STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165412	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Exira Care Center	411 South Carthage Exira, IA 50076

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074 Based on observations, clinical record review, and staff interviews the facility failed to ensure 1 of 3 resident's (Resident #1) Minimum Data Set (MDS) assessments were accurately completed. The facility reported a census of 38 residents. Findings include: On 11/7/24 at 11:32 AM Resident #1 sat at the dining room table with peers eating her lunch, wanderguard observed to be located on her left ankle. Review of Resident #1's census tab in her Electronic Health Record (EHR) documented her admitted as 5/2/24. According to the admission MDS assessment tool with a reference date of 5/15/24 it documented Resident #1 wandered daily. The MDS also documented a wander/elopement alarm was not used. According to the Quarterly MDS assessment tool with a reference date of 8/15/14 it documented Resident #1 wandered daily. The MDS also documented a wander/elopement alarm was not used. According to the Significant Change MDS assessment tool with a reference date of 8/15/14 it documented Resident #1 wandered 1 to 3 days during the 7-day review period. The MDS also documented a wander/elopement alarm was not used. The Care Plan Focus Area documented Resident #1 had poor safety awareness and dementia that could lead to wandering. The Focus Areas included hand written documentation dated 9/4/24 this was met and will be continued. The care plan documented wanderguard in the intervention/tasks section of the care plan. A document titled Elopement Risk Assessment Check List dated 5/2/24 documented Resident #1 had previous history of wandering, at home. Diagnosis of dementia, episodes of disorientation, episodes of non-acceptance of placement. High level of elopement risk, a wanderguard was put in place. A facsimile (fax) sent to Resident #1's physician documented the following note: Resident was admitted [DATE], staff noted wandering and exit seeking behavior upon admission, wanderguard placed on 5/6/24, family agreeable. On 11/8/24 at 2:05 PM Resident #1's physician indicated they agreed with the wanderguard being placed. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/7/24 at 1:01 PM Staff C Certified Nursing Assistant (CNA) stated Resident #1 had wanderguard on but was unsure how long she has had it. On 11/7/24 at 1:44 PM Staff B CNA stated she thought Resident #1 wore a wanderguard on her ankle but was unsure how long she has had it. On 11/7/24 at 2:45 PM Staff D CNA stated Resident #1 wore a wanderguard but was unsure how long she has had it. On 11/8/24 at 11:40 AM the Director of Nursing was made aware the MDS assessments that were completed since Resident #1's admission did not document the use of a wanderguard/elopement alarm. She acknowledged the MDS assessments should have documented that Resident #1 wore a wanderguard. At 1:53 PM the DON indicated they currently follow the Resident Assessment Instrument (RAI) for MDS assessments.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 37074 Based on observations, clinical record review, and staff interviews the facility failed to ensure 2 of 3 residents' (Resident #1 and #3) care plans included interventions for staff to follow should these residents exhibit wandering/eloping behaviors. Resident #1's care plan failed to include that she had eloped from the building on 10/31/24 and was found in a staff member's car. The facility reported a census of 38 residents. Findings include: 1. According to a significant change Minimum Data Set (MDS) assessment tool with a reference date of 10/9/24 Resident #1 had a Brief Interview of Mental Status (BIMS) score of 8. A BIMS score of 8 suggested mild cognitive impairment. Resident #1 had experienced hallucinations and delusions during the review period. The MDS documented she wandered 1 to 3 days during the review period. Resident #1 had no upper or lower extremity impairments, she utilized a walker and wheelchair for mobility. Resident #1 required supervision or touching assistance when going from a sitting to standing position. She was independent when ambulating. The MDS documented she did not utilize a wander/elopement alarm. The following diagnoses were listed for Resident #1: moderate dementia with psychotic disturbance, heart failure, renal failure, diabetes mellitus, thyroid disorder, depression, spinal stenosis, and repeated falls. The Care Plan Focus Area documented Resident #1 had poor safety awareness and dementia that could lead to wandering. The Focus Areas included a hand written note dated 9/4/24 this area was met and will be continued. The care plan documented wanderguard in the intervention/tasks section of the care plan. The care plan lacked interventions for staff to attempt when she is wandering and/or exit seeking. The care plan lacked documentation about her elopement on 10/31/24. The Progress Notes documented the following for Resident #1: a) On 10/14/24 at 10:05 AM the resident had some delirium and being off before her hospitalization . Resident #1 still sees little kids in her room but does not say anything because they will think she is crazy. She does still look for her husband occasionally, will pack up her belongings because she believes she is going home soon. She does make delusional statements frequently and wanders prior to her hospital stay. b) On 10/31/24 at 3:01 PM the resident has been extremely confused today (more than normal). Told this nurse that she started her period and wasn't prepared. Her adult brief was checked and there was no sign of blood, she was given a pad insert. After lunch she stated she needed to go to 4H and had already been there this morning. She stated she needed to find her car, wandered down another hallway, eventually opened the exit door and went out into the parking lot. She walked over to a staff's parked car and got inside. The door alarms sounded, staff found Resident #1 in the car and brought her back into the facility. Vital signs completed, no injuries noted, she will be an assist of one moving forward. Her family, hospice, and primary care provided (PCP) were notified. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c) On 11/4/24 at 2:10 AM staff went to check on resident and resident's refrigerator was unplugged and moved away from the wall, everything was out of the closet and in a laundry basket, hangers were all over the floor and resident had bed covered with things, resident had taken the string out of her jacket and knotted it around a bunch of hangers. d) On 11/5/24 at 2:30 PM she was wandering in hall one with a plant, a vase of flowers and a handful of clothes hangers in her arms, saying she was moving across the hall to #109. Redirected her back to her room where she had taken all of her clothes out of closet and had them folded in piles. Advised her to sit in her recliner and rest for a while. She was wandering without walker or cane. Stated her back was hurting, she was given Tylenol for pain. A document titled Elopement Risk Assessment Check List dated 5/2/24 documented Resident #1 had previous history of wandering, at home. Diagnosis of dementia, episodes of disorientation, episodes of non-acceptance of placement. High level of elopement risk, a wanderguard was put in place. 2. The quarterly MDS assessment tool with a reference date of 10/12/24 documented Resident #3 had a BIMS score of 4. A BIMS score of 4 suggested severe cognitive impairment. The MDS documented she wandered daily and utilized a wander/elopement alarm daily. The following diagnoses were documented for Resident #3: dementia with anxiety, stroke and had a pacemaker. The Care Plan Focus Area documented Resident #1 had poor safety awareness and dementia that could lead to wandering. The Focus Areas included a hand written note dated 10/30/24 this area was met and will be continued. The care plan documented wanderguard in the intervention/tasks section of the care plan. The care plan lacked interventions for staff to attempt when she is wandering and/or exit seeking. The Progress Notes documented the following for Resident #3: a) On 9/23/24 at 2:51 PM Resident #3 was out in the 100 hall by the exit door with the door alarm sounding. Staff went to the door and redirected Resident #3 back inside without difficulty. b) On 9/24/24 at 4:36 AM Resident #3 agitated throughout shift periodically. Wandering the halls saying that she has things to do and places to go. Frequently forgetting walker. Redirection made her agitated with staff. Defensive of her daughter when staff was caring for her. Calmed down some by the time staff was done taking care of daughter. This nurse tucked resident in her daughter's recliner in daughter's room. Resident seemed to relax and was thankful to this nurse with tears in her eyes. Has been about 30 minutes since interaction and resident seems to be staying comfortable in daughters recliner at this time. c) On 9/24/24 at 5:42 AM sending facsimile to the primary care provider to advise. Resident has frequent overnights of wandering. Residents daughter if effected by this by resident waking her up and doing things in her room. Staff redirects resident frequently throughout evening and night. Wondering if we could add a medication for sleep or increase melatonin dose. d) On 9/28/24 at 1:15 AM resident was up wandering in the halls most of night, she becomes irritable easily and is writing nonsensical notes. It is difficult for her to follow directions. A snack provided which she did sit down and eat. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e) On 10/22/24 at 12:56 AM resident having increased wandering around building, going through her room, and going through her daughter's room. Daughter expressed concern about resident's lack of sleep due to disease process. Daughter states resident has been awake since 3:00 AM on Sunday and hasn't slept. Resident frequently forgets to have walker with her. Staff is redirecting, reminding resident to have walker. Resident favors being with daughter in her room most of the day and night. Staff recently tried to get resident to go to her room to lay down but resident refused. Resident was tucked into daughter's recliner, chair reclined, and warm blanket applied with regular blanket to promote rest for resident. Eyes closed at this time. Daughter in bed by her with call light in reach due to resident's non-use of call light. Frequently checking resident at this time. f) On 10/25/24 at 11:26 AM spoke with Resident #3's family about the benefits of moving the resident to the Chronic Confused Dementing Illness (CCDI) unit. g) On 11/7/24 at 1:12 PM resident alert and pleasant, adjusting well to the CCDI unit. On 11/8/24 at 9:47 AM Resident #3 on the CCDI unit, standing with a staff member talking about wanting to leave out the doors. Staff let the resident know she did not have the code to get out the door. The resident questioned how others were getting in and out. Staff member asked if the resident wanted to sit down to eat her donut. Resident #3 agreed if the staff sat and had a donut with her. Resident #3 sat in her recliner, with her feet reclined and watched television. On 11/7/24 at 11:45 AM the Director of Nursing stated the paper care plans that were found in the binders at the nurse's station were the most current care plans. The care plans in the Electronic Health Record (EHR) are used as a template when creating the resident's care plans. During a follow up interview on 11/8/24 at 11:40 AM stated the interventions for residents that have wandering behaviors or at risk for elopement would be found under the chronic confusion section of the care plans. The care plans of Resident #1 and Resident #3 were reviewed with the DON. Interventions specific for wandering or elopement risk residents were not located on the care plans of the two resident reviewed. The DON stated she did not think to put Resident #1's elopement on her care plan. She indicated the care plans are updated and revised quarterly and as needed per standard nursing practice.

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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. 37074 Based on observations, clinical record review, facility document review, staff and resident interviews, and facility policy review the facility failed to supervise a cognitively impaired resident. Staff were unaware Resident #1 left the building on 10/31/24. Staff last saw Resident #1 at approximately 12:45 PM. The door alarm sounded at 1:01 PM, staff responded, took approximately 5 steps outside, did not see anyone, walked back in the facility, disarmed the door alarm and went back to work. At 1:30 PM a different staff member came into the back-parking lot, saw a car backed up against the curb and was blocking the parking lot. Staff realized it was Resident #1 in the driver's seat with the car running and the doors locked. The responding staff member failed to do a thorough check around the facility, failed to notify nursing staff that she did not see anyone, and failed to initiate a head count to ensure all residents were accounted for. The facility reported a census of 38 residents. On 11/7/24 at 4:20 PM the State Survey Agency informed the facility of the staff's failure to supervise a cognitive impaired resident creating an Immediate Jeopardy situation resulting in the resident leaving the building unattended, without the staff's knowledge on October 31, 2024. The facility staff removed the immediacy on November 4, 2024 when the staff implemented the following Corrective Actions: a) On 10/31/24 immediate education and coaching with staff on the facility's door alarm response procedure. b) On 10/31/24 all door alarms and wander guard alarms were checked for proper functioning. c) On 11/1/24 elopement drills were completed successfully. d) On 11/4/24 staff completed door response education. The facility updated the wandering assessment in their Electronic Health Record (EHR) to be completed on admission, 72 hours after admission and quarterly. e) Elopement drills will continue every quarter, alternating shifts for three quarters and reviewed at Quality Assurance (QA) meetings. If the drill is not successfully completed, they will increase the frequency to weekly. The scope lowered from a J to a D at the time of the survey after ensuring the facility implemented education about their policy and procedure with missing resident exercises. Findings include: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/7/24 at 11:32 AM Resident #1 sat at the dining room table with her peers. A wanderguard alarm was visible on her left ankle. At 2:13 PM pushed the 200 hall exit door egress bar. An alarm sounded at the door and increased in sound once the door was opened. Once outside and the door closed, the alarm still sounded. At 2:14 PM staff walked outside, surveyed the area and located the surveyor around the corner of the building. The alarm sounded until staff returned inside and deactivated the alarm. Once out the exit door, a sidewalk led to the street with a wheelchair accessible portion on the sidewalk. There is a parking lot once across the street. The area is flat and visible once around a small curve in the roadway. According to a significant change Minimum Data Set (MDS) assessment tool with a reference date of 10/9/24 Resident #1 had a Brief Interview of Mental Status (BIMS) score of 8. A BIMS score of 8 suggested mild cognitive impairment. Resident #1 had experienced hallucinations and delusions due the review period. The MDS documented she wandered 1 to 3 days during the review period. Resident #1 had no upper or lower extremity impairments, she utilized a walker and wheelchair for mobility. Resident #1 required supervision or touching assistance when going from a sitting to standing position. She was independent when ambulating. The MDS documented she did not utilize a wander/elopement alarm. The following diagnoses were listed for Resident #1: moderate dementia with psychotic disturbance, heart failure, renal failure, diabetes mellitus, thyroid disorder, depression, spinal stenosis, and repeated falls. The Care Plan Focus Area documented Resident #1 had poor safety awareness and dementia that could lead to wandering. The Focus Areas included a hand written note dated 9/4/24 this area was met and will be continued. The care plan documented wanderguard in the intervention/tasks section of the care plan. The care plan lacked interventions for staff to attempt when she is wandering and/or exit seeking. The care plan lacked documentation about her elopement as well. The Progress Notes documented the following for Resident #1: a) On 9/17/24 at 1:26 PM resident left the facility with her daughter for a hair appointment. b) On 10/7/24 at 1:30 PM resident returned to the facility with hospice orders but family stated they are still undecided. c) On 10/9/24 at 11:12 AM hospice at the facility and spoke with family and resident to admit to hospice care. d) On 10/13/24 at 5:36 AM hospice notified due to resident continuing to have severe back pain and her Fentanyl patch is not effective yet for pain control. e) On 10/14/24 at 10:05 AM the resident had some delirium and being off before her hospitalization . Resident #1 still sees little kids in her room but does not say anything because they will think she is crazy. She does still look for her husband occasionally, will pack up her belongings because she believes she is going home soon. She does make delusional statements frequently and wanders prior to her hospital stay. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	f) On 10/31/24 at 3:01 PM the resident has been extremely confused today (more than normal). Told this nurse that she started her period and wasn't prepared. Her adult brief was checked and there was no sign of blood, she was given a pad insert. After lunch she stated she needed to go to 4H and had already been there this morning. She stated she needed to find her car, wandered down another hallway, eventually opened the exit door and went out into the parking lot. She walked over to a staff's parked car and got inside. The door alarms sounded, staff found Resident #1 in the car and brought her back into the facility. Vital signs completed, no injuries noted, she will be an assist of one moving forward. Her family, hospice, and primary care provided (PCP) were notified. g) On 11/1/24 at 11:36 AM resident was less confused today, came out for breakfast meals, took her medications. No wandering noted, a urine sample was collected. h) On 11/2/24 at 9:27 PM had increased wandering throughout the facility this evening. She looked to be exit seeking. When asked what she was doing, she stated her husband was waiting in the car for her. She then continued to walk down hall one. An hour later, she was found pacing the hallway again, this time she stated my mother is coming to get me. After some convincing from the aides, she went back to her room. Resident is experiencing increased confusion and is becoming irritable. Will continue to monitor. i) On 11/3/24 at 1:22 PM resident has been having increase confusion the past couple of weeks (more than she normally is). Starting to revert back in time, looking for husband, etc. A urine sample was obtained but it showed no Urinary Tract Infection. Staff and family wondered if the Fentanyl patch could be a cause or her dementia is worsening. j) On 11/4/24 at 2:10 AM staff went to check on resident and resident's refrigerator was unplugged and moved away from the wall, everything was out of the closet and in a laundry basket, hangers were all over the floor and resident had bed covered with things, resident had taken the string out of her jacket and knotted it around a bunch of hangers. k) On 11/5/24 at 2:30 PM she was wandering in hall one with a plant, a vase of flowers and a handful of clothes hangers in her arms, saying she was moving across the hall to #109. Redirected her back to her room where she had taken all of her clothes out of closet and had them folded in piles. Advised her to sit in her recliner and rest for a while. She was wandering without walker or cane. Stated her back was hurting she was given Tylenol for pain. The facility's investigation contained the following interviews and summary: a) On 11/5/24 Staff B wrote she witnessed Resident #1 sitting, resting at the top of the 200 hall at 12:45 PM on 10/31/24. She stated she was resting when asked if she needed help. b) An undated note from Staff A Non-Certified Aide documented at 1:30 PM she came into the back parking lot and saw a car tire was backed up against the curb, blocking the parking lot. She realized it was Resident #1 in the driver's seat, so she got out of her car, asked her to unlock the door. Staff A then opened the door, put the car in park and took the keys out of the car. Staff A then called the facility to have someone come out to help. Staff F Registered Nurse (RN) and the Director of Nursing (DON) came out and brought Resident #1 inside. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c) An undated note from Staff C Certified Nursing Assistant (CNA) documented she saw the 200 hall exit door go off so she went to check it. She took a couple steps outside to check if anyone was out there but she did not see anyone. She needed help clearing the door alarm, so another staff member got it. d) A note dated 10/31/24 from Staff D CNA documented she saw Resident #1 in the 200 hall at 12:45 PM. Staff D was on her way to eat lunch. She heard Staff B CNA try to redirect Resident #1 and thought the situation was being handled. e) The DON received report from Staff H Licensed Practical Nurse (LPN), that Staff A was on the phone and that Resident #1 was in the employee parking lot in the front seat of an employee vehicle at 1:34 PM, on 10/31/24. Staff F and the DON went to the parking lot to investigate. Resident was sitting in the front seat of an employee vehicle; Staff A was with her. She looked to be unharmed or uninjured. She was escorted back to the building. The DON interviewed Staff A and had her write a statement. It was discovered that Staff C had responded to the door alarm at that 200 hall exit door and did not see anyone. When speaking with other CNAs it was discovered that Staff D and Staff B last saw Resident #1 at 12:45 PM, just before she exited the building. Staff B tried to redirect the resident. When interviewing Staff G she stated that Resident #1 had been more confused than normal possibly related to her recent order of a Fentanyl patch for back pain. Earlier that day she reported the increased confusion to the resident's Primary Care Provider (PCP) and the Hospice Nurse. After Resident #1 was escorted back into the facility, she was assessed; her vitals were normal and no injuries were noted. The facility provided a documented tilted Location Event Report 200 Hall Exit. The door alarm was activated on 10/31/24 at 1:01 PM and deactivated on 10/31/24 at 1:06 PM. On 11/7/24 at 1:01 PM Staff C stated she was working on the 300 hall the day Resident #1 left the building. She was checking on residents when her pager sounded indicating the 200 hall door was opened. She went down to the door, outside about five steps, did not see anyone so she cleared the alarm. She went straight to the door as soon as she saw the message on her pager. She thought the pager went off about 1:45-1:50 PM. When asked where she looked while she was outside, she indicated she peaked around the corner of the building, looked the opposite direction but did not think to look in the cars that were in the parking lot. There were staff member's cars in the parking lot when she went out there but did not look in them. Staff C denied knowing if a head count was completed since this happened at the end of her shift. Staff C indicated Resident #1's confusion has gotten worse; she packs items up in her room and says she needs to get out of here. On 11/7/24 at 1:41 PM call to Staff A with no answer, a message was left on her voicemail and a text message was sent to return the call. At the conclusion of the investigation, Staff A had not returned the call. On 11/7/24 at 1:44 PM Staff B stated after lunch on 10/31/24 Resident #1 was sitting on her walker on the 200 hall at about 12:45 PM. Staff B asked if she needed anything, the resident indicated she was resting. Staff B stated the next thing she knew, Resident #1 was outside in an employee's car. Staff B denied hearing the door alarm sounding because she was on her 15-minute break at approximately 12:50/12:55 PM. Staff B stated while she was out on her break she did not see Resident #1 outside. Staff B indicated she was working on the 200 hall that day, not the 100 hall where the resident resides. When she saw her at dinner she appeared to be a little lost. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/7/24 at 1:57 PM Staff F RN stated she got a call from Staff A on 10/31/24, indicating they found Resident #1 in the driver's seat of a staff member's car. When Staff F arrived, Staff A had the driver's side door open as the resident sat in the car. The car was backed up against the sidewalk's curb. Once around the building, there's a curve in the road that comes around the building. The car was not in a parking stall, it looked like it rolled back out of a parking stall. The car was not on and not in gear when she arrived. The resident had placed her walker in the back seat. Staff F stated she went outside about 1:30 PM after Staff A called. Resident #1 was assisted inside to the facility, but did not say anything as to what she was doing. Staff F indicated she was working in the office that day and did not see how Resident #1 was prior to her exiting the building. On 11/7/24 at 2:46 PM Staff E Assisted Living Aide stated she was running late to work on 10/31/24. She parked her car in the parking lot at the back of the facility. She stated there's a curve in the road, to the left was a corn field and to the right was the building. She parked her car facing the corn field in a parking lot. Later in the day, she took the garbage out, noticed there were nursing home staff members at her car and her car was backed up to the curb. Her car was resting on the curb that was behind the parking spot where she parked her car for the day. The resident was already out of her car and in the building with staff members. She was unable to recall where her keys were once she put her car in park, she was running later to her shift and just wanted to get clocked in before it showed she was late. Resident E denied finding damage to her car. On 11/7/24 at 2:35 PM Staff G stated Resident #1 had increased confusing that was worsening on 10/31/24. She indicated it was normal for her to walk around quite a bit and that day she had wandered down to the 200 hall. She indicated the hospice nurse and Social Worker spoke of how confused she was. That morning at breakfast, Resident #1 usually took her morning pills before she would leave the table. That day after breakfast she got up from the table and went to the bathroom. When Resident #1 did not come back done to get her medications, Staff G went down to her room and found her in her bathroom. Resident #1 stated she had started her period then later told her she need to go to the 4H building. She was off from her normal confusion. Staff G stated Resident #1 was very outgoing, independent and would walk around to different halls. While Staff G was in report, someone reported to her Resident #1 was found in a staff member's car that had backed up in a curb. She indicated this was probably about 1:45 PM. Staff were able to get Resident #1 in to the building. She remembered hearing the door alarm sounding and Staff C went to check, stated it was all clear. On 11/7/24 at 3:09 PM Resident #1 was sitting in a chair in her room by the window, wanderguard visible on her left ankle. Resident #1 remembered leaving the facility and getting in to a car. When asked why she was leaving she stated we were leaving to go back to the motel we were staying at. Resident #1 stated her husband was here to pick her up but he was driving the car. Now she's resting in the sunlight waiting for a ride. On 11/7/24 at 3:16 PM Staff D stated she saw Resident #1 on the 200 hall and Staff B redirected her, this was approximately at 12:50 PM. Staff D stated when the 200 hall door alarm sounded, Staff C went to the check to see what was going on, she did not see anyone but was unsure what Staff C did after that as she was answering call lights. Staff D stated this was approximately about 1:00 PM. When asked how Resident #1 was prior to leaving the building that day, she stated she was a little bit confused but did not work her hall that much. She added her behavior was strange that morning; she wanted to know if the facility had stairs to go to the dining room. Staff D assured the resident she just needed to go up the hall to the dining room. When the exit doors are opened staff get a page on their pagers but they can hear the alarm on the door when it's been engaged. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165412	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Exira Care Center	411 South Carthage Exira, IA 50076

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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	On 11/8/24 at 11:40 the DON stated a staff member approached her in the hall and stated she needed to go out to the parking lot because Staff A found Resident #1 in the parking lot. She grabbed Staff F to go outside with her right away. When they arrived to the parking lot outside of the 200 hall's exit door, Resident #1 was sitting in an employee's car with Staff A standing at the driver's side opened door. Staff A had opened the door, put the car in park and shut the car off. The DON noted Resident #1's walker was in the back seat, she looked unharmed so they helped her out of the vehicle and back inside. Resident #1 did have her wanderguard on at that time. Staff G completed the head to toe assessment once back in the facility. After the incident, she read the nurse's note and did not realize she was so confused. They started to decrease her Fentanyl patch dosage as they thought it was causing her confusion. A urine sample was collected to rule out a urinary tract infection, the urine sample came back negative. They have discussed moving her to the memory care unit but they would like to see how she does after they lower her Fentanyl dosage. They have noticed she seems to be doing better, still talks about going out but has not found her near any exits. The facility's Door Alarm Response Policy with an effective date of 7/19/24 and revised date of 10/31/24. The policy is to assure prompt response to door alarms/alerts. Staff to check the system for location of door alarming. Staff to immediately respond to the door that is alarming. Staff to walk to the door, walk outside, scan the facility grounds to identify the source of alarm. If the source of the alarm is a resident, assist the resident back in to the facility and notify the nurse on duty. Once the door is checked and the resident's safety is assured, reset the door alert. If the source of the alarm is not identified, account for location of all residents. If the resident is unaccounted for, immediately implement the missing resident policy. The facility's Missing Resident and Tenant Policy with an effective date of 7/14/24 and reviewed date of 11/1/24. The purpose of the policy is to ensure prompt and appropriate response by the staff and emergency personnel in an effort to maintain resident safety. In the event a resident is missing, the following steps shall be taken: - Search the building thoroughly. Look in closets, bathrooms, non-resident areas and in each and every bed. In the majority of incidents when a resident is missing, he/she is subsequently found in the facility, usually in an unexpected area. - Search the immediate grounds surrounding the building. - Notify the Administrator/DON to assist in the search. - Whoever is in charge of the facility should file a Missing Person's Report with the police.