STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165198	A. BUILDING _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA CITY REHAB & HEALTH CARE	3661 ROCHESTER AVENUE IOWA CITY, IA 52245

(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
F 000	INITIAL COMMENTS Correction date: 3/25/2024 The following deficiencies resulted from the investigation of complaints #119031-C, #118857-C, #118374-C, #117860-C, #117410-C, #115648-C, #115537-C, #115560-C, #115346-C, & #114933-C and facility reported incident #118061-I conducted February 27, 2024 to March 05, 2024. Complaints #114993-C, #115648-C, #117860-C, #118374-C, and #119031-C were substantiated. Facility reported incident #118061-I was substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F 000	The Plan on Correction does not constitute an admission or agreement by Iowa City Rehab & Health Care Center of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. This plan of correction shall serve as Iowa City Rehab & Health Care Center credible allegation of compliance.	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550	F 550 1. Resident # 7 no longer resides at the facility as of 2/14/24. 2. On 3/18/24 the Administrator audited residents' chart to validate inventory sheet was present. 3. Administrator/designee provided education to staff on 3/18/24 regarding the inventory policy and process for completing the inventory at admission, updates and discharge. 4. Administrator/ designee will conduct random audit weekly for 4 weeks and then monthly for two months of to ensure inventory sheets continue to be completed/reconciled as required. Results of these audits will be presented to the QAPI meeting monthly for 3 months for review and recommendations as needed. The Administrator is responsible for monitoring and follow-up. Date of Compliance: 3/25/24	3/25/24

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 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to document if the resident's emergency contact picked up the resident personal possessions after his death for 1 of 5 residents reviewed for personal possessions (Resident #7). The facility reported a census of 39 residents. Findings include: The Minimum Data Set (MDS) assessment dated 1/25/24 revealed Resident #7 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact.	F 550		

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F 550	Continued From page 2	F 550		

The Progress Note dated 2/14/24 at 10:52 PM, revealed the medical examiner called and said that the resident was deceased at the ER (Emergency Room).

The Progress Note dated 2/14/24 at 11:29 PM, revealed the nurse able to get in contact with the emergency contact at 11:20 AM. Emergency contact said that the hospital already called and informed her of the resident's passing. Emergency contact requested that all the valuables and belongings be kept for her to pick up tomorrow. She also would like a copy of the medical record.

The Progress Note dated 2/15/24 at 9:23 AM, revealed notified by floor staff that emergency contact in the facility this morning and removed some of resident's belongings. She stated she would return later today to get the rest of the belongings and a copy of his medical record. She reported that the resident's lawyer would be here today as well.

During an interview on 2/28/24 at 2:48 PM, Staff D, LPN (Licensed Practical Nurse) stated the night Resident #7 was sent to the hospital his neighbor lady came and brought him some groceries. Staff D stated the neighbor lady was the only person who came and saw the resident. Staff D stated the neighbor lady was the person they called for notification. Staff D asked if Resident #7 had a Power of Attorney (POA) and she stated yes, a lawyer guy but he never came in.

During an interview on 2/28/24 at 4:48 PM, the Housekeeping/Laundry Manager queried on the process for new admissions and she stated they

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F 550	Continued From page 3 labeled the resident's clothing and told them if issues arose to let her know. The Housekeeping/Laundry Manager was asked if the facility kept a list of the resident's property and she stated no they didn't make a list. During an interview on 2/29/24 at 9:32 AM, the Assistant Director of Nursing (ADON) queried on how they inventory property and she stated if the resident brought in big items such as a TV or their own personal wheelchair they noted it. She stated they didn't have a good process or itemizing the other items. The ADON was asked what the process they used for personal belongings after a resident's death and she stated usually Social Services, the Director of Nursing (DON), or her were notified when someone was there to pick up the resident's belongings. The ADON was asked if the family signed anything when they picked up the belongings and she stated she didn't think so. The ADON queried about Resident #7 personal property and she stated someone came in and got some of his belongings before office hours and the leadership team arrived. The ADON stated the staff assumed the lady who came in before 7:30 AM was the emergency contact. The ADON stated the person who picked up his belongings visited the resident the night before and apparently was not the emergency contact but another neighbor. The ADON stated two people got his stuff. The ADON stated Resident #7 kept track of his financial records and kept a checkbook, notebook, and folder at the facility and when they boxed up his stuff, those items were missing. The ADON stated the emergency contact came and picked up the boxed items. The ADON stated they didn't know who picked up his stuff earlier in the day and it could have been the emergency contact.	F 550		

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F 550	Continued From page 4 During an interview on 2/29/24 at 12:30 PM, the DON queried on personal possessions and she stated they knew what the residents came with by taking a visual look. She stated they wanted to add a log to fill out with new admissions. The DON was asked how they know who picked up the resident possessions and she stated typically family members picked up the resident's belongings but not as organized when the family picked the items up. She stated they don't keep a visitor log. The DON was asked about Resident #7 personal property and she stated she knew that was a mess and they only contacted the neighbor listed in the chart and the neighbor stated the hospital notified her of his death. The DON stated whoever came in the morning after he passed made it seem like she was the only person to pick up his stuff. She stated the staff presumed that neighbor lady was the emergency contact. The DON stated the emergency contact said she didn't come and pick up his items and we don't know if the emergency contact and the neighbor who visited were the same person. During an interview on 2/29/24 at 2:03 PM, the Administrator queried about Resident #7 and she stated after Resident #7 admitted a lady came in after hours and helped him with his finances and brought him dinner. She stated they contacted the emergency contact when they sent him to the hospital and notified her of his death. The DON stated the emergency contact stated the hospital already called her and informed her of the resident's death and she would come in the morning for his belongings. The Administrator stated a neighbor came in the morning after his death and took some of his belongings and the only person they notified of the resident's death	F 550		

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F 550	Continued From page 5 was the emergency contact. The Administrator stated the emergency contact called her and stated she didn't pick up his items. The Administrator stated the emergency contact never came in after the phone call to pick up the resident's items. The Administrator stated Staff D worked that day and the lady who picked up some of his belongings was the neighbor lady who came to visit the resident. The Administrator stated she didn't know who picked up the resident's stuff and it could have been the emergency contact could be the same lady that visited because she is the only person they notified of the resident's death. The Facility Personal Property Policy dated 8/2015 revealed the following information: a. enter resident/patient information at the bottom of the form b. upon admission, identify all of the resident's personal belongings by indicating quantity of those items listed. c. upon completion of the form, obtain a signature guaranteeing accuracy from the resident or resident's family/responsible party and a counter signature from a representative from the facility. d. the original kept in the resident's chart under Admissions tab. A copy given to the resident or resident's representative e. upon discharge/death indicate who belongings returned to and obtain signature.	F 550		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677	F677 1. DON/designee performed an observational audit of peri care on 3/7/24 for resident #15 with no concerns noted. 2. On and before 3/25/24 the DON/designee completed an observational audit of CNAs performing peri care. Concerns identified were addressed at the time of the audit. 3. DON/designee provided education to the nursing department on or before 3/18/24 regarding the procedure for peri care. Staff not educated by this date will be provided with education at the time of their next shift. 4. DON/designee will perform random peri care observational audits weekly for 4 weeks then monthly for 2 months to validate complete peri cares are being performed as required. Results of these audits will be presented to the QAPI meeting monthly for 3 months for review and recommendations as needed. DON is responsible for monitoring and follow-up. Date of Compliance: 3/25/24	3/25/24

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F 677	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to perform complete incontinent cares following urinary incontinence for 1 of 3 residents reviewed for incontinent cares (Resident #15). The facility reported a census of 39 residents. Findings include: The Minimum Data Set (MDS), dated 01/25/24, revealed Resident #15 had a Brief Interview for Mental Status (BIMS) score of 2 out of 15 indicative of severe cognitive impairment. Resident #15 required dependence on staff for toilet hygiene, dressing, personal hygiene, and transferring. Diagnoses included dementia with behavioral disturbance and End-Stage Renal Disease. The Care Plan, revised 02/16/24, revealed Resident #15 had a focus area for mixed bladder incontinence related to dementia with interventions to check resident as required for incontinence and wash, rinse, and dry perineum (vaginal and rectal areas), and change clothing as needed after incontinence episodes. The Weekly Skin Assessment, dated 02/21/24, revealed excoriated areas to bilateral buttocks with erythema (redness). On 02/28/24 at 09:30 AM, Staff E, Certified Nursing Assistant (CNA), assisted Resident #15 to stand and pivot transfer into bed to provide incontinent cares. Noted a large wet area on the back of Resident #15's pants, just over the right gluteal fold when they stood up. Staff E removed	F 677		

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F 677	Continued From page 7 the soiled pants and incontinence brief, then completed hand hygiene and changed gloves. Using wet wipes, Staff E cleansed Resident #15's vaginal area using a downward motion, but omitted cleansing backside of perineum or surrounding skin where the wet spot had been observed. Staff E applied a new incontinence brief as Resident #15 assisted with rolling side to side in bed. During repositioning, noted an area of redness over right gluteal fold. Staff E applied new pants and transferred Resident #15 back into the wheelchair, then removed gloves and performed hand hygiene. On 02/28/24 at 01:57 PM, Staff E reported they should have cleaned Resident #15's backside during cares and denied any red areas observed during Resident #15's incontinent cares. On 02/29/24 at 12:31 PM, Director of Nursing (DON), revealed the expectation of staff to clean a resident's backside with urinary incontinence. The DON stated, they are often sitting, so I would expect the back to be cleaned. The undated facility document titled, Peri Care Audit Tool, revealed the expectation of staff to cleanse residents front to back, including outer labia, thighs and rectal areas.	F 677	F689 1. Resident #5 wander guard placement validated by the DON on 3/14/24. On 3/14/24 the Administrator validated the door alarms are functioning properly. On 3/22/24 the Administrator validated Resident #5 has not had any additional elopements. 2. An observational audit was completed by DON/Designee on 3/25/24 of staff responses to door alarm sounding and validated staff understood education regarding door alarm and head count. 3. Staff received re-education on 3/25/24 by DON/designee related to expected follow-up when turning off door alarm. Staff not educated by this date will be provided with education at the time of their next shift. 4. Administrator/designee will audit weekly for 4 weeks then monthly for 2 months to validate door alarm checks continue to be completed and staff continue to respond appropriately when door alarm sounds. Results of these audits will be presented to the QAPI meeting monthly for 3 months for review and recommendations as needed. The Administrator is responsible for monitoring and follow-up as needed. Date of compliance: 3/25/24	3/25/24
F 689 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	F 689		

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F 689	Continued From page 8 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and the facility policy, the facility failed to ensure all of the residents were accounted for after they responded to and turned off a door alarm, which resulted in an elopement of a resident for 1 of 4 residents reviewed for adequate supervision of residents (Resident #5). The facility reported a census of 39 residents. Findings include: The Minimum Data Set (MDS) assessment dated 11/2/23 revealed Resident #5 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS revealed the resident independent with walking 150 feet in a corridor or a similar space. The MDS revealed diagnoses of anxiety disorder, depression, and schizophrenia (e.g. schizoaffective and schizophreniform disorders). The Care Plan revealed a focus area dated 12/20/23 for high elopement risk/wanderer related to impaired safety awareness and a lack of impulse control. The interventions dated 12/20/23 revealed distract resident from wandering/exit seeking by offering pleasant diversions, structured activities, food, and conversations, television, or book. The interventions dated 12/20/23 revealed monitor location of resident and documented wandering behaviors and attempted diversional interventions in behavior log. The interventions dated 12/20/23 revealed wanderguard in place to right ankle and checked placement and function every shift.	F 689		

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F 689	Continued From page 9 The Care Plan revealed a focus area dated 12/27/23 for resident eloped on 12/23/23 and 12/25/23 and resident placed on 1:1 related to high elopement risk. The interventions dated 12/27/23 revealed checked placement and function of wanderguard every shift; ensure resident on 1:1 staffing ratio; and observed actively exit seeking and redirection of his attention; and if unable to redirect staff to walk resident outside in appropriate clothing. The Electronic Medical Record revealed the following diagnoses: a. paranoid schizophrenia b. generalized anxiety disorder c. major depressive disorder The Physician Orders revealed the following orders: a. ordered 2/23/24 until 3/9/23: hydroxyzine HCL (hydrochloride) oral tablet 25 mg (milligrams)- give 25 mg by mouth every 8 hours as needed for anxiety and agitation b. ordered 12/20/23: check wander guard placement and function every shift, expiration: 5/29/24- three times a day for wander guard verify wander guard is on right ankle every shift The Behavior Note dated 12/23/23 at 2:55 PM, revealed the resident had no behaviors since the beginning of the shift. Resident came out of his room and went down straight to the dining room where he ate his lunch, then retired to his room as soon as he finished. Nurse continued to monitor for confusion. The Progress Note dated 12/23/23 at 6:55 PM, revealed the nurse called to the front door where	F 689		

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F 689	Continued From page 10 resident observed knocking at the door and asked to be let in. Resident came in with his shoes in his hand. The shoes were all covered in mud and his pants were dusty on the knee area. Resident wore no-skid socks at this time. Resident unable to state if he fell down and hit his head or not. Resident denied pain, but stated that he felt pain on his legs below his knees. No injuries observed. Resident stated, " I wanted to help my brother fix his bicycle, and then I got into mud and fell down". Vital signs assessed, head to toe assessment done. ADON (Assistant Director of Nursing) notified, NP (Nurse Practitioner) notified, family notified by message. Head to toe assessment done. Range of Motion (ROM) intact, rated pain in legs at 4/10. Pain medication as needed administered. Resident placed under a one-on-one supervision at this time. The Progress Note dated 12/23/23 at 7:04 PM, revealed the resident last seen by this nurse at about 5:00 PM. Resident ready for supper and already taken his 4:00 PM pills and blood sugar checks. Resident moved up and down across hallways as he sometimes did, conversed with anyone he finds on the hallway. The Participatory Action Research (PAR) Meeting Review dated 12/27/23 at 4:46 PM, the resident reviewed at PAR. Resident triggered due to elopement on 12/23 and 12/25. Resident on one to one supervision at this time. Resident's wanderguard in place and functioned as it should. Resident had no behaviors today, he moved to a room on center hallway that was closer to the nurse's station and across from administration's offices. Resident denied any SI/HI (suicidal ideation/homicidal ideation) or desired to go anywhere at this time. Resident verbally stated	F 689		

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F 689	Continued From page 11	F 689		

understanding that he was not supposed to leave facility. Resident hadn't displayed any pressured speech, confusion, agitation or aggressive behavior today. Resident remained on alert charting and one to one supervision. Advanced Registered Nurse Practitioner (ARNP) in house at this time and planned to see resident during her rounding.

The 5 day Investigation Summary Report revealed the following information:
a. Description of the Incident: Resident observed in the smoking area at approximately 5:10 PM by Resident #16. At approximately 5:15 PM Resident #5 re-entered the facility by the front door and assisted by staff and returned to his room. Resident #5 held shoes in hand and wore gripper socks.
b. Facility Investigative Findings: Resident last observed by Staff C, RN (Registered Nurse) at 5:00 PM when accu-checks and medications administered. Upon re-entry at 5:15 PM, Resident #5 stated "I wanted to help my brother fix his bicycle, and then I got into the mud and fell down." Resident #5 assessed by the charge nurse without injury noted. Resident #5 noted by staff earlier in the week with new onset of intermittent confusion. An elopement risk assessment completed on 12/20/23 which indicated high risk, a wanderguard place on Resident #5 right ankle and initiation of high-risk focus on his care plan. Per Statement from Staff B, CNA (Certified Nurse Aide) on 12/23/23 the door alarm sounded and she responded immediately and noted Resident #16 outside smoking and didn't see anyone else outside. Staff B notified the nurse Resident #16 outside smoking and nurse verified Resident #16 could smoke independently and the alarm

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	165198	A. BUILDING _____ B. WING _____	C 03/05/2024

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IOWA CITY REHAB & HEALTH CARE	3661 ROCHESTER AVENUE IOWA CITY, IA 52245

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F 689	Continued From page 12 silenced/reset. It appeared Resident #5 exited the smoking area and proceeded to walk around the outside of the facility to the front door to re-enter the building. The facility unable to determine if Resident #5 fell or sat down outside to remove his shoes. The resident treated for a UTI (urinary tract infection) started on 12/22/23. The Weather Conditions on 12/23/23 around 5:00 PM in Iowa City, Iowa: a. Temperature: 52 degrees Fahrenheit b. Relative humidity: 82% c. Winds out of the southeast 5 mph d. low clouds detected e. no precipitation During an interview on 2/27/24 at 1:22 PM, Resident #5 stated he remembered walking out of the facility in December. He stated he wanted to go outside because he felt locked in the facility. During an interview on 2/28/23 at 9:45 AM, Resident #16 stated he recalled the incident in December and stated Resident #5 walked outside towards the gate. He stated he didn't think anything about it and didn't tell anybody. Resident #16 stated staff came and spoke to him the next day about the incident. Resident #16 stated he didn't talk to Resident #5 when he walked past him. During an interview on 2/28/24 at 11:12 AM, Staff A, Dietary Aide, queried on the incident with Resident #5 on 12/23/23 and she stated she was the one who let him back into the facility. She stated she was in the process of picking up trays and heard banging on saw him outside and let him back in. She stated she didn't talk to him, she	F 689		

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F 689	Continued From page 13	F 689		

got the nurse to assess him.

During an interview on 2/28/24 at 1:26 PM, Staff B, CNA (Certified Nurse Aide) queried on the elopement on 12/23/23 and she stated the buzzers went off and she didn't see anyone and then saw a resident smoking and told another staff member and they said the resident smoking could smoke independently. Staff B stated she then went back to work and didn't think anything more of it. Staff B asked what she did when the door alarms went off and she stated she was supposed to check the alarm.

During an interview on 2/28/24 at 2:29 PM, Staff C, RN (Registered Nurse) queried on what she did when a door alarm went off and she stated she got someone to count and have every room accounted for and saw if anyone wandered. Staff C asked about the elopement on 12/23/23 and she stated she remembered Resident #5 wanting to go outside and shop and hanging out in the dining room near the smoking area. Staff C stated she didn't know how Resident #5 got out, might have gotten out when the smokers went out because some of the residents could smoke independently.

During an interview on 2/28/24 at 2:48 PM, Staff D, LPN (Licensed Practical Nurse) queried on any recent elopements and she stated Resident #5 eloped through the smoking area and jumped the fence and her and another staff member saw him at the front door with his shoes in his hands and then let him in. She stated Resident #5 held his shoes in his hands and had mud on his hands and feet. Staff D stated the resident was outside for approximately 5 minutes. She stated an assessment was conducted on him and the

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F 689	Continued From page 14 Administrator and the Director of Nursing (DON) notified. She stated the second time Resident #5 eloped through the east door and the staff responded right away and returned Resident #5 immediately back into the facility. Staff D stated the resident knew he needed to hold the door for 15 seconds before it would open. She stated Resident #5 admitted he shouldn't have went outside by himself. During an interview on 2/29/24 at 12:30 PM, the DON queried on the elopements with Resident #5 and she stated the resident eloped on 12/23/23 and on 12/25/23. She stated on 12/23/23 he went through the south door located near the smoking door and came in through the east door. The DON stated the first time, staff responded but didn't see him outside. She stated the gate in the smoking area didn't have a lock when the incident occurred and she didn't think the area was considered a secured area because the dementia residents went outside with staff. She stated he went out the east door on 12/25/23 and got to the grass and staff got him to come back in. The DON stated Resident #5 wore a wanderguard and the wanderguard alarm sounded different. The DON asked the expectation of staff when door alarms went off and she stated staff needed to check for residents and shut off the alarm and they needed to know the type of alarm, do a head count, notify management, and the police if needed. The DON stated staff needed to familiarize themselves with the elopement binder which revealed moderate to high risk residents, and know the elopement policy. The DON was asked how long she thought the resident was outside and she stated maybe 5 minutes, but unsure. The DON was asked if she thought things could have been done differently and she	F 689		

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F 689	Continued From page 15 stated staff responded quickly and didn't see Resident #5 and turned off the alarm and proud of their response, but wasn't thrilled the resident left outside and believed the incident was a good teachable moment for staff. During an interview on 2/29/24 at 2:03 PM, the Administrator queried on the elopement on 12/23/23 and she stated Resident #5 sat at the dining room table in the east dining room and when Staff B went outside and saw Resident #16, she came back in and tried to shut off the alarm, and when she couldn't get it turned off went and got the nurse. The Administrator believed Resident #5 went out the door when Staff B went to get the nurse to set off the alarm because Resident #16 initially set off the alarm when he went out to smoke. The Administrator stated Staff B was new and only been there for a week or week and half. The Administrator stated the gate only had a latch and Resident #5 went through the gate and since the incident a lock was placed on the gate. She stated the wanderguard went off but the alarm already sounded due to Resident #16 knew to hold the door for 15 seconds. She stated the results from the investigation revealed the resident was outside for approximately 5- 10 minutes. The Administrator was asked her expectations when a door alarm went off and she stated for another staff to go outside and look and a head count performed. The Facility Missing Resident Policy dated 6/18/19 revealed the following information: a. staff notify the charge nurse if resident cannot be located in the facility. b. notification to the supervisor or administrator on duty. c. a search of all rooms in the facility (including	F 689		

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F 689	Continued From page 16 utility rooms and service areas) completed if a resident thought to be missing. d. assigned staff member to check the area immediately outside the facility.	F 689		