STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165432	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Living Senior Campus	2421 Lutheran Drive Muscatine, IA 52761

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22506 Based on clinical record review the facility failed to notify a resident's physician upon discovering a positive COVID infection. (Resident #8) The facility reported census was 125. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #8 had a Brief Interview for Mental Status (BIMS) score of 12, indicating a marginally impaired cognitive status. Resident #8 was independent with transfers, mobility, toilet use and personal hygiene needs and needed moderate assistance with dressing. He was continent of bladder and bowel. Resident #8's diagnosis included renal insufficiency. According to Progress Note dated 8/25/24 at 1:51 p.m., Resident #8 tested positive for COVID. The progress note did not indicate the primary care physician was notified of the positive test result. According to a Progress note dictated by the Physician Assistant (PA) on 8/26/24 at 9:46 a.m., Resident #8 was being seen due to testing positive for COVID-19 infection. The PA indicated two days ago the resident developed upper respiratory symptoms: cough, rhinorreha, fatigue, body aches and mild shortness of breath. The PA indicated she was first made aware of covid positive today with a sheet of paper requesting cough syrup. The PA indicated oncall had not been notified. The Director of Nursing and Assisted Director of Nursing made aware today of delay in notification , and the importance of notifying immediately for both orders, and for Paxlovid (medication used to treat COVID-19) consideration.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22506 ; Based on observations, clinical record review, resident and staff interviews, the facility failed to ensure residents are provided incontinence care in accordance with professional standards of practice. (Resident #19, #20) The facility reported census was 125. Findings include: During observations on 10/1/24 at 1:00 a.m. upon entering the lounge area between 600 and 700 halls, there were three staff visiting. Two were sitting in recliners (Staff AA) with their feet elevated and one standing between them talking. The TV was on and there were no residents in the proximity of the lounge area. There was a bowl on an end table which appeared to have been recently eaten from. The three aides including Staff AA, Certified Nursing Aide, quickly got up, folded a sheet, picked up the bowl and proceeded to the nurse's station. At 1:30 a.m. Staff AA walked onto 700 hall and returned within two minutes and then 600 hall, again returning in less than 5 minutes. She remained at the nurse's station until 2:24 a.m. at which time she answered a call light accompanied by another aide on 700 hall, both returning within 5 minutes. At 3:00 a.m. Staff AA and another aide entered the 700 hall together, doing what appeared as rounds, but failed to check in every room. The two returned to the nurse's station within 15 minutes where they remained as the surveyor departed at 4:00 a.m. In an interview on 10/1/24 at 2:15 a.m. Staff Z, Registered Nurse, stated most aides do okay, but some have been known to take naps. Staff Z stated she will wake aides up when she sees them sleeping. Staff Z did not provide any names, noting she is an agency nurse and not familiar with everyone's name. According to a Kardex, there were 15 residents on 700 hall and of those 5, including Resident #19 and #20 that were identified as being incontinent and needing assistance with checking and changing. According to the Minimum Data Set (MDS) dated [DATE], Resident #19 had a Brief Interview for Mental Status (BIMS) score of 10, indicating a moderately impaired cognitive status. Resident #9 required moderate assistance with transfers, mobility, dressing, toilet use and personal hygiene needs and he was frequently incontinent of bladder and occasional incontinent of bowel. Resident #19's diagnosis included Non-Alzheimer ' s dementia, cerebrovascular accident (stroke), atrial fibrillation, benign prostatic hypertrophy. In an interview on 10/1/24 at 11:20 a.m. Resident #19 was sitting in his recliner holding a great grand child and visiting with family. Resident #19 queried regarding care at night. Resident #19 stated they don't check him at night until about 4:00 a.m. Resident #19 voiced dissatisfaction with overnight staff. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the Minimum Data Set (MDS) dated [DATE], Resident #20 had a Brief Interview for Mental Status (BIMS) score of 15, indicating an intact cognitive status. Resident #20 required independent to moderate assistance with transfers, mobility, dressing, toilet use and personal hygiene needs and was occasionally incontinent of bladder and bowel. Resident #20's diagnosis included congestive heart failure, renal insufficiency, respiratory failure, diabetes mellitus, arthritis. In an interview on 10/1/24 at 11:30 a.m. Resident #20 was sitting in her recliner with her TV on. Resident #20 queried regarding care at night. Resident #20 stated they don't check her at night, noting she is often saturated in the morning.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22506 Based on clinical record review and staff interviews, the facility failed to properly identify residents prior to administration of medications, failed to clarify medication orders, failed to initiate medication orders timely and failed to recognize medication errors when they occur and properly notify physicians of such errors, all in accordance with a professional standards of practice. (Residents #3, #7) The facility reported census was 125. Findings include: 1. According to the Minimum Data Set (MDS) dated [DATE], Resident #3 had a Brief Interview for Mental Status (BIMS) score of 14, indicating an intact cognitive status. Resident #3 was independent with transfers, mobility, dressing, toilet use and personal hygiene needs and continent of bladder and bowel. Resident #3's diagnosis included Non-Alzheimer's dementia, coronary artery disease and seizure disorder. According to a Progress Note dated 9/7/24 at 7:30 a.m. a nurse was informed by Staff Q, Agency Certified Medication Aide, that she had given a Resident #3 another resident's medications. Staff Q had stated while in the dining room she had asked a Resident #3 if his name was Resident #8's, Resident #3 stated yes, and Staff Q gave Resident #8's medications to Resident #3. Staff Q realized her error when Resident #8 came to the dining room table. In a statement written by Staff Q on 9/7/24, Staff Q states at around 7:00 a.m. she entered Resident #3's room and administered his medications. Staff Q stated the room was dark, so she did not get the best view of his face. Staff Q stated at 7:30 a.m. she was passing medications in the dining room and thought the resident (Resident #3) sitting at the dining room table was Resident #8. Staff Q stated she approached the resident (Resident #3) and asked if he was Resident #8. Resident #3 stated yes and then stated he had already taken his medications. Staff Q asked again if he was Resident #8 and Resident #3 shook his head yes and the took the medication which were set up for Resident #8. Staff Q stated she returned to her cart and then witnessed an aide bringing a resident to his dining room table. Staff Q asked the aide who the resident was and she was informed he was Resident #8. Staff Q stated she immediately reported her error to the Director of Nursing (DON). Staff Q stated when looking at the electronic medication administration record (eMAR) picture she thought she had had the right person sitting at his dining room table. According to a Progress Note dated 9/7/24 at 7:45 a.m. the nurse notified Administrative staff and left a message for the primary care physician (PCP). At 8:00 a.m. the PCP returned the call and gave orders for Resident #3 to be sent to the emergency department (ED) to be evaluated. At 8:37 a.m. the ambulance arrived and transported Resident #3 to the ED. According to a progress note dated 9/7/24 at 3:01 p.m. the root cause for the medication error was failure to follow medication administration rights and failure of not listening to a resident who stated he had already received his medications that morning. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the ED report, Resident #3 was admitted on [DATE] at 8:53 a.m. and discharged at 7:26 p.m. Resident #3 remained stable with no adverse side effects related to an over dose of antihypertensive medications. In an interview on 9/17/24 at 9:05 a.m. Staff C, Licensed Practical Nurse, stated when uncertain of a resident's identity when passing medications, she would use the photo on the eMAR, ask them their name and consult other staff. Staff C stated if a resident states the medication your giving isn't theirs, she would stop and re-verify the resident's identity and correct medication. Staff C stated she was aware of Staff Q's medication error on 9/7/24 involving Resident #3. Staff C stated Resident #3 is known to joke and Staff Q was from an agency and unaware of Resident #3's behaviors. Staff C stated Staff Q is a good aide. 2. According to the Minimum Data Set (MDS) dated [DATE], Resident #7 had a Brief Interview for Mental Status (BIMS) score of 15, indicating an intact cognitive status. Resident #7 required supervision to moderate assistance with transfers, mobility, dressing, toilet use and personal hygiene needs and was occasionally incontinent of bladder. Resident #7's diagnosis included coronary artery disease, peripheral vascular disease, renal insufficiency and fracture. According to the August Medication Administration Record (MAR), Resident #7 had been receiving Hydrocodone/Acetaminophen 5/325 milligrams, 0.5 tablet every 6 hours as needed for vascular foot pain, ordered on 7/29/24. On 8/5/24 the Physician Assistant (PA) wrote an order for Resident #7 for Schedule Hydrocodone 2.5/325 milligrams po daily at bedtime for feet pain and to continue as needed order (prn) for prn Hydrocodone. The order was transcribed incorrectly as (2) 5/325 milligrams at bedtime. 4 times the dose intended. Because of the pharmacy protocol of not sending a separate bubble pack of controlled medication, the prn bubble pack was utilized. This seemed to add to the confusion noting on the Controlled Medication Utilization Record (CMUR) one 0.5 milligram dose was removed for the scheduled dose on 8/6/24 and 8/8/24. Two doses were used on 8/7/24 and 4 doses were used on 8/9/24 and 8/10/24 depleting the doses sent in the prn bubble pack. Despite the variations of doses used, there was no one who stopped to clarify the proper dose. In an interview on 9/26/24 at 8:15 a.m. the Director of Nursing (DON) stated an agency nurse was the one who initially took the scheduled order of Hydrocodone/Acetaminophen for Resident #7 on 8/5/24. The order was unclear and the agency nurse failed to clarify the dose with the PA and transcribed the order incorrectly onto the MAR. The PA failed to provide an eScript to pharmacy and thus no scheduled dose bubble pack was sent. Nurses then improperly used the prn bubble pack to remove scheduled doses. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the August Medication Administration Record (MAR), Resident #7 had been receiving Lasix 60 milligrams twice daily from 7/31/24 until 8/12/24. The Lasix had been placed on hold from 8/13/24 through 8/19/24 and restarted on 8/20/24 as 40 milligrams in the morning and 20 milligrams at noon. According to an order dated 8/23/24, the PA ordered an additional 40 milligrams of Lasix to be given at noon (60 milligrams total) that day and then change order of Lasix to 40 milligrams twice daily beginning tomorrow (8/24/24). The August MAR indicated that staff failed to initiate the extra 40 milligram dose to be given at noon on 8/23/24, until 8/24/24 and the 40 milligram doses twice daily to be started on 8/24/24 were not started until 8/25/24. The August MAR also indicated the 40 milligram morning and 20 milligram noon doses initiated 8/20/24, were errantly continued along with the 40 milligram twice daily doses started on 8/25/24. The medication errors of additional 40 milligrams of Lasix in the morning and additional 20 milligrams of Lasix at noon on 8/25/24 and 8/26/24 were not identified by staff as medication errors.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22506 Based on clinical record review, observations, facility video and staff interviews, the facility failed to ensure a resident with exit seeking behavior did not exit the facility without staff knowledge. (Resident #4) The facility reported census was 125. The State Agency informed the facility of the Immediate Jeopardy (IJ) on 9/17/24 at 3:30 pm. The IJ began on August 4, 2024. Facility staff removed the Immediate Jeopardy on 9/24/24 through the following actions: - Resident placed on 1:1 observation on 8/4/24 until he was moved to the locked Memory Care Unit on 8/5/24. - Neuro checks initiated, witness statement obtained, and notifications made on 8/4/24. - Elopement assessment and care plan updated 8/5/24. - Staff education on elopement and documentation began 8/4/24. - Residents wander guard immediately checked for functionality on 8/4/24. - Staffing was reviewed for time of incident and determined not to be a contributing factor. How will you identify other residents who are at risk for being affected by this alleged deficient practice: All residents at risk for elopement have potential to be affected by this alleged deficient practice. What measures will you put into place or what system changes will you make to ensure that the deficient practice does not recur. - Staff education for elopement began 8/4/24. - All residents with wander guards were reviewed, tested and ensured orders were put in place for monitoring on 8/4/24 and 9/19/24. - Elopement drills were conducted 7/31/24 and 8/5/24. - Elopement Risk Assessments were reviewed on all residents and revised, if necessary, on 8/4/24. - All elopement care plans were reviewed and revised as necessary on 8/4/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Elopement Book at front desk was reviewed and updated as necessary on 8/4/24. - All Maintenance logs were reviewed and found in compliance with alarm monitoring on 8/4/24. - TARS reviewed and physician orders updated to include what functionality of the alarm looks like on 9/19/24. - Ideacom, our wander guard service vendor, sent a technician to Lutheran Living on 9/19/24 at approximately 7:30 PM and recalibrated the Wanderguard after the system passed all tests. The technician was unable to duplicate the issue and felt it was a technology glitch. Technician increased the sensitivity of the wander guard zones for optimal coverage. - Main entrance was monitored by staff, until Ideacom technician arrived to evaluate system and increase sensitivity. - Implementation of a Weekend Manager on Duty to ensure we have coverage at the front entrance every day of the week. - Wanderguard alarm on doors will continue to be monitored ongoing. - Wanderguard bracelets on residents will continue to be monitored ongoing. How the corrective action will be monitored to ensure that the deficient practice does not recur. - Negative findings will be corrected immediately and reported at Quality Assurance and Performance Improvement Meeting and conduct education training as needed. - Ongoing random reviews of this system will be incorporated into the monthly - Quality Assurance Performance Improvement Program. The scope lowered from J to D at the time of the survey after ensuring the facility implemented the education, audits and their policy and procedures. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #4 had a Brief Interview for Mental Status (BIMS) score of 5, indicating a severely impaired cognitive status. Resident #4 required maximal to dependent assistance with transfers, mobility, dressing, toilet use and personal hygiene needs and he was frequently incontinent of bladder and bowel. Resident #4's diagnosis included cerebrovascular accident (stroke) with hemiplegia, Non-Alzheimer ' s dementia and atrial fibrillation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to the facilities Elopement Risk Screen Tool dated 7/8/24, Resident #4 scored 30 and was determined at high risk for elopement. Resident #4's Care Plan indicated he was at risk for elopement with goal to keep resident safe and secure during his stay and interventions to: 1. Complete quarterly and as needed Elopement Assessments. 2. Observe, monitor, document behaviors, and mood exit seeking concerns and notify supervisor, social worker and physician as needed. 3. Notify supervisor if wanderguard (Accutech LC1200) is missing or not functioning properly. 4. Wanderguard bracelet placement-wanderguard is placed on wheelchair. Monitor per facility protocol. According to the August Treatment Administration Record (TAR), staff are to ensure Wanderguards are checked for proper placement and functioning each shift. August TAR indicates Resident #4's wanderguard was recorded as functioning and placed properly on his wheelchair throughout August. In an interview on 9/22/24 at 6:12 p.m. a visitor/witness (MB) stated on the morning of 8/4/24 she was visiting a friend and another resident outside the front entrance. She saw Resident #4 outside in his wheelchair talking on the phone. Resident #4 then began propelling himself down the sidewalk. The visitor (MB) stood and started towards Resident #4 as he began to gain speed down the slope, then tipped over onto his right side, onto the grass. The visitor (MB) turned back to the facility and ran inside to get help. The visitor (MB) stated the staff responded immediately. The visitor (MB) stated there was no alarm sounding or staff present outside during the time Resident #4 was outside. The visitor (MB) stated the alarm sounded when Resident #4 was propelled by staff back into the facility. In an interview on 9/22/24 at 5:56 p.m. Staff G, Certified Nurse Aide, stated she was working the day shift on 600 hall 8/4/24. Staff G stated she was on 300 hall that morning, talking to a resident when a family member ran in stating Resident #4 had tipped his wheelchair over, outside. Staff G stated she hollered for Staff H on 300 hall as they ran to the front entrance to help Resident #4. Staff G stated several staff arrived and took care of Resident #4 and got him back inside. Staff G stated there was no alarm sounding when she got to the front entrance. According to a statement written by Staff H on 8/5/24, Staff H, Certified Nurse Aide, stated she was working on 300 hall on 8/4/24 when she was asked by another staff (Staff G) for help. Staff H stated she ran behind Staff G with her nurse (Staff B) behind her. Staff H stated they all went outside where they found Resident #4 on the ground. They made sure he was okay and helped him back into his wheelchair. Once back inside the nurse took his vital signs and she went back to her hall. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 9/18/24 at 6:05 p.m. Staff B, Certified Medication Aide, stated after returning to 300 hall following her lunch break, she was informed by Staff H, that Resident #4 was outside on the ground near the tree. Staff B stated she started out, then was directed back in to get the nurse, before returning outside to assist. Staff B stated Resident #4 had tipped his wheelchair onto his right side onto the grass, near a tree along the sidewalk. Staff B stated she helped get Resident #4 back into his wheelchair. Staff B stated there was no alarms sounding when she initially went outside, but upon returning the wanderguard alarm did sound. Staff B stated wander guard tags are checked each shift for functioning and placement and when a wanderguard door alarm sounds it must be coded to disarm. According to a statement written by Staff M, Licensed Practical Nurse, Staff M stated she was alerted by staff to go outside the building as Resident #4 was on the ground with his wheelchair tipped over. Family members explained that Resident #4 was outside sitting area using his phone and the next thing they noticed, he began propelling his wheelchair on the sidewalk and the wheelchair tipped over onto the grass. Staff M stated she immediately instructed one staff to call the assigned nurse (Staff F) to make sure she was aware of the fall incident. Staff M sated Resident #4 was assessed, alert with no facial grimacing or voicing of pain or discomfort. Resident #4 was turned onto his back and active and passive range of motion performed. Resident #4 was then placed in a sitting position with gait belt applied and assisted up with assistance of 4 staff and transferred into his wheelchair. Resident #4 had a wander guard tag attached to his wheelchair and upon entering back into the facility the alarm sounded. Further assessment was conducted in the facility and noted pulse was 49. Verbal report given to staff and the nurse and Resident #4 was propelled to the dining room for lunch. The Assistant Director of Nursing was notified of the incident by text. In an interview on 9/18/24 at 6:42 p.m. Staff J, Certified Nurse Aide, stated she recalls the day before (8/3/24) Resident #4 eloped, she questioned whether the wanderguard was working properly. That day Resident #4 was near the elevator near the memory care unit next to wanderguard door units and the alarm did not sound. Staff J stated normally the elevator wanderguard alarm would sound when residents with Wanderguards get too close. Staff J stated she reported her observation to the nurse. In an interview on 9/18/24 at 6:32 p.m. Staff L, Certified Nurse Aide, stated on the morning of 8/4/24 she was assigned on 400 hall and Resident #4 was already actively trying to exit and stating he was leaving. Staff L stated this behavior had intensified over the last week. Staff L stated she had redirected him several times that morning and propelled him back to 400 hall lounge around 9:30 a.m. Then, while caring for another resident, she was informed Resident #4 had gotten outside. Staff L stated she came up front and several staff were outside with Resident #4. Staff L stated there was no wanderguard alarm sounding. Staff L stated the wanderguard alarm is loud and can easily be heard in the 400 hall. (continued on next page)

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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	In an interview on 9/19/24 at 9:15 a.m. Staff E, Certified Medication Aide, stated she was working day shift on 400 hall 8/4/24. That morning Resident #4 was adamant about leaving and was exit seeking all morning, requiring redirection and propelling him back to 400 hall several times. During staff break times, the nurse (Staff F) stated she was going to give the resident some medication and that she would keep an eye on him. Staff E stated she went on break and returned 30 minutes later and began helping another aide, when a 300 hall aide came and stated Resident #4 had gotten outside. Staff E stated she got to the front door and by then several staff were already outdoors. Staff E stated there was no wanderguard alarm sounding, however it did sound as Resident #4 was brought back inside. Staff E stated the wanderguard alarm can be heard throughout the facility and requires a code to disarm it. In an interview on 9/19/24 at 11:14 a.m. Staff K, Certified Nurse Aide, stated she was working 400 hall on Saturday, 8/3/24 and noted Resident #4 was insistent on leaving and exit seeking all day. Staff K stated she shared this with the Sunday, 8/4/24 staff. Staff K stated she was working on the 500 hall on Sunday, 8/4/24 and had redirected Resident #4 more than once that morning. Staff K stated on the morning Resident #4 eloped, the alarm sounded briefly, then turned off. Staff K explained that the wander guard will alarm on the phones and display a code. In Resident #4's case, the phone alerted and displayed WG Hall 400, indicating it was a wander guard from someone on 400 hall. Staff K states she remembers that code at the time Resident #4 exited the building and it only lasted a few seconds. Staff K stated she was at the front entrance when Resident #4 was brought back in. Observation of facility video of the front entrance on 8/4/24, noted at 10:51:51 a.m. Resident #4 is observed exiting the front entrance in his wheelchair behind a visitor who had just coded the door open. At 10:57:30 a. m. a visitor is observed coding the front door and exiting. The video shows Resident #4 outside and visitors looking towards Resident #4. One visitor (MB) stands and starts towards Resident #4, then turns and runs into the facility at 11:02:50 to alert staff. At 11:03 a.m., nearly 11 minutes after Resident #4 exited the facility unsupervised and undetected, staff exit to assist Resident #4. Through testing the alarms, interviewing staff and watching the video, it was confirmed the wanderguard alarm never activated when Resident #4 exited the facility. During an observation on 9/19/24 at 10:57 a.m. Staff P, maintenance, was asked to test the wanderguard alarm system at the facilities front entrance. Staff P brought the wanderguard tag in close proximity to the wanderguard monitors and the alarm failed to sound. Minutes later a second attempt activated the wanderguard alarm requiring a code at the front door to disarm the alarm.