STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065249	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Tree Care Center	2050 S Main St Delta, CO 81416

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to prevent misappropriation of property for three (#7, #22 and #57) of eight residents reviewed for personal property out of 37 sample residents.Specifically, the facility failed to prevent the loss of property for Resident #7, Resident #22, and Resident #57 from their rooms.Findings include:I. Facility policy and procedureIdentifying Exploitation, Theft and Misappropriation of Resident Property policy and procedure, revised April 2021, was provided by the regional corporate resource on 2/27/26 at 12:14 p.m. It read in pertinent part, As part of the Abuse Prevention Strategy, volunteers, employees and contractors hired by the facility are expected to be able to recognize exploitation of residents and misappropriation of resident property. Exploitation, theft and misappropriation of resident property are strictly prohibited. It is understood by the leadership in this facility that preventing these occurrences requires staff education and training. The quality assurance and performance improvement (QAPI) committee reviews and creates plans of action to address quality deficiencies that may lead to exploitation, theft or misappropriation of resident property.II. Resident #7A. Resident statusResident #7, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included pressure ulcer of the right heel, chronic kidney disease and chronic obstructive pulmonary disease (COPD)The 12/10/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident's behavior of rejection of care occurred 1 to 3 days during the assessment look-back period.B. Resident interviewResident #7 was interviewed on 2/23/26 at 4:28 p.m. Resident #7 said he went to the bank to withdraw $200.00 from his account and spent $50.00. The resident said he could not locate the remaining $150.00 from his wallet in his room. Resident #7 said he reported the incident to the activity department and the social services director (SSD). He said he believed the facility completed an investigation, but there was no restitution made to him for his loss of the money. Resident #7 said he refused to sign the grievance form because he did not receive his money back. Resident #7 said he was not offered a lockbox until his money went missing. The resident said he had not lost any money since he was offered a lockbox.C. Record reviewThe facility's loss of property investigation for Resident #7, dated 12/16/25, was provided by the nursing home administrator (NHA) on 2/25/26 at 11:38 a.m. It documented Resident #7 reported to an unidentified staff member that he was missing $150.00 of his $200.00. The investigation revealed that Resident #7, in a conversation with NHA on 12/19/26, mentioned that his money might have been stolen or thrown away with his old wallet. The resident's financial advisor was contacted by the facility and confirmed Resident #7 withdrew $200.00 from his account on 12/11/25.The police were notified and Resident #7 was provided with a lockbox for valuables. Resident #7's care plan was updated to reflect the resident's agreement to keep money in a lockbox and not visible to others. The facility's admission procedure was updated to include notification upon admission of the availability of a (continued on next page)

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lockbox for residents' personal use.The facility concluded the incident of loss of property was unsubstantiated.-However, the resident could not find $150.00 of the $200.00 that his financial advisor confirmed the resident withdrew from his account on 12/11/25.-The facility updated its admission procedure to include notification upon admission of the availability of a lockbox for residents after the incident of missing money was reported (see above).-A grievance form for Resident #7, dated 12/15/25, was provided by the SSD on 2/25/26 at 1:25 p.m. It revealed that Resident #7 stated that on 12/11/25, he withdrew $200.00 from his bank accounts. The resident reported that later the same evening around 9:00 p.m., he requested that an unidentified nurse DoorDash him a McDonald's food order. Resident #7 confirmed receipt of the food and stated that he gave the nurse $50.00 out of his $200.00 to cover the cost of the food and delivery. The next day, 12/13/25, Resident #7 reported switching to use a new wallet and disposing of the old one. Resident #7 reported on 12/15/25 that he was missing $150.00. The resolution listed on the grievance form was that the incident was reported to the State Agency.-However, both the interview with Resident #7 and the facility's investigation revealed the resident's financial advisor confirmed a withdrawal of $200.00 on 12/11/25 (see above).A review of Resident #7's progress notes and electronic medical record (EMR) documented that Resident #7 was yelling at a certified nurse aide (CNA) on 12/10/25 at 8:00 a.m. that he needed to go to the bank. The EMR did not reveal any other information regarding Resident #7's missing money.-The safety and security care plan revealed that it was not initiated until 12/27/25, 12 days after the resident's allegation of missing money. Interventions included staff were to ensure Resident #7 had a lockbox available and accessible, and to educate the resident on safe use and proper storage of personal belongings.III. Resident #22A. Resident statusResident #22, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included muscle weakness, anxiety disorder and insomnia. The 11/19/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. Resident #22 was dependent and required substantial assistance with personal hygiene, toileting, and set assistance with eating.B. Resident interviewResident #22 was interviewed on 2/24/26 at 9:42 a.m. Resident #22 said some time last year (2025), her daughter had brought her $50.00 for spending money. Resident #22 said she had kept the money in an envelope in the back of the top drawer of her dresser. The resident said she recalled being out of her room, likely at activities, when the incident of her missing money occurred. She said upon returning to her room, she discovered her top dresser drawer was open and $30.00 was missing from the envelope. Resident #22 said she reported the theft to the facility, and an investigation was conducted, which included a search of her room; however, they were unable to locate the missing money. Resident #22 said she had begun keeping her money hidden in a different location and felt it was now secure.C. Record reviewThe facility's misappropriation investigation for Resident #22, dated 1/30/26, was provided by the NHA on 2/25/26 at 11:38 a.m. It documented Resident #22 reported to a CNA that she was missing money from her wallet. An investigation was started and the resident's wallet was found to have $28.00 in cash. Resident #22 said her daughter gave her $50.00, not $28.00 and said she was missing the rest of her money. The resident's daughter confirmed she gave her mother $50.00, in addition to $8.00 that her mother already had. Resident #22 said she had not participated in any outing that would require her to spend money. The resident stated that she used a debit card for all online purchases and had not spent any physical cash.The investigation revealed there had been a pattern of misappropriation of Resident #22's property.Description of the misappropriation of Resident #22's property included an incident reported on 12/4/25 of a missing $40.00 on A-hall, an incident reported on 12/15/25 of $150.00 on A-hall, and the current incident involving Resident #22 additionally occurred on A-hall.Based on interviews and (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a review of documentation, the facility concluded there was possible misappropriation of some source, but the source was not identified. The interventions implemented were communication to residents and residents' families and utilization of visible stain theft detection powder was ordered and a process was in place.-However, the interventions failed to include staff and resident education for the prevention of misappropriation of residents' property.-A review of Resident #22's care plan did not reveal any updates, including interventions to prevent further misappropriation of property for the resident.-A review of Resident #22's progress notes and electronic medical record (EMR) did not reveal any information regarding the property misappropriation incident.A grievance form for Resident #22, dated 1/30/26, was provided by the SSD on 2/25/26 at 1:25 p.m. It was documented on 1/30/26 at approximately 9:15 a.m. that the director of nursing (DON) reported to the SSD that Resident #22 informed her that she was missing $30.00. The resolution listed on the grievance form was that the incident was escalated to the grievance official, the NHA for review and it was reported to the State Agency. There was no documentation included on the grievance form indicating restitution for the missing money was made to Resident #22.-However, the interview with Resident #22 and the facility's investigation revealed the resident's daughter confirmed giving the resident $50.00, together with her additional $8.00, totalling $58.00, which resulted in $30.00 being unaccounted for.IV. Resident #57A. Resident statusResident #57, age greater than 65, was admitted on [DATE] and discharged on 2/9/26. According to the February 2026 CPO, diagnoses included COPD, chronic respiratory failure, chronic kidney disease and muscle weakness.The 10/24/25 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of seven out of 15.B. Record reviewThe facility's misappropriation investigation for Resident #57, dated 12/4/25, was provided by the SSD on 2/25/26 at 1:25 p.m. It documented Resident #57 reported to the SSD that she was missing $64.00. The report revealed that an immediate investigation of staff, family, and the resident's roommate occurred. During the course of the investigation, the facility conducted interviews and a search with the resident's permission. The investigation documented Resident #57 and her family gave varying information related to the amount of cash missing. The facility did not identify any alleged assailants or a pattern of missing items. The investigation could not determine whether the money was lost or stolen.The resident did not want law enforcement notified; however, the police were notified.The facility provided a lockbox for the resident and the allegation of missing money was not substantiated; however, there were several incidents of misappropriation of residents' property during the same period and the facility failed to provide education for staff on the prevention of misappropriation of residents property (see above investigation).A grievance form for Resident #57, dated 12/4/25, was provided by the SSD on 2/25/26 at 1:25 p.m. It revealed Resident #57 reported to the SSD that she was missing $64.00 given to her by a friend. The resident's representative was interviewed by the facility, and she confirmed that Resident #57 received $40.00 from a friend.A review of Resident #57's progress note and EMR did not reveal any other information related to the incident of misappropriation of the resident's property.V. Staff interviewsCNA #3 was interviewed on 2/25/26 at 1:45 p.m. CNA #3 said she had not heard or witnessed any residents having property go missing in her unit. CNA #3 said she had not been trained by anyone in the facility on the prevention of the misappropriation of property for Resident #7, Resident #22 and Resident #57. CNA #3 said she was not involved in addressing the incidents; therefore, she did not receive any training.CNA #3 said she was familiar with the facility's grievance process. She said she would assist residents who needed help writing a formal grievance and report the incident to the SSD, the NHA, and possibly the DON.Registered nurse (RN) #3 was interviewed on 2/25/26 at 1:55 p.m. RN #3 said he had not had any incident of misappropriation of residents' property on (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his shift. RN #3 said he heard a few months ago of an incident of misappropriation of property on other units. He said he was not aware of the details, whether it was substantiated or not. RN #3 said he was not involved in the investigation and had not received any training related to misappropriation of residents' property. RN #3 said he understood and followed the facility's grievance process by reporting all incidents of misappropriation of residents' property immediately to the SSD.The SSD was interviewed on 2/26/26 at 1:51 p.m. The SSD said when a missing item of property was reported, she conducted a search for the property with the resident's permission. She said that if the property could not be located, a grievance form would be completed, and investigations would begin immediately. The SSD said if she was not able to reach a resolution with the resident involved, she would escalate the incident to the NHA, the grievance official. The SSD said she conducted the investigation for the incidents of misappropriation of residents' property for Resident #7, Resident #22 and Resident #57. She said she was unable to locate the three residents' property. The SSD said she escalated the incidents to the NHA. The SSD said she did not know whether the three incidents were substantiated. The SSD said the residents did not receive restitution for the missing property.The NHA and the DON were interviewed together on 2/26/26 at 3:30 p.m. The DON said she was involved in investigating allegations of misappropriation of residents' property. She said that incidents of misappropriation of property for Resident #7, Resident #22 and Resident #57 were confirmed by their families and representatives.The NHA said she was the grievance official and reported all three incidents of misappropriation of property for Resident #7, Resident #22 and Resident #57 to the police and the State Agency. The NHA said the facility had acquired a visible-stain theft-detection powder to help eliminate such occurrences. The NHA said the three residents did not receive restitution for the loss of their properties. She said she did not know the reason for several incidents of the misappropriation of residents' funds at the facility. The NHA said she did not know the facility's policy on restitution and had to verify and get back with an answer. The NHA said the facility was currently working on hiring a business office manager who would be in charge of securing residents' property. She said the facility was now offering lockboxes for residents who required them for storing valuables.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents were free from accidents or hazards for one (#42) of six residents reviewed for accident hazards out of 37 sample residents. Specifically, the facility failed to prevent an elopement for Resident #42 on 1/15/26. Findings include:I. Facility policy and procedureThe Wandering and Elopement policy, revised March 2019, was provided by the nursing home administrator (NHA) on 2/26/26 at 1:00 p.m. It read in pertinent part, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If a resident is identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. II. Facility investigationThe facility's investigation was provided by the NHA on 2/24/26 at 5:18 p.m. The facility's investigation identified Resident #42, who resided on the secured memory unit, was seen sleeping in his bed on 1/15/26 at 5:30 a.m. Resident #42 was not located when staff checked on him at 6:02 a.m. and was determined to be missing from the facility at 6:05 a.m. The staff initiated a search inside and outside the facility and contacted the police. The police located the resident off premises at 7:06 a.m. The resident was returned to the facility by a police officer. The investigation documented Resident #42 was missing for approximately an hour to an hour and a half.Resident #42's vital signs were taken when he returned to the facility. His oxygen saturation level was at 85 percent (%) and his temperature registered at 96.4 degree Fahrenheit (F). According to the investigation, the resident appeared at baseline cognitively and physically but was transported to the emergency department at the hospital at 7:22 a.m., via non-emergent transport for an evaluation due to an abrasion to his right elbow and his history of seizures. The investigation documented Resident #42 was treated at the hospital with warm intravenous (IV) fluids to increase his body temperature and then returned to the facility approximately an hour and a half to two hours later. The investigation documented the facility implemented 15-minute safety checks for 72 hours to ensure Resident #42 remained in the secure unit. His care plan was reviewed and redirection techniques were increased. Tactile busy boards were moved to more prominent locations on the secured unit for a higher visual awareness and access.The investigation indicated Resident #42 eloped from the secured unit and the facility by going out a window in the secured unit. According to the facility investigation, all door alarms were operable and working appropriately at the time of the elopement and no alarm had sounded. Upon perimeter checks, an open window was found with the screen replaced except for the bottom which was not secured to the window frame. A safety stop on the window was found to be broken. The investigation documented Resident #42 opened the window in another resident's empty room and broke the safety stop. The resident then exited through the window, replaced the screen except for the very bottom and climbed over the fence to exit the secure courtyard.The facility's investigation documented additional measures were taken to prevent a recurrence of elopement to include all the windows were assessed and windows with the small plastic safety stops were disabled with metal screws to ensure that the windows could not be opened to full capacity, leaving one window operable with stronger safety stops for egress. III. Resident #42 A. Resident status Resident #42, age less than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included personal history of traumatic brain injury (TBI), Wernicke's encephalopathy (neurological disorder), altered mental status, other specified disorders of the brain, unspecified dementia of unspecified severity with other behavioral disturbance, alcohol-induced persisting dementia, delirium due to known physiological condition and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	generalized epilepsy and epileptic syndromes.The 1/30/26 minimum data set (MDS) assessment documented Resident #42 had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. The MDS assessment identified he was independent with mobility and did not require a mobility device. According to the MDS assessment, Resident #42 had wandering behaviors. B. Observation and staff interviewsOn 2/23/26 at 2:50 p.m. Resident #42 came out of his room and into the dining room. The certified nurse aide (CNA) offered him a snack and put on a western show for him. After a few minutes, Resident #42 told registered nurse (RN) #1 that he had to be somewhere else and she needed to let him go. RN #1 told him he did not need to be anywhere else right now. At 3:42 p.m. Resident #42 was by the back door of the memory care unit. He was repeatedly pushing on the emergency push bars in an attempt to open the door.At 3:43 p.m. RN #1 came up to Resident #42 and showed him the red light above the door and told him when the red light was on, the door was locked. He looked at the red light on the door, touched the light and then continued to push on the emergency bars of the door. At 3:45 p.m. activity assistant (AA) #1 told Resident #42 that she would take him for a walk after she was done playing a game with the other residents. At 3:47 p.m. the CNA tried to redirect Resident #42 from the back door but he continued to try to open the door so the CNA sat down in a chair by the door.At 3:48 p.m. Resident #42 walked down the hallway and attempted to open the main entrance door to the secured unit by pushing buttons on the keypad. The resident then entered a resident's room next to the entrance door. At 3:50 p.m. the resident walked back up the hallway and sat on the couch in a small lounge and closed his eyes. On 2/24/26 at 3:40 p.m. a sign was on the outside door of the memory care unit. The sign directed staff not to force the door closed. On 2/26/26 at 10:18 a.m. the secured courtyard was observed with the maintenance director (MTD). Observation of the secured unit courtyard identified the courtyard was surrounded by a six foot fence with a latching device on the outside of the fence. The MTD said a resident would not have been able to open the gate from inside the courtyard. He said he was told that Resident #42 could have used the tree to climb over the fence. He motioned to a tree in the corner of the courtyard that was approximately four feet away from the fence. He said the facility determined the tree was used in the resident's elopement because some of the resident's personal items were found on the backside of the fence near the tree. The MTD said after Resident #42's elopement, additional measures were put in place with the windows so residents could not get out to the courtyard by using the windows. He said he reviewed the doors on the secured unit and reminded the staff to allow the entrance door on the secured unit to fully shut on its own while making sure residents were not near the door. He said the door should not be forced closed or it would not lock properly. C. Record reviewThe mood and behavior care plan, revised 2/7/26, identified Resident #42 had a pattern of elopement attempts.The care plan identified Resident #42 had a history of kicking out window screens, slamming windows in an attempt to open them and going into other residents' rooms and bathrooms due to a traumatic brain injury (TBI), dementia, delirium and other disorders of the brain. The care plan interventions, initiated 11/15/25, included assisting and encouraging the resident in developing the most appropriate methods of coping, interacting and expressing his feelings appropriately, and offering opportunities for positive interaction and attention by talking to him and providing activities. According to the care plan, staff should discuss the resident's behavior with them, when reasonable, and explain/reinforce why the behavior was inappropriate and/or unacceptable. The staff should intervene when necessary to protect the rights and safety of others, to include approaching/speaking in a calm and controlled manner, offering redirection and removing him from a situation to alternate location as needed and administering medications as ordered with monitoring and documentation of side effects and effectiveness. The care (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan intervention, revised 2/7/26, directed staff to anticipate and meet Resident #42's needs.The elopement/wandering care plan, revised 10/16/25, identified Resident #42 was an elopement risk. According to the care plan, Resident #42 had a history of leaving his home unattended and had an impaired awareness of safety. Interventions included placing the resident on a secured unit and personalization of his room with familiar objects (initiated 7/2/26), ensuring a staff awareness of his elopement risk and identifying his pattern of wandering and need to intervene when appropriate (initiated 8/4/25), encouraging the resident to maintain his own personal space (initiated 9/2/25) and providing redirection for his wandering behavior by offering pleasant diversions and structured activities (revised 10/16/25). The 1/15/26 at 7:00 a.m. change of condition evaluation documented Resident #42 had a change in skin condition or skin color. The evaluation documented Resident #42 had an abrasion to his right elbow and reddened skin to both hands. According to the evaluation, the resident was transported to the hospital.The 1/15/26 at 10:54 a.m. nursing progress note documented the resident returned from the hospital to the facility. The note identified Resident #42 was treated for acute hypothermia. According to the note, his laboratory (lab) work was normal, and there were no broken bones or internal bleeding. The note indicated he had scratches on his hands and knees. The resident was provided breakfast and his morning medication and then helped to bed where he was sleeping soundly. The note indicated the facility initiated 15-minute checks to monitor his whereabouts. -Review of the progress notes did not identify Resident #42's 1/15/26 elopement from the facility. IV. Staff interviewsRN #1 was interviewed on 2/24/26 at 3:45 p.m. RN #1 said Resident #42 was at risk for elopement and had eloped in the past. She said she was not on shift at the facility when the resident eloped on 1/15/26, but said she was told that he went out a window, put the screen back in place and then jumped over the fence of the secured courtyard to get out. She said he was found south of the facility. RN #1 said Resident #42 was now on 15-minute checks which were logged on a form. She said the staff needed to continue to ensure his location. The MTD was interviewed on 2/24/26 at 3:50 p.m. The MTD said each window on the secured memory unit had a plastic stopping device put in place to prevent the windows from fully opening. The MTD said he was not told which window Resident #42 was believed to have eloped from. He said he noticed in November 2025 that one of the window screws was coming loose from a plastic stopper, so he tightened the device and started a weekly check to ensure all the window stopping devices were secured. The MTD said in December 2025 he installed a top panel to the windows for extra securement so the window could not be easily removed. He said in January 2026, after Resident #42's elopement, he installed self-tapping screws on the left side of each double window in the secured memory unit to prevent the removal of the windows. The NHA, the director of nursing (DON) and the staff development coordinator were interviewed together on 2/26/26 at 12:03 p.m. The DON said CNA #10 went outside to take trash out to the dumpster in the early morning of 1/15/26. The DON said CNA #10 noticed a picture and a magazine on the back side of the fence that she recognized belonged to Resident #42. CNA #10 re-entered the facility through the courtyard and reported that Resident #42 was gone. The NHA said staff did a full search and contacted the police. The NHA said Resident #42 was last seen at 5:30 a.m. The NHA said CNA #10 found the resident's belongings at approximately 5:50 a.m. and he was determined to be not in or around the facility shortly after 6:00 a.m. The NHA said the resident was located by the police on the other side of the highway near the railroad tracks. She said he would have had to cross the highway to get to the railroad tracks. The DON said Resident #42 was cold when he was found. She said he left without a coat so his body temperature was 96.4 degrees F. She said his oxygen saturation level was at 85%. The DON said his oxygen saturation levels were low (by use of a pulse oximeter on his finger) but his fingers were cold, so the (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 - Minimal harm or potential for actual harm Residents Affected - Few	results may not have been completely accurate. She said he went to the hospital for an evaluation and was brought back two to three hours later. She said Resident #42 was placed on 15-minute checks for ongoing monitoring and supervision after the elopement and he would remain on 15-minute checks. The DON said she interviewed the staff who were working at the time of Resident #42's elopement. She said the staff did not report that they did not hear an exit door alarm sounding, which she felt ruled out that the resident did not exit through a door to leave the facility. The NHA said the staff found a broken window stopper on the window ledge of a wide open window in room [ROOM NUMBER] and the window screen was not fully secured to the window frame. The NHA said the facility did a complete check of all the windows in the facility and additional screws in the seals were inserted in the windows to ensure the windows were all secured. She said the facility conducted two hour perimeter checks until the window in room [ROOM NUMBER] was fixed and all residents were accounted for. The NHA said the MTD made sure all the door alarms were in proper working order and the courtyard was secured. The DON said the facility added a sign to the outside of the secured unit doors that reminded visitors to make sure no one was near the door when they entered the secured unit and not to push the automatic doors to the unit closed because it could cause the doors not to properly lock. The NHA said verbal education with staff was conducted with the memory care staff on 1/15/26. The staff development coordinator said she conducted education with all staff on 1/21/26 which focused on elopement risk and ensuring all windows and doors were secure. The staff development coordinator said the memory care unit staff received dementia care education on 2/18/26 and the facility would have an all-staff dementia training in March 2026.