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	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewater, A Wesleylife Community	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, family, and staff interviews, the facility failed to provide timely physician and family notifications for 1 of 4 residents (Residents #1) who experienced a change in condition or treatment. The facility reported a census of 39 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS listed Resident #1 as independent with eating. She required moderate assistance with sit-to-stand, chair-to-chair, and toilet transfers. In addition, she required supervision with all other activities of daily living (ADLs) and mobility. The MDS included diagnoses of atrial fibrillation (AFib - irregular heart rhythm), a stroke, traumatic brain injury, and a narrowed heart valve that restricts blood flow through the heart. Resident #1 received a diuretic (a medication that increases urine output to remove salt and water from the body) during the 7-day lookback period.The hospital's Physician Discharge summary dated [DATE] indicated Resident #1 received a diuretic during hospitalization. The order directed to start 7/12/25 until 8/11/25 at 11:59 PM, normal paused since that day until manually restarted.The pharmacy's Request for Clarification admission Orders signed by the physician on 7/14/25 reflected the admitting physician discontinued Resident #1's diuretic.The Nurses' Note dated 7/14/25 at 3:37 PM indicated the facility received clarification from the provider to discontinue the as needed (PRN) diuretic.Resident #1's clinical lacked notification provided to the family of the discontinued diuretic.The Care Plan dated 7/14/23 lacked directives to notify the family or provider of anything other than abnormal labs to the medical doctor (MD).The Summary of Daily Skilled Services dated 7/17/25 reflected Resident #1 had 3+ edema from her left arm from her elbow to her hand.The Plan of Care Note dated 7/21/25 at 1:33 PM indicated the facility had a Care Conference. The meeting included the facility's representatives, Resident #1 and her representatives. The Occupational Therapist reported edema in Resident #1's arms that made it more difficult for her to perform her ADLs. The Director of Nursing (DON) reviewed Resident #1's weights, medications, and answered questions her and her family.The Progress Notes lacked notification to the provider of Resident #1's edema until 7/22/26. The note didn't include Resident #1 had difficulty accomplishing her ADLs.The N Adv Skilled Evaluation dated 7/23/25 at 9:18 AM reflected Resident #1 informed her daughter that she would like her children to all come see her and she would like to hear the voice of Jesus.The Progress Notes lacked notification to the provider about Resident #1's request to her daughter or her change in behavior. On 2/4/26 at 3:01 PM, Staff A, Registered Nurse (RN), stated whoever processed a medication change should notify the resident's family or representative. In addition, she explained they should document the communication in the nurse's notes (progress notes). Staff A reported if a resident suddenly requested family to come see them and made a new comment about heaven, it would constitute a change of condition. At that time, they should notify the provider. She added the staff should (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document it in the resident's progress notes.On 2/5/26 at 6:24 AM, Staff B, Licensed Practical Nurse (LPN), explained whoever processed the medication change orders should notify the resident's family or representative and document the communication in the nurse's notes. Staff B added if a resident requested family to come see them and made a new comment about heaven, the staff should ask the resident more questions. If the resident never made those type of comments before, it would be a change of condition. Staff B explained they would base notifying the provider on further mental assessment. She reported the resident's progress notes would have the provider communication.On 2/5/26 at 11:09 AM, Staff C, RN, stated the nurse who received the order to change the medication should notify the resident's family or representative. Then they should document the communication in the progress notes.On 2/5/26 at 2:38 PM, the Director of Rehabilitation Services (Rehab Director) stated they expected the nursing department to contact the physician with changes in condition.On 2/5/26 at 4:53 PM, Staff C confirmed she couldn't locate documentation indicating the facility notified the provider.On 2/10/26 at 12:03 PM, the DON reported the staff should notify the family and physician for any change of condition in a resident and document it in the progress notes.The Change of Condition - Physician Notification policy effective December 2024 directed prompt communication with the Physician and Nurse Practitioners are essential to the continuity of resident care and well-being. Communication of the following changes are necessary to determine course of treatment.1. Results in an injury that has the potential for physician intervention.a. Acute symptoms (list is not inclusive-examples only):b. Change in vital signsc. Other conditions as deemed necessary2. Notify charge nurse or supervisor.3. Document time of call, name of the provider spoken to; reason for call and result or orders received.4. Update the resident's care plan to address the change; include new or additional problem (if applicable), goal and approaches. The Change of Condition - Resident Family/Responsible Party Notification policy effective February 2025 instructed to notify the family and/or responsible party of any change in the resident's condition or plan of care. The policy directed staff to document in the resident's medical record, the time called, the person spoken with, what was reported, and their response, if any.

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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 interviews, and policy review, the facility failed to personalize 1 of 4 residents' Care Plan (Resident #1) by failing to include their use of diuretic medication therapy. The facility reported a census of 39 residents.Findings include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS listed Resident #1 as independent with eating. She required moderate assistance with sit-to-stand, chair-to-chair, and toilet transfers. In addition, she required supervision with all other activities of daily living (ADLs) and mobility. The MDS included diagnoses of atrial fibrillation (AFib - irregular heart rhythm), a stroke, traumatic brain injury, and a narrowed heart valve that restricts blood flow through the heart. Resident #1 received a diuretic (a medication that increases urine output to remove salt and water from the body) during the 7-day lookback period.The hospital's Physician Discharge summary dated [DATE] indicated Resident #1 received a diuretic during hospitalization. The order directed to start 7/12/25 until 8/11/25 at 11:59 PM, normal paused since that day until manually restarted.The pharmacy's Request for Clarification admission Orders signed by the physician on 7/14/25 reflected the admitting physician discontinued Resident #1's diuretic.The Nurses Note dated 7/21/25 at 1:30 PM, Staff E, Registered Nurse (RN), documented the staff monitored Resident #1 for increased edema to bilateral lower extremities (BLE). In addition, Staff E documented the notified the provider of Resident #1's complaint of shortness of breath with exertion and phlegm in back of her throat.The Nurses Note dated 7/22/25 at 6:42 PM, Staff C, RN, documented receipt of new diuretic medication orders due to Resident #1's increased weight and edema.The Care Plan revised 8/6/25 lacked Resident #1's diuretic medication therapy nor provided staff with directions what to monitor or when to intervene.On 2/4/26 at 3:15 PM, Staff A, RN, stated the Care Plan should include a change in the resident's treatment within 48 hours of initiation.On 2/5/26 at 6:41 AM, Staff B, Licensed Practical Nurse (LPN), stated the Care Plan should include a change in the resident's treatment within 24 hours of the change.On 2/5/26 at 11:25 AM, Staff C stated the Care Plan should include the change in the resident's treatment within 24 hours of initiation.On 2/10/26 at 12:03 PM, the Director of Nursing (DON) stated any nurse could update the Care Plan, but the facility designated the MDS Coordinator to manage medication updates.The Comprehensive Care Plan Process revised December 2025 directed the Comprehensive Care Plan must describe the services furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.

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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, policy review, family, and staff interviews, the facility failed to provide assessments and interventions for 1 of 4 residents (#1). The facility reported a census of 39 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS listed Resident #1 as independent with eating. She required moderate assistance with sit-to-stand, chair-to-chair, and toilet transfers. In addition, she required supervision with all other activities of daily living (ADLs) and mobility. The MDS included diagnoses of atrial fibrillation (AFib - irregular heart rhythm), a stroke, traumatic brain injury, and a narrowed heart valve that restricts blood flow through the heart. Resident #1 received a diuretic (a medication that increases urine output to remove salt and water from the body) during the 7-day lookback period.The Summary of Daily Skilled Services dated 7/17/25 reflected Resident #1 had 3+ edema from her left arm from her elbow to her hand.The facility's Physician Notification Fax dated 7/19/25 indicated Resident #1 had a history of congestive heart failure (CHF).The Nurses Note dated 7/21/25 at 1:30 PM, Staff E, Registered Nurse (RN), documented the staff monitored Resident #1 for increased edema to bilateral lower extremities (BLE). In addition, Staff E documented the notified the provider of Resident #1's complaint of shortness of breath with exertion and phlegm in back of her throat.The Plan of Care Note dated 7/21/25 at 1:33 PM indicated the facility had a Care Conference. The meeting included the facility's representatives, Resident #1 and her representatives. The Occupational Therapist reported edema in Resident #1's arms that made it more difficult for her to perform her ADLs. The Director of Nursing (DON) reviewed Resident #1's weights, medications, and answered questions her and her family.The Nurses Note dated 7/22/25 at 6:42 PM, Staff C, RN, documented receipt of new diuretic medication orders due to Resident #1's increased weight and edema.The N Adv Skilled Evaluation Note dated 7/23/25 at 9:18 AM, Staff F, Licensed Practical Nurse (LPN), documented Resident #1's respiratory assessment. The assessment reflected Resident #1 had diminished (difficult to hear breath sounds) lower lung sounds when listened from the resident's back but indicated she didn't have difficulty breathing or shortness of breath.The Nurses' Note dated 7/29/25 at 9:21 AM, Staff C documented about the family's concern with Resident #1's breathing. Staff C's assessment indicated Resident #1 had audible (loud) wheezing (a high-pitched sound caused by decreased space) noted in her lungs, fluid buildup in her forearms, and a 2-pound (lb.) weight increase from the preceding day. In addition, Staff C documented they contacted the provider because the family requested a change to Resident #1's diuretic due to increased effectiveness.The Nurses Note 7/29/25 at 11:42 AM, the provider changed Resident #1's diuretic per the family's request.The Nurses Note dated 7/30/25 at 3:58 AM, Staff G, RN, documented Resident #1 continued to have respiratory wheezing but denied shortness of breath.Resident #1's clinical record lacked assessments of her lung sounds following 7/30/25.On 2/4/26 at 11:13 AM, Staff C stated staff assess daily weights, lung status, edema, and breathing for residents with CHF.On 2/5/26 at 6:30 AM, Staff B, LPN, explained the staff assess weight, lung sounds, and edema for residents with CHF.On 2/5/26 at 11:45 AM, Staff H, RN, stated the staff assess weight, lung sounds, congestion, edema, and shortness of breath for residents with CHF.On 2/10/26 at 12:03 PM, the Director of Nursing (DON) stated staff should include any change of condition on the hot sheets for nursing follow-up.The Change of Condition Monitoring Process policy effective February 2025 defined a condition change as an alteration from normal status. A significant change in resident status refers to observed changes in the resident's condition warranting immediate nurse assessment, intervention, and appropriate documentation in the clinical (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record. Physician notification and follow-up is necessary. It included a physical decline in the resident's condition.