STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165232	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HOME ASSOCIATION	714 DIVISION , AUDUBON, Iowa, 50025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 Ok ✓ Lg	INITIAL COMMENTS Correction date: 9/5/2025 The following deficiencies resulted from investigation of facility reported incident #2582120-I conducted September 03, 2025 to September 04, 2025. Facility reported incident #2582120-I resulted in a deficiency. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F0000		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure	F0580	1. Notifications completed and documented for 2 of 2 residents identified in noncompliance. 2. Staff education on notification of changes and documenting. 3. Orange paper reminders to notify families/legal representatives of changes in orders. Pages placed in front of binders where orders are filed. 4. Audit for compliance weekly x 4 weeks. 1. MagLock control button engaged to secure locking doors to CCDI unit. 2. 15 min checks to ensure MagLock stayed engaged until more security ensured following day. 3. Hard plastic box covers placed over MagLock control buttons on both levels to prevent accidental disengagement. 4. Video and audio monitor placed in room outside CCDI where wanderguard box for door is and where the lighted panel is. This magnified alarm sound and made lights immediately visible to CCDI nurses' station. 5. All door alarms and wanderguards checked. 6. Ensured every exit has at least 2 layers of security in a combination of	✓ 9/14/25 9/5/25 9/5/25 By 10/20/25 8/4/25 8/4/25 8/5/25 8/5/25 8/5/25 8/5/25

			any of: Wanderguards Door bar alarms Coded key pads Break away magnetic alarms	
			7. Nurse not immediately responding to alarm and shutting it off counseled on proper protocol for an alarm.	8/5/25
			8. All staff educated on elopement policy and procedure.	8/5/25
			9. Random elopement drills during first 30 days post elopement.	8/2025
			10. Securitas temporarily repaired wanderguard alarms with weak sound or repeated alarming.	9/10/25
			11. New upgraded wanderguard blue system ordered for the building through Securitas.	9/8/25
			12. Audit door alarm and elopement drill compliance x 3 months.	By 12/15/25

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 reverse for further 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.

[signature] LNHA	165232	(X6) DATE 9/19/25 ✓	

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F0580 SS = D	Continued from page 1 that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on Electronic Health Records (EHR) review, observation, document review, Medication Administration Record - Treatment Administration Record (MAR-TAR), staff interview and family interview the facility failed to notify the resident's representative / family / Power of Attorney (POA) for a new physicians order and change in condition when a wander guard was placed on the resident for 2 of 3 residents (Residents #2 and #3) reviewed. The facility reported a census of 42 residents. Findings include: 1. The Minimum Data Set (MDS) dated 7/6/25 documented Resident #2 had a Brief Interview for Mental Status (BIMS) score of 2 indicating severe cognitive impairment. The MDS also documented Resident #2 had diagnoses of dementia with psychotic disturbances and Alzheimer's disease with late onset.	F0580		

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F0580 SS = D	Continued from page 2 Review of Resident #2's undated EHR titled, Clinical Resident Profile documented Resident #2 had a POA. Observation on 9/3/25 of Resident #2 with a wander guard placed on the right lower leg. Review of Resident #2's MDS dated 7/6/25 documented utilization of a wander guard. Review of Resident #2's EHR titled, Clinical Physician Orders documented a physician's order started 8/14/25 to check wander guard placement every day and night shift. EHR titled, Orders also documented a physician's order started 8/14/25 to check wander guard function at bedtime. Review of Resident #2's MAR-TAR documented a physician's order started 8/14/25 to check wander guard placement every day and night shift. The MAR - TAR also documented a physician's order started 8/14/25 to check the wander guard function at bedtime. Review of Resident #2's document titled, Elopement Evaluation documented evaluation was faxed to physician with statement that Resident #2 was at risk for elopement due to wandering. Could the facility replace a wander guard device on the resident to prevent elopement with a reply from Resident #2's physician of yes dated 8/14/25. Review of Resident #2's EHR titled, Progress Report documented no notification of new order for wander guard to Resident #2's representative / Power of Attorney (POA). On 9/3/25 at 3:03 PM Resident #2's POA stated he was not aware that Resident #2 had a wander guard placed. Resident #2's POA stated he had not been notified in the last month of any wander guard placement. 2. The MDS dated 6/10/25 documented Resident #3 had a BIMS of 11 indicating moderate cognitive impairment. The MDS also documented Resident #3 had diagnoses of mild intellectual disabilities, major depressive disorder and generalized anxiety. Review of Resident #3's undated EHR titled, Clinical Resident Profile documented Resident #3's sister as her POA. Review of Resident #3's MDS dated 6/10/25 documented utilization of a wander guard.	F0580		

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F0580 SS = D	Continued from page 3 Review of Resident #3's EHR titled, Clinical Physician Orders documented a physician's order started 9/2/25 to check wander guard placement every day and night shift. The EHR titled, Orders also documented a physician's order started 9/2/25 to check wander guard function at bedtime. Review of Resident #3's MAR-TAR documented a physician's order started 9/2/25 to check wander guard placement every day and night shift. The MAR-TAR also documented a physician's order started 9/2/25 to check the wander guard function at bedtime. Review of Resident #3's fax dated 9/1/25 documented a request for an order for a wander guard with a physician's response of "yes, may use wander guard" dated 9/1/25. Review of Resident #3's EHR titled, Progress Report documented no notification of new order for wander guard to Resident #3's representative / Power of Attorney (POA). On 9/3/25 at 2:06 PM Resident #3's POA stated she knew that Resident #3 had a wander guard because Resident #3 talked to her about it. Resident #3's POA stated she was not notified by the facility staff that Resident #3 had a wander guard placed on her. Resident #3's POA stated Resident #3 had talked to her on the phone and was upset about the wander guard. Resident #3's POA explained that was how she found out Resident #3 had a wander guard placed. On 9/4/25 at 4:04 PM Staff A, Licensed Practical Nurse (LPN) stated she had applied a wander guard to Resident #3 because on 9/1/25 Resident #3 was trying to leave with her sister out the double doors. Staff A explained she requested the order for the wander guard from the physician and did not notify the residents representative / POA of new order or placement of the wander guard. Staff A acknowledged she should have notified Resident #3's representative / POA. On 9/3/25 at 3:11 PM the DON stated Resident #2 had a wander guard on and it was removed. The DON explained she had left it to Staff B to notify Resident #2's family. The DON acknowledged there was no documentation for family/representative/POA notification for wander guard use on Resident #2 or #3. The DON stated she would expect that there would be family notification of the wander guard placement as well as any new order for a resident at the facility.	F0580		

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F0580 SS = D	Continued from page 4 On 9/4/25 at 11:36 AM the Administrator stated the facility's expectation was the resident's family / POA would be notified of new orders, change in orders, medication changes, or incidents. The Administrator explained there would be an order from a physician for the wander guard use. The Administrator acknowledged she would expect notification to the resident's family / POA of the wander guard application. On 9/4/25 at 9:00 AM the DON explained the facility had no policy with family/POA notification of change in condition, new orders, change in orders or application of wander guard.	F0580		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on clinical Medication Administration Records - Treatment Administration Records (MAR-TAR), Electronic Health Records (EHR) review, document review, family interview, staff interview, and policy review the facility failed to provide adequate nursing supervision when a resident left the facility from a Chronic Confusion or Dementia Illness (CCDI) unit and walked outside into the back yard of a neighboring resident unknown to the staff for 1 of 3 residents (Resident #1) reviewed. The facility reported a census of 42. Findings include: 1. The Minimum Data Set (MDS) dated 5/12/25 documented Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment. The MDS documented utilization of a wander guard and wandering behavior had occurred 1-3 days reviewed for the MDS. Review of Resident #1's EHR dated 8/4/25 at 7:15 PM by	F0689		

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F0689 SS = D	Continued from page 5 Staff A, Licensed Practical Nurse (LPN) titled, Progress Notes documented that Resident #1 was found outside across the back parking lot on a private lot where a man was mowing his yard. Review of Resident #1's document dated 8/4/25 titled, Risk Management entered by Staff A documented Resident #1 went outside and was brought back in by Staff C, Registered Nurse (RN). Body assessment completed, no injuries were noted. Document further documented Staff C and Staff D came and asked Staff A if all the residents were accountable for the CCDI unit. Staff went into every room and were unable to locate Resident #1. Document continued with Staff C found Resident #1 outside, stated Resident #1 was in the yard where a man was mowing and he told Staff C that Resident #1 wanted to get on the lawn mower. Reported by the man that Resident #1 had a fall. On 9/3/25 at 10:17 AM Staff D, LPN stated 8/4/25 was the first night she had ever worked at the facility and she was orientating. Staff D stated she was orientating with Staff C the night of 8/4/25. Staff D stated she was orientating upstairs at the facility. Staff D stated she was passing medications with Staff C. Staff D stated she heard an alarm going off. Staff D stated another staff told Staff C the alarm was going off downstairs on the CCDI unit. Staff D stated when she was done passing medications to the resident they were on, both of them went downstairs. Staff D stated Staff C yelled up to the nurse and CNA on the CCDI unit asking if all the residents were present or accounted for. Staff D stated Staff C then went to the right and out the door that way. Staff D stated once she was at the end of the hall she went down and she could see Staff C outside with Resident #1. Staff D explained it was a CNA that was upstairs that told them the alarm was for downstairs but did not remember which CNA. Staff D stated she did not know which door Resident #1 went out. Staff D explained Staff C brought Resident #1 back in from outside. Staff D stated Staff A was working the memory care unit on 8/4/25 as the nurse and she completed the assessment. Staff D stated when Staff C and Resident #1 was walking back; they were not on the other side of the water gutter. Staff D acknowledged the alarm went off for about 5 minutes before they responded. On 9/3/25 at 12:47 PM Staff C, RN acknowledged she worked for the facility. Staff C acknowledged that she worked upstairs the night of 8/4/25. Staff C stated she was doing the medication pass and around 6:30 PM the alarm on the CCDI unit went off. Staff C explained she went to the control box and noticed it was the wander	F0689		

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F0689 SS = D	Continued from page 6 guard alarm for the CCDI unit. Staff C acknowledged she waited a bit to see if the alarm would be responded to by the staff in the CCDI unit. Stated passed medications to a resident and when she exited the residents room a second alarm went off. Staff C explained it was a door alarm. Staff C stated she went downstairs and looked in the hallway and saw some residents walking inside the CCDI unit. Staff C acknowledged she shut the wander guard alarm off outside the double doors of the CCDI unit. Staff C explained she started walking to the door that was alarming and it had shut off. Staff C stated she then went to the CCDI unit and looked for the residents in the room and noticed Resident #1 was not in the room. Staff C explained she asked Staff E, Certified Nursing Assistant (CNA) if Resident #1 was down in the day room and Staff E said she thought Resident #1 was the resident who got out and sent Staff D down wing 5. Staff C explained she went to the employee entrance and the wing 6 alarm was going off again. Staff C stated she looked out the door and saw Resident #1 walking. Staff C stated Resident #1 had already walked across the back parking lot and onto the grass. Staff C stated when she found Resident #1 her shirt was inside out and her left arm was outside the sleeve and was missing a sock. Staff C stated she asked Resident #1 what she was doing and she told her that she wanted to get on the ride. Staff C stated the guy on the riding lawn mower told her that Resident #1 had fallen. Staff C stated then Staff F, Dietary Cook was at the employee entrance. Staff C stated Staff F was waving at us and she brought Resident #1 back to the facility with her. Staff C stated Staff F met her at the end of the parking lot. Staff C stated Resident #1 was past the gutter in the blue house's back yard. Staff C stated Staff F helped Resident #1 with her across the gutter. Staff C stated that was when Staff A met them outside and asked if she had slipped out with Staff F on the unit and Staff F told Staff A no she had just got on the unit when she was gone. Staff C stated she called the DON and told them what was going on and to chart everything and had everyone write a statement. Staff C stated Staff A was told what to do on the unit after the elopement. Staff C stated to Staff A what the witness said and to complete an unwitnessed fall assessment on Resident #1. Staff C stated later on that day they found out that the magnetic lock was not turned on so the lock was reset for the double doors on the CCDI unit. Staff C explained when the alarm was going off everyone was supposed to respond. Staff C acknowledged she might have let the ball drop because she did not respond when she first heard the alarm. Staff C stated Staff E was standing in front of the nurses station on the CCDI unit and Staff A was	F0689		

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F0689 SS = D	Continued from page 7 standing behind the nurses station. Staff C stated when you are on the CCDI unit you could not hear the alarm for the wander guard because it was outside the double door. Staff C stated emails were sent out with education about responding to every alarm immediately after that elopement. Staff C stated there was a box placed over the switch for the magnetic lock. Staff C stated she did not direct the CNA's upstairs to respond. Staff C stated once Resident #1 was back she had staff do a head check hourly on the resident with a wander guard upstairs. Staff C stated the wander guard alarm was going off for about 3 minutes before she went to respond. Staff C explained the wander guard alarm was very loud upstairs. On 9/4/25 at 4:04 PM Staff A, LPN acknowledged she was at the facility on 8/4/25. Staff A stated she was working the CCDI unit on 8/4/25. Staff A stated she went to work and was passing pills. Staff A stated she saw 2 nurses coming up and told her the alarm was going off. Staff A stated she did not hear an alarm going off on the unit. Staff A stated the alarm was not working. Staff A stated there were 2 other staff working on the CCDI unit. Staff A stated Staff E was working on the CCDI unit with her. Staff A stated once Resident #1 returned Staff E said she heard a faint alarm. Staff A stated she asked Staff E "why did you not tell me you heard an alarm?". Staff A stated Staff E did not tell her why she did not tell her about the alarm. Staff A stated Staff E appeared teary eyed as if she did something wrong. Staff A stated she told Staff E she needed to always tell her right away when she heard an alarm. Staff A stated there was only one hallway on the CCDI unit and all the resident rooms were on that hallway. Staff A stated she was in a resident's room passing medications at the time. Staff A stated some of the residents take their medications at 6PM and those were the medications she was passing. Staff A stated she did not see any resident leave or hear the double doors shut. Staff A stated the CNA's were taking care of residents at the time she thought. Staff A stated she completed the assessment on Resident #1. Staff A stated Resident #1 did not have any injuries. Staff A stated she started neuro checks and door checks. Staff A stated Resident #1 went out through the double doors. Staff A stated she did not think the double doors were locked with a magnet. Staff A stated Staff G, CNA told her that the alarm panel upstairs the magnetic lock was shut off. Staff A stated Resident #1 had made it off the unit and outside. Staff A stated she thought it would take Resident #1 about 5 minutes to get to where she made it outside. Staff A stated when the alarm went off staff should have responded immediately. Staff A stated there were 2 nurses upstairs and one of them was	F0689		

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F0689 SS = D	Continued from page 8 orientating. Staff A stated Staff C was orienting Staff D. Staff A stated Staff C stated the alarm was going off but did not tell her how long. Staff A explained that when 2 nurses were upstairs one of the nurses should have come downstairs immediately to check on the alarm. Staff A stated there were 13 residents on the CCDI unit 8/4/25. On 9/3/25 at 3:24 PM Staff E, CNA stated she was working on the CCDI unit at the facility on 8/4/25. Staff E stated she was familiar with Resident #1. Staff E stated she was talking to the nurse at the nurses station just after returning from break and she remembered an alarm but was very faint. Staff E explained she looked down the hall and saw the double doors closing. Staff E realized someone just went out the doors. Staff E stated she had heard the wander guard alarm before and just before she got to the double doors Staff C told her the alarm was going off. Staff E explained she started looking to see if all the residents were accounted for. Staff E stated Resident #1 was exit seeking that day. Staff E stated Staff C found Resident #1 out door #6 and the alarm was going off down hall 6. Staff E stated Staff C returned Resident #1 to the CCDI unit. Staff E stated she was working with Staff A on the CCDI unit that day with another CNA. Staff E stated Staff A and herself were at the nurses station talking when Staff C entered the CCDI unit looking for a missing resident. Staff E stated they were standing just outside of the nurses station at that time. Staff E stated she did not know where the other CNA was at that time. Staff E stated she did not hear anyone call down on the phone. Staff E stated the light at the nurses station was always red. Staff E acknowledged if the light would be green then the magnetic door would not be locked. Staff E explained she noticed it was green after the incident. Staff E stated usually you can hear the door alarm but not the wander guard when you are in a residents room or at the nurse station. Staff E explained the only alarm she heard was very faint. Staff E stated when an alarm goes off the staff are supposed to check rooms to ensure the residents are present. On 9/3/25 at 2:45 PM Staff F, Dietary Cook acknowledged she was working on 8/4/25. Staff F stated she was familiar with Resident #1. Staff F stated she was just finishing up her shift and was taking the laundry down to the laundry room. Staff F stated she was talking to Resident #1 and when the elevator door closed Resident #1 was in her room. Staff F stated about 3-5 minutes later the upstairs nurse came down and asked where Resident #1 was and told her she was just in her room. Staff F stated the nurse ran through the door. Staff F	F0689		

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F0689 SS = D	Continued from page 9 stated she put up the cart and went out the back door because she figured that she would recognize her. Staff F stated Staff C had found Resident #1 and she was in a neighbor's lawn. Staff F stated Staff C started bringing Resident #1 back. Staff F stated Resident #1 had grass on her shirt but did not appear to have an injury. Staff F explained they walked her back up to the building and then Staff A came out and they all returned Resident #1 to the CCDI unit. Staff F stated Resident #1 was on the other side of the water gutter when she came outside. Staff F stated she helped Staff C and Resident #1 cross the water gutter on the way back. Staff F stated she did not hear the alarm going off. On 9/3/25 at 11:15 AM Staff H, CNA acknowledged she was working at the facility on 8/4/25. Staff H stated she worked 6pm - 6am. Staff H stated she was working upstairs at the facility that night. Staff H stated she was on hall 1 that night and the alarm was going off and saw that it was downstairs. Staff H stated she kept trying to call them and nobody answered the phone. Staff H stated she went downstairs and Staff F told her that Resident #1 ended up getting out the door. Staff H stated the alarm was continuously going off when she came up the hall. Staff H stated she was in a resident's room at that time. Staff H stated she could not hear the alarm in the residents room. Staff H stated she was on her way with Staff I, CNA and the alarm shut off before they got in the elevator. Staff H stated she did not go downstairs. Staff H stated Staff I went downstairs. Staff H stated she did not know if any of the upstairs nurses went downstairs. On 9/3/25 at 1:39 PM Staff I, CNA stated he was down hall 2 for the evening of 8/4/25. Staff I stated he did not hear the alarm when he was in a room with a resident. Staff I stated the rule was if you are attending or completing care on a resident was to stay with the resident and then respond. Staff I stated he stayed with the resident because the resident was in a compromising situation. Staff I stated once the resident was no longer in a compromising situation he responded but other staff had already responded. Staff I stated the other staff upstairs were taking care of their own residents. Staff I stated he could hear the alarm in the room but the resident was in a situation where they could not be left. Staff I stated he knew the alarm was from downstairs. Staff I stated the alarm was going off for about 5 minutes or 10 minutes. Staff I acknowledge the alarm went off for a while before it was responded to. On 9/3/25 at 4:44 PM Staff G, CNA stated she was	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165232	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HOME ASSOCIATION	714 DIVISION , AUDUBON, Iowa, 50025

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F0689 SS = D	Continued from page 10 working on 8/4/25 upstairs at the facility. Staff G stated she knew who Resident #1 was. Staff G stated she was in a residents room when the alarm went off. Staff G stated when she made her way to the nurses station she was told by Staff H that the charge nurse had gone downstairs to answer the wander guard alarm on the CCDI unit. Staff G stated she could not hear the alarm from the residents room she was in. Staff G stated she did not know how long the alarm had been going off. Staff G stated she was not aware of any of the CNA's checking on the alarm. Staff G stated the charge nurse was trying to find out why the doors were not locking. Staff G stated she was the staff that saw that the switch was green and that was what shut off the door locks on the magnetic doors. Staff G explained the alarms are supposed to be checked promptly to determine if a resident had left. On 9/3/25 at 3:11 PM the DON stated during the investigation of Resident #1's elopement on 8/4/25 the main concern was with the response from staff. The DON stated the concern was that there was not an immediate response to the alarm. The DON stated immediate education was provided about the response. On 9/4/25 at 11:36 AM the Administrator stated during the investigation of the elopement there were concerns with the system being outdated and/or if it was working properly. The Administrator stated the nurse could have paged through the phone but if the staff were in rooms they would not have heard the page from the phone. The Administrator explained that the chances of both the wander guard alarm being faint and the magnetic lock on the double doors to the CCDI unit being deactivated was very slim but that was what occurred during the incident on 8/4/25. The Administrator explained the facility's determination was that the magnetic lock shut off button probably was hit by the monitor on the medication cart that is usually parked in front of the button. The Administrator explained now there was a clear box over the button like you would find on a thermostat. Review of Policy revised 8/5/25 titled, Friendship Home Elopement/Wandering documented the purpose was to ensure that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents. Adequate supervision will be provided to help prevent accidents or elopements. Any staff member becoming aware of a missing resident will alert personnel using facility approved protocol. Review of undated procedure titled, Staff Education:	F0689		

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F0689 SS = D	Continued from page 11 Responding to Elopement Alarms documented the purpose was to ensure all staff respond immediately and appropriately when an elopement alarm sounds (e.g. wander guard or door alarm). Every second counted to keep the residents safe. Licensed nursing staff should respond to the origin of the alarm if known and call code wander using the overhead page or other communication tools. CNA / direct care staff should stop current tasks and immediately begin search unless a resident would be left unattended in unsafe conditions.	F0689		