STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165163	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
On With Life	715 SW Ankeny Road Ankeny, IA 50023

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on clinical health record review, facility document review, staff interviews, and policy review, the facility failed to provide adequate supervision resulting in residents attempting to or exiting the building without staff knowledge for 2 of 3 residents reviewed for inadequate nursing supervision (Residents #1 and #2). The facility reported a census of 21. Findings include: 1. The Minimum Data Set (MDS) Assessment completed on 2/18/26 revealed Resident #1 with a Brief Interview for Mental Status score of 9, indicating a moderate cognitive impairment. The MDS further noted Resident #1 as inattentive with disorganized thinking that is continuously present without fluctuations. Diagnoses include attention and concentration deficit, traumatic brain injury, and quadriplegia. Resident #1 required staff supervision for transfers to/from bed and chair and utilized a manual wheelchair independently. The MDS indicated a wander/elopement alarm was not in use at the time. The Care Plan initiated on 11/11/25 and updated on 11/25/25, identified Resident #1 with decreased safety awareness and impulsivity. Interventions included 15-minute safety checks, use of a bed alarm, video monitor while in bed, and use of a wheelchair pin release seatbelt (prevents the resident from unbuckling themselves). The Care Plan was further updated on 12/25/25 to reflect Resident #1 no longer needed staff supervision when moving about the facility in a manual wheelchair. The facility document dated 3/25/26 detailed Resident #1 attempting to exit the building unattended on 3/25/26 at approximately 2:30 PM. One of the facility's therapist made a comment to Resident #1 how nice it was outside and maybe a therapy session would be outside. Shortly after this conversation, Resident #1 self-propelled themselves to a building exit door and pressed the door opener. This immediately set off the door alarm and staff intervened immediately. The facility believed this was not a true elopement as Resident #1 thought they were to go outside for therapy. The leadership team decided to assess the resident's outside privileges. The resident was able to safely self-propel a wheelchair and successfully navigate themselves to/from their room and therapy gym. A wanderguard alarm (a wearable tracking tag to alert staff if leaving a defined area) was brought up but not initiated. Resident #1 remained on 15-minute safety checks. The Incident Report #823 detailed Resident #1's witnessed fall on 3/30/26 at 1:40 PM. Staff noticed the resident outside self-propelling themselves from the front door to the sidewalk along the building. While in the wheelchair, Resident #1 fell off the sidewalk into the parking lot. Immediate medical assistance was provided, 911 called, and the resident transported to the emergency room. Emergency Department records dated 3/30/26 detailed Resident #1 with a cut to their right eyebrow and bruising under the eye. Further testing revealed fractures to the right eye socket, cheekbone, and upper jaw. Resident #1 returned to the facility the same day. Discharge instructions included out-patient management for the facial fractures with an otolaryngologist (ENT) and a 7-day course of an antibiotic. The Post Fall Evaluation Progress Note dated 3/30/26 at 1:58 PM detailed Resident #1 had exited the building, unattended, behind visitors. While self-propelling themselves along the sidewalk, the front wheel of the wheelchair went over the curb and the wheelchair tipped over with the resident belted into the chair. The Chronic Care Management Progress Note dated 3/31/26 at 11:12 AM, completed by the facility's Physician Assistant (PA), noted the facial cut with stitches around the right eye. The PA noted the hospital's (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	discharge instructions to follow-up with ENT for the facial fractures. The Appointment-Departure Progress Noted date 4/9/26 at 1:40 PM noted Resident #1 left the facility to a same day surgery appointment for repair of facial fracture. The resident was expected to return later in the evening. The Post-operative Note dated 4/9/26 documented the surgical repair to Resident #1 facial fracture. The surgeon completed a right zygomatic open reduction and internal fixation (placement of metal hardware to realign the right cheekbone to its correct position). An undated facility document notates an interview with Resident #1 on 3/31/26 at 9:00 AM. When asked why they went outside, the resident replied, Well it must have been nice outside. When asked if they recalled what made the wheelchair tip over, the resident replied, There must have been a curb. In an interview on 6/10/26 at 9:30 AM, Staff A, Administrative Assistant, detailed the events of 3/30/26. They were on the phone when Resident #1 came into the lobby area unattended. The phone was positioned to the right of the main desk area and not facing the front door. They had looked down into a file drawer during the call. When the call ended, Resident #1 was gone. Staff A was not sure where the resident had left to, maybe to the administrative offices which were adjacent to the lobby area. Approximately 5-10 minutes later, Staff A heard commotion outside. Staff A went to see what was going on and saw Resident #1 on the ground. In an interview on 6/10/26 at 9:50 AM, Staff B, Certified Nurse Aide (CNA), detailed the events of 3/30/26. Staff B was sitting in a vehicle with another staff member prior to the start of their shift. Staff B noticed Resident #1 was outside unattended and realized the resident was not cleared to be outside alone. Just after realizing all of this, one of the wheelchair wheels caught the curb and tipped over. They, along with the co-worker, exited the vehicle and ran to the resident. The wheelchair was tipped over on its side with Resident #1 still buckled in. Both staff members stayed with the resident until facility nurses and the ambulance arrived. In an interview on 6/10/26 at 10:10 AM, Staff C, CNA, noted they had completed a 15-minute safety check on Resident #1 at approximately 1:15 PM. The resident was in their room completing a word puzzle, as per their norm. Staff C states the resident did not say anything to them during this interaction. At approximately 1:30 PM, Staff C along with another staff member had just come out of another resident's room and was told of an incident outside. Staff C confirmed Resident #1 able to self-propel themselves in a wheelchair. In an interview on 6/10/26 at 10:25, Staff D, CNA, detailed events of 3/30/26. Staff D was sitting in a vehicle with another staff member prior to the start of their shift. Staff D noticed Resident #1 was outside unattended. A split second later, a wheel went off the curb and the wheelchair tipped over. They, along with the co-worker, exited the vehicle and ran to the resident. Upon arrival, Staff D attempted to remove the pin release seat belt but did not have the appropriate instrument to do so. A therapy staff member, who also ran over, released the seat belt. Staff D noted Resident #1 was moaning in pain and startled. In an interview on 6/10/26 at 11:40 AM, Staff E, Physical Therapy Assistant, detailed events of 3/30/26. Staff E was outside overseeing a therapy session with separate residents and a therapy student. Staff E noticed Resident #1 was outside unattended and started to walk toward them. It did not look like the resident was going back inside and was propelling themselves away from the entrance door. At that moment, Resident #1 tipped over in the wheelchair. Staff E ran to the resident and then inside the facility for help when the two CNA staff members arrived. Staff E returned the resident, released the pin release seat belt, and applied pressure to the resident's head wound as it was bleeding. When medical staff from the facility arrived as well as the paramedics, Staff E left the scene. Staff E stated they had worked with Resident #1 all throughout their admission. The resident appeared to be more alert in the mornings but exhibited more confusion in the afternoons. Staff E believed Resident #1 did not have the cognition to know he was not to be outside alone. Staff E explained Resident #1 moved well throughout the facility independently, did not need staff assistance to get to/from their room to specific locations, such as therapy gym or dining room. However, given overall cognition, was not safe for outside independence. In an interview on 6/10/26 at 4:35 PM, the Director of Nursing, DON, recalled the first event with Resident #1 where they attempted to leave the building. Up until that point in time, the resident had (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	not shown any signs of exit-seeking and was able to navigate inside the facility independently. After discussions, the interdisciplinary team felt this was a one time incident and did not feel the situation would be repeated. The decision was made not to place a wander guard alarm and to further assess outdoor privileges. The DON noted staff spoke with Resident #1 after the event on 3/30/26. The resident could not say where he was going or why he was up front in the lobby area. In a follow-up interview on 6/11/26 at 11:45 AM, the DON explained the following changes were implemented after Resident #1 left the building unaccompanied: a. Front entrance door now alarmed. If a code is not entered or a staff badge swiped, an alarm will sound b. [NAME] tags attached to wheelchairs to alert staff to a resident's outside privileges c. Wander guard alarm implemented immediately with an attempted resident elopement 2. The MDS Assessment completed on 5/15/26 revealed Resident #2 with a BIMS score of 13, indicating intact cognition. The MDS further noted Resident #2 as inattentive with disorganized thinking that is continuously present without fluctuations. The resident utilized a motorized wheelchair independently. Medical diagnoses include history of a traumatic brain injury (TBI).The Occupational Therapy Assessment completed on 5/6/26 noted Resident #1 with decreased safety awareness, decreased awareness of self-limitations, and difficulty sustaining focus/attention.The Speech and Language Evaluation completed on 5/15/26 noted Resident #2 with a history of TBI with chronic cognitive deficits involving attending, short-term and delayed memory, and executive functioning (working memory, self control/inhibition, and mental flexibility). The Care Plan initiated on 5/8/26 described Resident #2 as moderately independently with a self-propelling manual wheelchair.The Incident Report #823 and an undated facility document titled Final Investigation Summary detailed Resident #2's exit from the facility unattended by staff on 5/15/25. The resident informed several staff members they were going outside to wait for their spouse. Each staff member informed the resident they could not go outside alone to wait. The resident waited inside the building by an exit door used by staff and visitors. At approximately 6:17 PM, another resident's family member interacted with Resident #2 and asked if they would like to go outside. The resident said yes and the family member entered the door code to silence the alarm. Resident #2 proceeded to exit the building unaccompanied by staff. Approximately 15 minutes later (6:32 PM), Staff F, RN, was leaving the building at the end of their shift and found Resident #2 outside alone. Staff F sat with the resident outside until the spouse arrived, Staff F then informed the charge nurse of the incident at 6:37 PM. In a statement obtained by facility staff on 5/16/26, the family member who let Resident #2 out the door acknowledged they did so. During an interview on 6/10/26 at 3:15 PM Staff G, RN, explained talking briefly with Resident #2 as they were leaving the building at the end of their shift. This was approximately 6:15 PM. The resident was sitting about 10 feet from the exit door, waiting inside. There were no other staff, residents, or visitors around. During an interview on 6/10/26 at 3:30 PM Staff F recalled reminding Resident #2 they needed to wait for their spouse inside the building. This was approximately 5:30 PM. Resident #2 acknowledged and made no further comments about leaving by themselves. Staff F stated they found the resident outside about 25-30 feet from the door at 6:30 PM. The resident was not in any distress. They explained someone let them out but could not recall who this was. During an interview on 6/10/26 at 11:40 AM Staff E, PTA, noted Resident #2 with impaired cognition. The interdisciplinary team was trying to get the resident more independent but cognition and safety awareness was poor. During an interview on 6/10/26 at 4:45 PM the Assistant Director of Nursing (ADON) acknowledged the incident on 5/15/26. The ADON noted Resident #2 could successfully take themselves to/from the therapy gym. No previous exit-seeking behaviors previously. In a follow-up, the ADON confirmed Resident #2 was removed from 15-minute safety checks on 5/12/26 (admitted to facility on 5/8/26). During an interview on 6/11/26 at 12:00 PM, the DON explained newly admitted residents are placed on 15-minute safety checks for at least 72 hours. If a resident does not display unsafe behaviors, the 15-minute checks can be removed. Staff will also round on residents every 2 hours, regardless if on 15-minutes checks or not. The Elopement Procedure document, revised 05/26, defines an elopement when a resident exits the facility's (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	property without permission, undetected, and unsupervised. A witnessed elopement is when a resident exits the facility's property with staff as a result of appropriate response to door alarms. Staff should not block doors when someone is attempting to elope due to risk of resident and staff injury. If the resident does leave the building, two more staff should accompany the resident. Staff should stay with the resident. An excerpt from the Family Education Manual states the following: a. For safety and security of residents, doors are alarmed with a code needed to exit b. Staff will provide the code as needed c. Do not share code with other residents or family members d. When entering/exiting the building, ensure no other residents leave the building unless accompanied by staff.