

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165597	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/16/2025
NAME OF PROVIDER OR SUPPLIER  Edgewater, A Wesleylife Community		STREET ADDRESS, CITY, STATE, ZIP CODE 9225 Cascade Avenue West Des Moines, IA 50266	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>47079</p> <p>Based on clinical record review, family and staff interviews, personnel file review and policy review, the facility failed to provide timely assessment and interventions for 1 of 4 residents who experienced a change in condition (Resident #1). The facility reported a census of 40 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) for Resident #1 dated 3/26/25 revealed a Brief Interview for Mental Status (BIMS) score had not been completed but indicated his memory was ok. It included diagnoses of anxiety, depression, respiratory failure, secondary malignant neoplasm of unspecified site (cancer that has spread to another location in the body from an unknown origin). It also revealed the resident required supervision with eating, moderate assistance with oral hygiene and upper body dressing, maximum assistance with bathing and lower body dressing, was dependent with toileting hygiene and putting on and removing footwear and required maximum assistance with transfer mobility. It further revealed the resident did not use supplemental oxygen therapy.</p> <p>On 4/10/25 at 12:02 PM, Resident #1's relative stated she arrived on 3/26/25 at 7:00 PM and observed the resident breathing differently and he complained of being cold. She stated she located a Certified Nurse Aide (CNA) and requested the nurse. She asserted Staff A, Licensed Practical Nurse (LPN), verbalized she was passing medications and would respond real soon. The resident's relative indicated she then told Staff B, CNA, that Resident #1 needed help. She stated Staff B and Staff C, CNA, obtained the resident's temperature of 102 degrees Fahrenheit (F) and the oxygen saturation (O2 sat) of 75% on room air. She stated Staff B, CNA, got an oxygen tank and Staff C, CNA placed the resident on oxygen (O2) and notified Staff A, LPN of the resident's temperature (T) and O2 sat. The relative stated Staff A, LPN, arrived to the resident's room approximately 45 minutes after she was initially notified of the relative's concern regarding the resident's condition.</p> <p>On 4/10/25 at 4:07 PM, Staff C, CNA, stated Resident #1 was having trouble breathing on 3/26/25 and she notified the nurse. She said she took the resident's oxygen level (O2 sat) and it was at 75%. She stated she then applied oxygen at two (2) liters per minute (lpm) via nasal cannula (NC) and rechecked the resident's O2 sat which resulted 83%. She stated the Staff A, LPN, arrived 5 - 10 minutes later. She further stated the resident's relative requested the nurse a couple of minutes after she arrived and at least 45 minutes passed before Staff A, LPN, came to see the resident.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Electronic Health Record (EHR) included a physician's order for Albuterol HFA; inhale two (2) puffs into the lungs every 4 hours as needed (PRN) for wheezing/shortness of breath dated 3/24/25 and Oxycodone 5 mg tablet by mouth every 4 hours as needed for pain dated 3/26/25.</p> <p>An EHR progress note dated 3/26/25 at 7:45 PM revealed Staff A, LPN, arrived to the resident's room and checked his vital signs with the following results: blood pressure (BP) 131/93 mmHg, T 98.4 degrees F, respiratory rate (RR) 28, and O2 sat 91%. It also indicated Staff A administered the Albuterol and Oxycodone. It also indicated Staff A asked the resident's relative to give the medication time to work.</p> <p>The EHR O2 Sats Summary indicated Staff A, LPN, documented on 3/26/25 at 8:00 PM the resident's O2 sat was 91% on room air. At 9:00 PM, Staff A, LPN, documented the resident's other relative notified her that an ambulance had been called for Resident #1. Staff A also documented she then contacted the on-call provider to send the resident to the hospital per the family's request.</p> <p>The Emergency Medical Services (EMS) report dated 3/26/25 at 9:20 PM revealed Resident #1 was receiving supplemental O2 at 2 liters per minute (lpm) via nasal cannula. It indicated at 9:26 PM, the resident's O2 sat was 77% and was switched to the EMS O2 tank at 4 lpm via nasal cannula.</p> <p>The Care Plan revised 3/26/25 did not included any respiratory related staff interventions or directives.</p> <p>A Notice of Corrective Action form dated 3/28/25 indicated the facility acknowledged Staff A's failure to provide timely assessment.</p> <p>On 4/16/25 at 1:49 PM, Staff C, CNA, stated she put oxygen on him because he had labored breathing, his O2 sat was 75%, and the family was present asking staff to do something.</p> <p>On 4/16/25 at 2:04 PM, Staff B, CNA stated he heard Staff C call for Staff A to come to the resident's room. He stated he went to the resident's room and the resident reported being short of breath. Staff B stated he got an oxygen tank and notified Staff A that she needed to come to the resident's room.</p> <p>A policy titled Change of condition monitoring process reviewed 2/2025 defined a change of condition as:</p> <ol style="list-style-type: none"> <li>1. Accidents where there is direct harm to the resident</li> <li>2. A noted reaction to a medication</li> <li>3. Changes in cognitive function</li> <li>4. A physical decline in resident's condition</li> <li>5. An emotional change in the resident</li> <li>6. Any condition change for which the physician directs staff to notify him/her, regarding the resident</li> </ol> <p>(continued on next page)</p>		

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