STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165303	A. Building B. Wing	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Centers of Independence West Campus	1610 Third Street NE Independence, IA 50644

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews, and facility policy review, the facility failed to provide supervision for an ambulatory cognitively impaired resident for 1 of 2 residents identified by the facility as an elopement risk (Resident #1). On 10/17/25 around 8:11 PM, Resident #1 went out the B-wing door, walked down the facility sidewalk, across the facility graveled parking lot, across a residential street, across a hospital parking lot and into the hospital ambulance garage. The Emergency Medical Service (EMS) Personal contacted the facility to inform them that the resident was at the emergency room entrance at 8:32 PM. The facility had been unaware the resident had eloped (ran away) until contacted by the Emergency Personal. The resident was identified with cognitive impairment, impaired safety awareness, and wandering behaviors. Staff failed to determine the cause of an activated exit door alarm, and assure that all residents were safe and accounted for. This failure resulted in Immediate Jeopardy to the health, safety, and security of the resident. The facility identified a census of 52 residents.On November 4, 2025 at 2:15 PM, the Iowa Department of Inspections, Appeals and Licensing (DIAL) staff contacted to notify them the Department determined an Immediate Jeopardy (IJ) situation existed at the facility. The IJ began on October 17, 2025. The IJ was removed per past non-compliance on October 20, 2025. The facility staff removed the Immediate Jeopardy through the following actions:*Facility wide education and reinforcement completed on 10/20/25, -One-on-one and group education provided by Quality Assurance leadership on: door alarm response, immediate headcount requirements, documentation expectations,-Staff not present at initial training were educated prior to the next shift worked-Education emphasized alarm fatigue risk and requirement to verify resident location before silencing alarm-Dual-staff verification for alarm re-implemented and emphasized on 10/20/25.-Use of the Communication board implemented for documentation after door alarm activation in exit attempts events on 10/20/25-Outside motion lights tested and confirmed functional on 10/17/25-Orientation revised to include mandatory elopement and alarm-response training on 10/20/25-Weekly audits in place for alarm responses, headcounts, and documentation-audits started on 10/24/25The facility implemented their plan of correction and removed the immediacy on 10/20/25 and the scope was lowered from a J to a D. Findings include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated severely impaired cognition. The MDS revealed the resident was able to be understood, rarely/never understood others, had wandering behavior that occurred daily and disorganized thinking (rambling, unclear or illogical flow of ideas, or switching from subject to subject). The resident was independent with ambulation throughout the facility with no assistive devices. The MDS included diagnoses of hypertension, (a condition in which the force of blood against the artery walls is consistently too high), Non-Azheimer's Dementia (any form of dementia that is not caused by Alzheimer's disease), and anxiety (a common mental health condition characterized by excessive worry, fear, and nervousness that can interfere with daily life). The Care Plan focus area with no date, indicated Resident #1 was at risk for elopement/wandering related to dementia, resident will at times head towards the exit door but is easily redirected and at times will make statements about wanting to go home. The Interventions directed the following:a. During my wandering times or my increased confusion times, nursing staff will increase supervision with me. I usually will go with staff if they hold my hand softly.b. Engage resident in purposeful activities such as folding towels, helping put table cloths on dining room tables.c. If you see me packing up my items or wandering around with my purse, please intervene offer toileting, offer food or drink, offer purposeful activities.An Elopement Risk Evaluation completed on 5/28/25 at 1:41 PM, checked that the resident has a known history of elopement.A Behavior Note dated 7/18/25 at 7:40 PM, documented the resident became confused and started to pace the hallway immediately after supper and eloped the facility through the main entrance at 7:30 PM while the writer was passing medications on the C-hallway and the rest of the staff were helping other residents with cares. Redirection and reassurance by the staff. The staff at first tried to redirect the resident back in the building, but the resident became more agitated and started walking away from the staff. The staff decided to walk with the resident to the hospital, as the resident stated that she was going to the hospital. After walking from the facility premises to the hospital, staff were able to convince the resident to come back to the facility. A General Progress Note dated 7/20/25 at 4:30 PM, documented the resident eloped from the building through D exit door at 4:05 PM. When the door alarm went off, there was a staff member in the hallway at the time