STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165597	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 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 observation, clinical record review, and staff, resident, Nurse Practitioner and Podiatrist interviews, the facility failed to provide the necessary assessments for 1 of 4 residents reviewed with a condition change (Resident #4). The facility identified a census of 38 residents. Findings include: A Minimum Data Set (MDS) assessment form dated 10/2/19, listed [DIAGNOSES REDACTED]. The MDS documented a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (cognitively intact), and independent with transfers, ambulation, locomotion on and off the unit, toilet use and personal hygiene. The resident required extensive assistance of one staff member with bed mobility and dressing and the resident had no skin conditions. The resident had a potential impairment to skin integrity related to a history of pressure ulcers to her coccyx and elbow, decreased mobility and incontinence. The interventions included the following: a. Check skin daily during cares and notify the nurse of any abnormalities. (dated 10/30/19) b. Monitory/document location, size and treatment of [REDACTED]. (dated 10/30/19) The Podiatrist Progress Note dated 11/18/19 included the following documentation with a hand written note on the bottom which stated the facility received the note via mail on 11/25/19. a. The patient had been unable to provide self nail care due to her medical conditions and severe nature of her nail deformity which caused pressure and limited the patient's ability to function without pain. b. She related to pain to the right hallux (big toe) nail today. c. Each digital nail was elongated, thickened, ridged, lysing (cell membrane breakdown) with friable subungual debris which, after debridement to underlying nail bed, revealed a characteristic fungal/yeast/mold odor or consistency. No surrounding [MEDICAL CONDITION], deep incurvartion or evidence of a bacterial infection. d. There appeared a mild incurvartion noted to the bilateral borders of the bilateral hallux with no soi. The area appeared more significant to the bilateral borders of the right hallux nail, with a hyperkeratic lesion noted to the distal hallux area. e. Class findings included absent posterior tibial pulses, diminished dorsalis pedis pulses, lack of digital/pedal hair growth, the above note nail changes, some telangectasias (dilated small vessels) , thinning of the skin, skin temperature having been cool, dependent rubor (flushed skin) and lower leg [MEDICAL CONDITION] bilaterally. Mild pigmented skin changes due to vascular compromise. All muscle groups are not within normal limits bilaterally. There appeared no evidence of dermatological breakdown, no signs or symptoms of infection and no open [MEDICAL CONDITION], bilaterally. f. There appeared a hyperkeratic (corn or a callus) lesion noted to the lateral 4th digit on the right foot. The assessment included a symptomatic onychomyocosis (nail fungus) digital nails digits 1 thru 5 bilateral vascular compromise. A Skin Observation sheet with an entry dated 11/18/19 documented the resident had discoloration. A written statement from the Corporate Nurse on the skin sheet and (not dated) stated the resident had no skin issues with baths on 11/11/19, 11/14/19 and with AM cares on 11/18/19 at 10:16 a.m. The skin issue noted with the 11/18/19 evening bath of discoloration occurred after the Podiatrist visit. Review of the facilities Progress Notes form from 11/18/19 thru 11/19/19 revealed no documentation a Podiatrist treated the resident and/or any assessment of her bilateral lower extremities (feet). A Progress Note entry dated 11/20/19 at 10:58 a.m. revealed the following documentation: Per night shift report the resident expressed increased anxiety with much use of the call light. The resident complaint about her bunions on her right foot. The resident continued anxious and restless that morning with complaints of general discomfort and that she just hurt all over. The resident complained her right foot hurt all the time and she couldn't' hardly stand to walk on it. Upon assessment of the right lower extremity the foot presented with increased redness, [MEDICAL CONDITION] and redness around the great toe and the top of the foot extending to the great toe side of the foot. The resident's temperature registered at 100.1 degrees Fahrenheit. The nurse administered as needed Tylenol with a plan for the Physician to have assessed the resident on rounds that day. A Non-Pressure Skin Condition Weekly Assessment Form dated 11/20/19 described the right foot great toe as follows: a. Increased redness, warmth and [MEDICAL CONDITION]. b. Area cleansed with normal saline, dried and protected. (The facility failed to measure any of the areas) c. The Physician and family were notified. A fax form dated 11/20/19 included the following documentation: a. Vital signs - Temperature 100.1, Respirations 20, Pulse 86 and Blood Pressure 110/62. b. The night shift reported increased anxiety, increase use of the call light and frequent complaints her bunions on her right lower extremity were hurting. The resident continued restless and with frequent use of the call light. The resident reported general discomfort , stated she hurt all over and had right lower extremity pain. Assessment of the right foot demonstrated increased warm, [MEDICAL CONDITION] and redness. The nurse asked the Physician or Nurse Practitioner (NP) to have [MED] 500 milligrams (mg.) by mouth (po) 3 times a day for (x) 10 days, start [MEDICATION NAME], check a CBC (complete blood count), consult with Podiatry and continue to have monitored. A physician progress notes [REDACTED]. Fungal toenails noted on the area where the toenail usually would have sat. This area wasn't draining and was closed at an estimated size of 0.5 cm x 0.5 cm with brown, purple middle and a white color around that. In an interview with the resident's Nurse Practitioner (NP) 3/10/20 at 3:41 p.m. she confirmed the following: a. How long it took Osteomylitis to have appeared depended on the cause but in the case of this resident it had been rapid. The Podiatrist punctured the resident's foot and introduced bacteria. Due to the fact the resident had Osteopenic bones her conditioned deteriorated rapidly. b. She confirmed if the resident complained of pain to her foot the area should have been assessed. c. When asked if she felt an outcome of an amputated right great toe on 1/4/20 would have been a normal disease progression she stated the resident had [MEDICAL CONDITION], Osteopenia, a stationary lifestyle, a corn was removed, poor circulation and advanced age so it did not surprise her it went that fast. d. When the NP went to see the resident she asked if she saw a Podiatrist that day she never told her one way or another. The NP looked in the Nurses Notes and nothing had been documented so there was not an accurate trail to discover the source of the problem. Review of a staffing schedule for 11/18/19 indicated the following nursing staff worked in the area the resident resided: a. Staff A, nurse worked from 6 a.m. until 6 p.m. b. Staff B, Licensed Practical Nurse (LPN) worked from 6 p.m. until 6 a.m. During an interview 3/6/20 at 2:14 p.m., Staff A stated he had not known the Podiatrist provided her service at the facility on 11/18/19 while he worked and he never received a list of residents the Podiatrist treated. During an interview 3/6/20 at 2:31 p.m., Staff B stated she had not observed the Podiatrist at the facility on 11/18/19 while she worked and she never received a list of residents the Podiatrist treated. Review of the staffing schedule for 11/19/19 indicated the following nursing staff worked in the area the resident resided: a. Staff E, nurse worked from 6 a.m. until 6 p.m. b. Staff D, nurse worked from 10 p.m. until 6 a.m. During an interview 3/10/20 at 4:31 a.m., Staff E confirmed she helped out in the area the resident resided but was unaware a Podiatrist treated the resident. During an interview 3/10/20 at 6:21 p.m,. Staff D had been unaware a Podiatrist treated residents on 11/18/19. The staff member also indicated she observed the resident's foot/toe on rounds the night shift of the 19th that ran into the 20th and she described the toe as maybe slightly discolored with no deformity or swelling. She admitted she failed to document her

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.

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) assessment and the Director of Nursing (DON) talked to her about that issue. During an interview with the Podiatrist 3/10/20 at 4:38 p.m., she indicated she could not recall if she talked to any staff while she treated specific residents at the facility on 11/18/19 or not. During an interview 3/10/20 at 3:09 p.m., Staff C, Registered Nurse (RN) described the resident's right great toe on the date of hospitalization as purple with the arch described as red however she could not recall if the area had been swollen. The nurse could not recall a blister but she described a weird part. During an interview with the resident's Nurse Practitioner on 3/10/20 at 3:41 p.m., she confirmed in the case of this resident her Osteomylitis occurred rapidly because the Podiatrist punctured the resident's foot and introduced the bacteria. The resident also had [DIAGNOSES REDACTED]. The nurse confirmed if the resident complained of pain to the site there should have been assessments. When she assessed the area there had been fungus on the toe and redness on the tip but it really had not been bad. When asked if she felt the area could have been prevented if properly assessed on 11/18/19, following the Podiatrist treatment, the Nurse Practitioner indicated she went to see the resident and asked if she saw a Podiatrist but she never told her. The Nurse Practitioner looked into the Nurse's Notes (Progress Notes) with no documentation present of a Podiatrist visit. The NP stated a night nurse should have assessed the area but at least she reported the situation to the day nurse. emergency room Progress Notes dated 11/22/19 indicated their impression as follows: a. Presumed [MEDICAL CONDITION]/ulcer at the right great toe. There had been suspect Osteomylitis that affected 12 millimeters (mm) of the distal phalange of the great toe. There appeared to have been an abscess within the planter soft tissue at the level of tissue at the level of the third and fourth proximal metatarsals. b. The principal [DIAGNOSES REDACTED]. Anxiety b. Chronic Leukocytosis c.[MEDICAL CONDITION] d. Foot abscess e. [MEDICAL CONDITION] f. NSTEMI (non-ST elevated [MEDICAL CONDITION] infarction) The resident passed away 1/19/20 at 7:28 p.m. with cause of death as multiple organ failure.