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	10/16/2025

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 0689 Level of Harm - Minimal harm or potential for 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 record review, facility document review, staff interview, and policy review, the facility failed to provide adequate nursing supervision to prevent a resident from exiting the facility into a patio area without staff's knowledge for 1 of 4 residents reviewed. The facility reported a census of 39.Findings include:The Minimum Data Set (MDS) for Resident #1 dated 8/11/25 revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderately impaired cognition. It included diagnoses of diabetes mellitus, dementia, Parkinson's disease, and encephalopathy. It also indicated the resident required setup assistance with eating, moderate assistance with oral hygiene, showering, dressing, and personal hygiene, maximal assistance with toileting hygiene and footwear, and supervision with all forms of mobility. It also revealed the resident wandered 1 to 3 days in the seven (7) day lookback period.A Progress Note dated 8/14/25 indicated the resident went outside the facility, knocked on the window, and waved to the on-duty nurse. It also indicated the nurse ran outside to assist the resident back into the facility. It also revealed the resident's wander management system (device used to protect at-risk residents from wandering into unsafe areas) was in place and activated the door alarm upon reentry into the facility.The Electronic Health Record (EHR) included a physician's order dated 8/14/25 for staff to monitor pendant for function and placement daily.The Care Plan dated 8/14/25 included the resident was an elopement risk/wanderer related to Impaired safety awareness and directed staff to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. The facility also re-initiated a new wander management system device and staff were directed to check it daily to be sure it was functioning properly. The Care Plan had no other dated wandering entries.A Facility Self-Report dated 8/15/25 indicated the resident was brought back inside the facility within one (1) minute per video footage.On 10/16/25 at 10:45 AM, Staff A, Certified Nurse Aide (CNA) demonstrated the proper functioning of the long-term care door alarms.On 10/16/25 at 11:29 AM, Staff B, Licensed Practical Nurse (LPN) stated the resident was fully clothed in street clothes. She stated she saw him a few minutes before he exited the facility and redirected him to his room. She added he was outside for a very short period of time and estimated maybe 3-5 minutes. She also stated the residents do not get the door code and Resident #1 exited through an unalarmed patio door that typically remains locked but had not been relocked after another family used it. She stated the previous requirement was for staff to check the patio doors during their shift and at that time, she had not done that task yet. She said since the event, staff must check the patio and exit doors at the beginning of and during each shift to ensure they are locked and secure.On 10/16/25 at 12:53 PM, Staff C, LPN, stated staff must verify the patio doors are locked at the beginning and middle of each shift. 6a, 2p, 6p, and 10p. She added staff verify the facility exit doors are locked at the beginning of each shift and signed out on a different sheet.A document titled Education for a questionable resident's wandering dated 8/18/25 educated staff to address the basic needs of an exit-seeking (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: 165597	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2025

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	resident and offer diversional activities of the resident's interest. It also educated staff to seek assistance until resident safety is ensured.On 10/16/25 at 1:48 PM, the Director of Nursing (DON) stated the facility door codes were all changed and staff should have met the resident's basic needs at the time he approached her.A policy titled Elopement Risk / Elopement (Missing Resident) Process revised 07/2024 indicated staff would encourage activities which the resident enjoys in order to occupy/distract the resident when the resident is identified at risk for elopement.