STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165175	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greater Southside Health and Rehabilitation	5608 SW 9th Street Des Moines, IA 50315

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on record review, observation, resident and staff interviews, police report, and policy review the facility failed to properly secure exit doors and failed to ensure residents were adequately supervised for 1 of 7 residents reviewed for wandering and elopement risk (Resident #1). The facility staff failed to know the whereabouts of a resident who left the facility unattended. Resident #1 was last seen by staff on 8/21/24 at approximately 9:00 PM, and not found until 8/23/24 at approximately 6:45 AM. The resident reported he had walked several blocks from the facility to a retail store, and later admitted himself to the Emergency Department (ED) for an evaluation. On 8/27/24 at 12:00 PM, the Iowa Department of Inspections, Appeals, and Licensing staff contacted the facility staff to notify them the Department staff determined an Immediate Jeopardy (IJ) situation existed at the facility. The IJ began on 8/21/24, the day Resident #1 left the facility without staff knowledge. Facility staff removed the Immediate Jeopardy on 8/28/24 through the following actions: a. Temporary alarms put in place until a permanent new call light and wander guard system could be installed. b. All staff educated on the presence and use of the alarms, and the need to check/investigate the doors and surrounding area outside whenever a door alarm sounded and prior to deactivating the alarm effective 8/27/24. Staff orientation included the elopement policy. Agency staff required to read and sign the education in the schedule binder prior to their worked shift effective 8/27/24. c. The facility conducted a door alarm drill for staff on the day shift on 8/22/24. d. Current residents were assessed for elopement/wandering risk on 8/22/24. Residents assessed at high risk had a further evaluation completed, their care plan updated with resident-centered information and interventions, and a wander alert device initiated as necessary. e. A facility-wide evaluation of the wander alert system conducted on 8/22/24. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	f. All residents shall be educated upon admission and during Resident Council quarterly about the facility's voluntary discharge process, leave of absence process, and signing out with the charge nurse whenever the resident left for an outing with family/friends. The scope was lowered from J to a G the time of the survey after ensuring the facility implemented education and their policy and procedure. Findings include: The Census List revealed Resident #1 admitted to the facility on [DATE] to Side 1 (upper level) hallway and then moved to the Side 2 (lower level) hallway on 7/17/24. The Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 admitted to the facility from another long-term care (LTC) facility on 7/11/24 and had diagnoses of debility, diabetes, malnutrition, schizophrenia, and a hip fracture. The MDS recorded the resident had a Brief Interview for Mental Status score of 14 out of 15, which indicated cognition intact. The resident had no behaviors. The MDS indicated the resident used a walker and had independence for toileting, dressing, bed mobility, and transfers. The MDS documented the resident had no wander or elopement alarm. The Care Plan initiated 7/12/24 and revised on 8/7/24, revealed the resident had a self-care deficit in activities of daily living (ADL's) related to a recent left femur fracture. The resident transferred and ambulated independently using a front-wheeled walker, and he was his own responsible party. The Care Plan revealed the resident took medication for schizophrenia and had a risk for falls. The Care Plan lacked any information regarding prior wandering or elopement, or if the resident had a wander guard (a wander alert system). The Care Plan revised on 8/23/24 revealed the resident had impaired safety awareness and at risk for elopement related to a history of attempts to leave the facility unattended at a previous care facility. The staff directives included to monitor the placement of a wander guard on his left ankle. A Nursing Admission Evaluation dated 7/11/24, completed by Staff I, Registered Nurse (RN), revealed Resident #1 admitted from another care facility. Resident alert but confused and deemed an elopement risk. An alarm protocol was initiated and a wander guard applied. The Progress Notes dated 7/11/24 to 7/31/24 revealed the following: a. On 7/11/24 at 2:48 PM, Staff I, RN, documented Resident #1 admitted to the facility from another LTC facility. Resident alert and oriented, and ambulated on his own without difficulty. The resident has a known history of wandering so a wander guard placed on his right ankle. Staff educated on the importance of listening for the wander guard alarms and to monitor the resident. b. On 7/11/24 at 3:54 PM, resident had a history of elopement while at home and attempted to leave a facility without informing staff. Elopement risk score 4, indicating the resident at risk for elopement. The resident met the elopement risk criteria for wandering and verbally expressed a desire to go home, packed up belongings to go home, or stayed near an exit door. He also had admitted to the facility within the past 30 days and had not accepted the situation. c. On 7/12/24 at 4:14 PM, the resident wandered the hallways a few times but had no exit seeking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. The Progress Notes indicated the resident exhibited behaviors on: 8/1/24 at 12:39 PM 8/2/24 at 9:28 AM 8/2/24 at 4:48 PM 8/4/24 at 8:18 AM The progress notes lacked the behaviors the resident exhibited. e. On 8/8/24 at 12:59 PM, the nurse practitioner (NP) saw the resident. The NP ordered to monitor the resident for insomnia and wandering, Trazadone (an antipsychotic medication) 25 milligrams (mg) at bedtime (HS), and continue psychiatric services. Resident is his own power of attorney (POA) and aware of the new orders. f. On 8/22/24 at 1:10 AM, Certified Nursing Assistant (CMA) reported resident not in bed. Unable to locate the resident after a search of the facility and grounds done. Director of Nursing (DON) and provider on-call informed of the missing resident. Awaiting further instructions from the DON. g. On 8/22/24 at 1:30 AM, DON called back and informed Staff D, Licensed Practical Nurse (LPN) to call the police and report the resident missing. Police called. h. On 8/22/24 at 1:45 AM, police arrived. Resident last seen by staff at approximately 8:30 PM wearing jeans, dark shirt/hoodie, and a red hat. Resident had a wheeled walked and ambulated independently in the facility. The temperature outside was 61 degrees. The resident's roommate reported he saw the resident packed belongings into a black bag before he noted Resident #1 missing. Roommate unable to recall what time he last saw Resident #1. Resident #1 did not say anything to him about leaving the facility. Resident's walker not located at the facility or on the grounds. Police will inform the facility if and when they found the resident. i. On 8/23/24 at 7:03 AM, Social Services (SS) visited Resident #1 upon his return to the building. He stated he wanted to see the world and find his friend to get a painting job. He also stated he went to the hospital due to his knees swelled up and hurt. Hospital paperwork given to the nurse. A provider's Encounter Note dated 8/6/24 revealed Resident #1 had increased agitation and wandering at night (HS), and referred to psychiatric services. Resident alert and oriented to self. The resident reported chronic left hip pain. He had an unsteady walk, and had impaired memory and insight/judgement. Trazadone 25 mg ordered every HS. The Order Summary Report revealed the following: a. Monitor wandering every shift started on 8/8/24. b. Monitor placement and functioning of the wander guard every shift started on 8/25/24. Document a (+) if the wander guard in place on right ankle and functioned correctly, and a (-) if the device not working. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated 7/1/24 to 7/31/24 lacked documentation of a wander guard. The MAR dated 8/1/24 to 8/31/24 revealed to monitor behaviors such as restlessness, agitation, and elopement started on 7/11/24 and discontinued on 8/5/24 at 5:21 PM. An order to monitor placement and functioning of the wander guard was added to the MAR on 8/25/24 at 3:20 PM. The TAR dated 8/1 - 8/31/24 revealed an order to monitor the resident for insomnia and wandering every shift started on 8/8//24 at 12:50 PM. A Police report created 8/22/24 at 2:41 AM revealed a police officer dispatched to the facility for a missing person on 8/22/24 at 1:10 AM. Staff D reported Resident #1 had gone missing from the facility in what they believed was a voluntary basis on 8/21/24 at 9:00 PM. Staff D reported Resident #1 had a history of walking away from the car/home/facilities he had been placed in. Resident #1 left with a silver walker and took his clothes with him. Staff reported the individual was homeless previously and that could be where he headed. Staff were advised to call if he resurfaced on his volition (own will). The ED Physician's Note recorded Resident #1 triaged in the ED on 8/22/24 at 9:11 PM. The resident presented to the ED for complaint of bilateral knee pain rated at 10 out of 10. The resident had a history of a fall and left hip fracture in 4/2024. X-rays of both knees revealed no acute findings. Labs revealed CK (an enzyme found in heart tissue and the muscle) was elevated and believed to be possibly related to him riding a bike for transportation. He was diagnosed with musculoskeletal pain and referred to follow up at a free clinic. He discharged from the ED on 8/23/24 at 5:13 AM. An Elopement/Wandering Evaluation dated 8/23/24 revealed the resident at high risk for elopement due to a history of wandering and an elopement in the past 6 months. A Condition Monitoring assessment dated [DATE] revealed the resident had an elopement on 8/22/24. Staff I documented a head-to-toe assessment completed and no abnormal findings noted. Resident alert and oriented x 4 (person, place, time, situation) and stated he was going out to see the world. Resident denied pain and rated pain 0 on a 0 to 10 pain scale. Resident seen at the ED on 8/22/24. Resident told SS he fell , and told Staff I his knees were bothering him so he went to the ED. Resident spent the night of 8/22/24 in the ED for observation. Resident had discharge paperwork with education about osteoarthritis. The Facility's Investigation File revealed the following written statements: a. A written statement dated 8/21/24 by Staff E, CNA, revealed she started her shift at about 10:14 PM. Staff realized the resident wasn't in his room. We looked everywhere but we did not find him. b. A written statement dated 8/22/24 by Staff F, CNA, revealed she saw Resident #1 a little bit after supper. He walked up the ramp without his walker and the dietary supervisor handed his walker to me. I gave the walker to Resident #1. He then walked toward the smoke door. It was around 6:45 PM when Staff G, RN, and I saw him. He wore a dark top and had a red ball cap on. It's 2:15 AM and it's 61 degrees in Des Moines. I searched all rooms and bathrooms on side one and side two and also checked the courtyard, as at one time you could walk around the building from the courtyard to circle drive. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview 8/26/24 at 10:15 AM, Resident #1 reported he had lived at the facility about a month. He could come and go from his room as he liked. On the evening he left the facility, he was just going to go for a walk. He liked to walk to get exercise. He reported he walked down to the family dollar store. He doesn't know if they were open, he didn't go inside. Resident #1 stated at the crack of dawn though, he got out of there. He didn't want to get in trouble. Resident #1 stated he just wanted freedom. During an interview 8/26/24 at 10:40 AM, Staff A, Certified Medication Assistant (CMA) reported Resident #1 doesn't have any behaviors. He was independent and required some cues and reminders. Resident #1 got out of the facility about 3-4 days ago. She was uncertain what happened or why he left. The resident told staff when he returned to the facility he left because he was in pain and went to the hospital, but he never told staff he was in pain. Staff A reported wander guards are reliable. If a resident had a wander guard, it alarmed whenever the resident got near the doors. Whenever an alarm sounded, she checked the panel by the nurse's station to see which exit door was alarming, checked the door, then called out 'clear and disabled the alarm. The alarm tone sounded different if there was a wander guard in the area. Staff A reported Resident #1 had a wander guard since he came in 7/2024. His wander guard was still assembled. She thinks Resident #1 was small enough and somehow got the device off his wrist or ankle. Resident #1 could dress himself and reach his extremities. On the day of the incident (8/21/24), she administered his medication around 7:45 - 8:00 PM. There was a culture party that night and there were a lot of people and activities going on. Staff didn't have their undivided attention on all of the residents. She left around 9:00 PM, after she gave residents their medications. Staff A reported she thought maybe Resident #1 slipped out of the facility when the partygoers were leaving. Staff A reported she didn't see Resident #1 outside with the smokers at 7:30 PM. Between 8 and 8:30 PM, staff noticed he wasn't around. Resident #1 wasn't found prior to her leaving at 9:00 PM. Staff A reported the nurse who was supposed to work 6 PM - 6 AM didn't come to work until after 10:00 PM. The CNA let Staff G, RN, know they hadn't seen Resident #1. Staff looked for him. She looked in his room. She did not find a wander guard in his drawer, in his bed, or under his pillow. She thinks he had the wander guard on. Staff A reported Resident #1 often sat in a chair by the exit door. Staff A stated she didn't think there were enough eyes and ears to watch all of the residents. There were also a lot of new staff who were not as familiar or knew the residents. Staff A reported staffing on the evening shift consisted of 3 CNA's, 1 CMA, and 1 nurse for 50 residents on Side 2 (lower level). Wednesdays were a heavier shower days because several residents required a Hoyer for transfers, which left only 1 CNA to watch the other residents. Staff A stated the outside door to the Circle Drive didn't lock. Staff had to put a rock in the door in order to get back into the building. Staff A relayed there are no cameras in the building that she knew of to monitor the hallways or exit doors. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview 8/26/24 at 11:00 AM, Staff B, Licensed Practical Nurse (LPN), reported he worked the 6 AM to 6 PM shift on the lower level and took care of Resident #1 on the day he left the building. Staff B recalled Resident #1 didn't have any behaviors, complaints, or anything out of the ordinary when he saw him during his worked shift. He normally filled out a change in condition assessment if a resident had a change in condition such as new behaviors. He checked the wander guard on his ankle and it functioned. Resident #1 is very compliant, and he went out to the courtyard to smoke during the smoke time. He had no complaints of wanting to leave, and he attended all three meals. He was not exit seeking. Resident #1 liked to sit in the chair by the vending machine and the SS's office. The chair sat alongside the wall near the exit door to Circle Drive. Staff B thought the resident maybe walked by the exit door, he sat down, and it triggered the alarm. The facility had a Culture night that evening. It was an introduction for the staff and residents to get to know the new company and the people. He didn't know what happened (with Resident #1 missing) because he got his prize and left the facility. He didn't hear any alarms going off, and he didn't notice anybody walking in the area when he left the building. He stated he had not witnessed Resident #1 try to leave before. During an interview 8/26/24 11:20 AM, Social Services reported Resident #1 stayed to himself and liked to go for walks. She had not seen him try to leave the facility before. He sat in the chair by the exit door and watched the cars outside the window. The SS reported she was not in the facility when Resident #1 apparently left the facility. She got a text (message) from the DON the resident had left the building. The text came at 2:30 AM (on 8/22), but she didn't get the text message until she got up that AM. She drove around looking for Resident #1 before she came to the facility for work. She read his PASRR, and called the social worker at another facility to see if they knew a contact for the resident. She found out from staff at another care facility the resident had eloped from their facility, but the SS didn't know that before until this elopement happened. She also called the mission and shelters. The resident went to the ED sometime after he left the facility and was evaluated for knee pain. The Dr told him he had arthritis. He was discharged from the ED. Staff were out looking for him all day. She called the hospitals and shelters three times but still unable to locate him. Staff H, CNA, found Resident #1 sitting on a park bench near 6th (Avenue) and University. Staff H worked the evening/night shift. He went back to get him and he was gone. Someone had picked him up. She asked the resident after staff brought him back to the facility where he was going or why he left the facility. He told her he tried to find his friends and wanted to get a painting job. He wanted to see the world. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview 8/27/24 at 8:05 AM, Staff C, CNA, reported he had worked at the facility since 8/8/24 and worked the 10 PM to 6 AM shift. He had two days of orientation to go over exits, fire extinguishers, on-line education, and things like that. Resident #1 was independent but he checked on the resident and made sure he was ok, and helped do whatever he needed. A company had just bought the facility on 8/1/24. They were having a get to know you party, where staff introduced themselves to each other. The facility was pretty crowded inside. Staff C reported he worked the floor and took care of residents during the time. Resident #1 was ok. When the party got over, Resident #1 went out with the other residents to smoke. Staff C took care of residents while another staff person went out and supervised the smoking residents. The surveyor asked Staff C when he noticed Resident #1 missing. Staff C responded he noticed Resident #1 wasn't in his room but that was not unusual because he was independent and could go around the facility. Residents were allowed to go to different parts of the facility, go outdoors to the courtyard, or anywhere in the building at this facility. The residents had freedom to go where they wanted. Staff C reported he was assigned to 14-15 residents. He couldn't watch the residents when they could go all over the place. Staff C stated the facility needed to look at the resident ratio for safety reasons. Staff C stated around 12 or 12:30 AM, he noticed the resident had not been seen, so they checked the premises. They discovered he was not around. Staff C said come to think of it, he had not seen Resident #1 since he went out to smoke, but there was no cause for concern because he had never left the facility before. The resident was quiet and went about his business. He doesn't bother anyone. Staff C reported no interventions on Resident #1's care plan prior to the incident. He just kept an eye on him and kept him safe. Since the incident, he checked on the resident every hour. The facility also provided education about elopement and how to check the exits. During an interview on 8/26/24 at 12:30 PM, Staff D, LPN, reported she normally worked the 6 PM to 6 AM shift but she didn't come into work until 12:00 AM (on 8/22/23). When she arrived, another nurse was doing treatments and the CNA's made rounds. Staff D reported as she sat at the desk on the lower level, Staff C told her Resident #1 not in his room when he made rounds. Staff C had just started working at the facility and was not as familiar with the residents. She told him where to look. He came back and told her he couldn't find Resident #1. She told everyone they needed to look for him. Some staff got in their car and drove around to see if they could find him. They searched upstairs, downstairs, and the courtyard but still didn't see any signs of him. She talked to Resident #1's roommate. His roommate said he saw Resident #1 packing things in a black bag. Resident #1 didn't mention anything to his roommate about leaving. They continued to search for him. Staff D stated she attempted to call the Administrator but he didn't answer, so she called the DON and told her about the resident. She asked the DON if she should call the authority to report him missing. The DON said she needed to check on something first. Staff D reported she called the police around 1:30 AM. Resident #1 wandered at a facility he resided at previously. Staff D stated she was unsure what interventions were in place for Resident #1. She thought Resident #1 had a wander guard on him but he had a history of taking the wander guard off. She doesn't recall if he had a wander guard on prior to the incident. Staff D stated she was unsure if the wander guard was documented on the TAR but the wander guard should be listed on the resident's care plan. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview 8/26/24 at 12:10 PM, Staff E, CNA, stated she normally worked the 10 PM to 6 AM shift. Resident #1 didn't require a lot of care. Most of his cares were done when she got there on the night shift. She made sure he was in his room. Resident #1 would be up and wandered. He would go toward the doors. She let the nurse know to keep an eye on him. Sometimes he got a drink from the machine or got a cup of coffee and drank the coffee in the dining area. He also sat by the nurse's station. Resident #1 had a wander guard on when he lived upstairs (Side 1) and also had the wander guard when he moved downstairs (Side 2). He got moved downstairs for safety reasons. Staff E reported she came to work at 10 PM on the day of the incident, the search for Resident #1 was already going on. The nurse that was working had just started back, and didn't know what he looked like. Staff looked in rooms and around the building, under beds, closets, in the bathrooms, and checked other residents' rooms. They searched around the building and on the road. Some aides drove to the gas stations, across the street to the church, and behind the facility. They checked everywhere where he possibly could be. The last time someone saw him, he came in from a smoke break, it was between 8:45 -9 PM. The staff were busy putting residents back to bed, but there had been a gathering before this. Staff E reported it puzzled them that he had went outside of the building, because when an alarm went off, they checked the door and did a count of the residents. Staff E guessed maybe after the party, the wander guard didn't go off. Resident #1 was independent. He usually came out of his room and got something to drink, then returned to his room. He often sat in the area by the exit door. The chairs near the vending area were not in that location previously. The chairs had recently been placed there because the upstairs area was too packed. Someone was supposed to come and get the chairs. Staff E confirmed no cameras in the area by the exit doors but she heard the company planned to install cameras. Staff E stated she felt they had the required staff on duty the evening of the incident. During an interview 8/27/24 at 3:10 PM, Staff F, CNA, stated she only worked on Wednesdays and Saturdays 16-hour shifts. On the evening of Wednesday, 8/21, around 6:45 PM, she saw Resident #1 ambulate from the lower level dining room toward the upper level dining room without his walker. A dietary staff member from downstairs brought his walker to him. After that, she brought residents from the dining room to their room on the upper level and performed cares and helped the residents into bed. The night shift nurse walked down the hallway and asked her if she had seen Resident #1. She said no. She went and searched the resident rooms on the upper level, then the lower level, and the courtyard. She let the nurse know she couldn't find him. She also told another aide who came in at 10:00 PM to look for him. They went room to room and looked for him but still were unable to find him. Resident #1 resided on the upper level a couple days when he first got admitted . She doesn't know if he had a wander guard on when he got admitted or if he had a wander guard on when he resided downstairs. She didn't take care of him. Staff F stated on 8/21/24 evening, a culture night party was going on. The party started at 7:00 PM. There was a lot of activity going on, and people (staff) were coming and going. No alarms went off during this time. No alarms went off during her shift except the smoke door exit alarm. The alarm went off when the residents who smoked and the staff who supervised the residents came back into the building. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165175	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greater Southside Health and Rehabilitation	5608 SW 9th Street Des Moines, IA 50315

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff F reported normally when an alarm went off, she checked the door, went outside and checked the parking lot and looked down the sidewalks to see if she saw anyone. She then came back into the facility and checked the rooms to ensure each resident was accounted for. Staff F reported she entered a code to exit the facility, and she pressed the green button on the wall to enter the building so it doesn't set the alarm off. The alarm may also trip if it took too long for someone to enter or leave the facility. Staff had to go to the Side 1 nurse's station desk and press the button to clear or deactivate the alarm to the exit door. Staff F reported staff not supposed to shut the alarm off until everything was clear. In a follow up interview 8/27/24 at 4:35 PM, Staff F reported the residents' smoke time scheduled at 7:30 PM but it depended on how fast the resident smoked their cigarette and how long they stayed outside. The smoking time varied from 15 minutes to 1/2 hour. During an interview 8/26/24 at 1:35 PM, Staff G, RN, stated she worked the 6 PM to 6 AM shift. She worked on Side 1 and also had responsibility for a few residents on the [NAME] end of Side 2. Whenever an alarm sounded, she checked to see which area alarmed. Staff G reported many times visitors came or left the facility and didn't enter the code, which triggered the alarm to go off. If she didn't see anyone when the alarm sounded, she looked outside to see if she saw someone, and then checked and accounted for the residents. The alarm sounded if a resident with a wander guard, got near the exit door. Staff G reported she checked the wander guards every shift. A list of residents due for wander guard checks showed up on the computer. Wander guard checked for placement and functioning and documented in the EHR. Staff G reported she was uncertain if Resident #1 had a wander guard prior to the incident. She was not normally assigned to Resident #1. On the evening of the incident, Staff C came and told her he had tried to find Resident #1. She told him to check the courtyard. The other nurses were aware and they had done a headcount. She went and checked the public bathrooms. Staff also checked other areas of the building. She went to Resident #1's room. The roommate mentioned Resident #1 had packed things in a black bag but the roommate didn't know what time that occurred. Staff C and Staff G looked for the black bag. Staff G stated she looked in the closet and his half of the closet was empty. A staff person drove around to areas by the facility to see if they could find him outside. Staff G reported she didn't hear any wander guard alarms while she passed meds and when she went in and out of the resident rooms. There was culture party downstairs in the dining room and there were a lot of people coming in and out. The door alarm kept going off so she checked the door and turned the alarm off. The maintenance man from a sister facility also helped her turn off the alarm by the nurse's station. She stood by the medication cart in the hall by the upper dining room, but she saw who came or left from the party. At the time, residents waited to go outside to smoke. She asked the residents to wait until the people from the party left. She did not see Resident #1 leave the facility when she worked that night. She seldom saw Resident #1 upstairs. She saw him by the exit door to the courtyard once, but he liked to sit by by the Circle Drive exit doors. Staff G again reported she was ce [TRUNCATED]