a. On 8/2/25, Resident #4 began having nasal congestion and drainage while out for dinner with his wife. It was believed to be allergies per his wife and nasal spray was reordered. b. On 8/3/25, Resident #4 continued to have increased nasal congestion and drainage with lethargy and appeared to be swallowing hard. c. On 8/4/25, Resident #4 continued to have increased symptoms including flushed face, tachypnea (fast respirations), pulse oximetry of 90% on room air, drooling, crackles in lungs and temperature of 99.9 degrees Fahrenheit. Orders for respiratory panel and Chest X-ray (CXR) were obtained. d. On 8/4/25, the chest X-ray results showed nodular opacities in left lower lung that were likely infection or aspiration. The respiratory panel showed Resident #4 was positive for Parainfluenza virus and was sent to the Emergency Department (ED). Observations revealed the following: a. On 8/4/25 at 12:10 PM, Resident #4 was sitting in the dining room eating lunch. b. On 8/5/25 at 9:10 AM, Resident #4 was noted to be in droplet isolation precautions In an interview on 8/5/25 at 11:31 AM, Staff C, LPN Stated Resident #4 was placed in Transmission-Based Precautions (TBP) this morning after returning from the ED at approximately 7:45 AM. Stated Resident #4 started having symptoms on 8/2/25 and was getting worse each day until she sent him to the ED on 8/4/25. Stated she was not sure why Resident #4 was not in isolation prior to 8/5/25. Stated Resident #4 was out to meals 8/4/25. In an interview on 8/7/25 at 4:00 PM, Staff D, RN stated that when a resident develops signs and symptoms of respiratory illness they should be isolated and put up precaution signs on the door and get a respiratory panel. When results are in they would change or discontinue isolation based on test results. Stated that if signs and symptoms of COVID, residents would be placed in Airborne precautions and wear N95 mask, face shield, gown and gloves. Stated she would have expected Resident #4 to be placed in TBP when symptoms started. Stated Resident #4 was placed in Droplet precautions after talking with the corporate office. Also stated this was the guideline from the Centers for Disease Control (CDC) she had for Influenza. When this surveyor corrected that the diagnosis was Parainfluenza, she looked in the CDC guidance and noted that the isolation recommended was Contact isolation with Standard precautions. In an interview on 8/7/25 at 4:25 PM the DON stated Resident #4 was placed in Droplet isolation after talking with the Corporate office and they noted that Parainfluenza is transmitted through (continued on next page)

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	165790	A. Building B. Wing	08/12/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	droplets when coughing or sneezing. The CDC guidelines for TBP for Parainfluenza is Contact isolation with Standard Precautions for the duration of the Illness. Those guidelines can be found at https://www.cdc.gov/infection-control/hcp/isolation-precautions/appendix-a-type-duration.html#P In a policy titled Infection Prevention and Control dated 2001, it states that an infection prevention and control program is established and maintained to proved a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.