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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Home Association	714 Division Audubon, IA 50025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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. 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 [DATE] 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 [DATE] 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 [DATE] documented utilization of a wander guard.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. 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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 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 [NAME]. 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 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 [NAME] told her that Resident #1 had fallen. Staff C stated then Staff F, Dietary [NAME] 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