STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm Mattoon, IL 61938

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to initiate an elopement care plan for three (R37, R39, R40) residents out of four residents reviewed for elopement in a sample list of 40 residents. Findings include:1.R40's Electronic Medical Record (EMR) documents medical diagnoses as Dementia, Disorganized Schizophrenia, Anxiety, Major Depressive Disorder, Psychotic disorder with Delusions, Mild Intellectual Disabilities and unsteady on Feet. R40's Minimum Data Set (MDS) dated [DATE] documents R40 as severely cognitively impaired. R40's Elopement Risk assessment dated [DATE] documents R40 as being a high risk for elopement. R40's Elopement care plan was initiated 3/30/26. This same care plan did not include a focus area, goal nor interventions prior to 3/30/26 for R40's high risk for elopement. 2.R37's Minimum Data Set (MDS) dated [DATE] documents R37 as cognitively intact. R37's Elopement Risk Evaluation 2/12/26 documents R37 as a high risk for elopement. R37's Elopement care plan was initiated 3/30/26. This same care plan did not include a focus area, goal nor interventions prior to 3/30/26 for R37's high risk for elopement. 3. R39's Minimum Data Set (MDS) dated [DATE] documents R39 as cognitively intact. R39's Elopement Risk Evaluation 12/23/25 documents R39 as a high risk for elopement. R39's Elopement care plan was initiated 3/30/26. This same care plan did not include a focus area, goal nor interventions prior to 3/30/26 for R39's high risk for elopement. On 4/1/26 at 11:35 AM V41 (MDS/Care Plan Licensed Practical Nurse) stated she started reviewing resident charts who were at high risk for elopement on 3/13/26. V41 stated she is still in the process of the initial review and has not looked at any resident care plan that was considered low or moderate risk for elopement yet (4/1/26). V41 stated she added elopement care plans for R37, R39 and R40 on 3/30/26. V41 stated she was unsure if any of the residents assessed as low or moderate risk for elopement have had their care plans reviewed yet. On 4/1/26 at 1:25 PM V1 (Administrator) stated all residents who are at any level of risk for elopement should have had their care plan initiated, reviewed and/or updated by 3/16/26. V1 stated after the initial review and updating on 3/16/26 the Interdisciplinary Team (IDT) should have reviewed all care plans for those residents at risk for elopement weekly. V1 stated the care plans should have been updated on 3/16, then reviewed on 3/23 and again on 3/30. V1 stated the elopement care plans should have been initiated when each resident (R37, R39, R40) was first assessed as being at risk for elopement. V1 stated V41 should have initiated R37, R39 and R40's care plans on 3/16/26 when updating all resident care plans who are at risk for elopement. V1 confirmed R37, R39 and R40's Elopement care plans were initiated on 3/30/26. The facility policy titled The Safety and Supervision of Residents dated 2001 documents the facility Quality Assurance Performance Improvement (QAPI) committed and staff shall monitor interventions to mitigate accident hazards in the facility and modify as necessary. The QAPI committee and staff shall monitor interventions to mitigate accident hazards in the facility and modify as necessary. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Implementing (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions to reduce accident risks and hazards shall include communicating specific interventions to all relevant staff, assigning responsibility for carrying out interventions, providing training, as necessary, ensuring that interventions are implemented, and documenting interventions. The facility will monitor the effectiveness of interventions by ensuring that interventions are implemented correctly and consistently, evaluating the effectiveness of interventions, modifying or replacing interventions as needed and evaluate the effectiveness of new or revised interventions.

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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	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 observation, interview and record review, the facility failed to provide supervision and ensure a door alarm was audible to staff to prevent a cognitively impaired resident with exit seeking behaviors from eloping from the facility for one of four residents (R4) reviewed for elopement in the sample list of 40 residents. R4 was found eight blocks from the facility by a citizen who called emergency services when they saw R4 wandering in the road. These failures resulted in R4 falling and suffering abrasions to R4's palm and knee and R4 being exposed to significant danger including road hazards, uneven terrain and railroad tracks. Findings include: The immediate jeopardy began on 3/13/26 when R4 eloped unsupervised from the facility.V1 (Administrator) was notified of the Immediate Jeopardy on 3/27/26 at 3:53 PM. The facility presented an abatement plan to remove the immediacy on 3/27/26. The survey team reviewed the abatement plan and was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility three separate times on 3/31/26 for revisions. The facility presented a fourth revised abatement plan on 4/1/26 and the survey team accepted the fourth revision of the abatement plan on 4/1/26.The surveyor confirmed by observation, interview and record review that the immediacy was removed on 4/1/26, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training through ongoing Quality Assurance Performance Improvement (QAPI) review. R4's Electronic Medical Record (EMR) documents R4 admitted to the facility on [DATE] with medical diagnoses of Dementia with behavioral disturbance, Alzheimer's Disease, Anxiety, need for assistance with personal care and Major Depressive Disorder. R4's Minimum Data Set (MDS) dated [DATE] documents R4 as severely cognitively impaired. This same MDS documents R4 requires supervision for bed mobility, transfers and walking up to 150 feet. R4's Elopement assessment dated [DATE] documents R4 as a high risk for elopement. R4's Social Service assessment dated [DATE] documents R4 has a behavior of wandering. R4's Care Plan focus area dated 12/11/25 documents R4 is at risk for wandering and/or elopement. This same care plan documents R4 may demonstrate a risk of leaving the facility unattended due to impaired safety awareness. This same care plan documents an intervention dated 12/11/25 that instructs staff to monitor R4's location and distract R4 from wandering by offering pleasant diversions, structured activities, food, conversation, television and/or a book. This same care plan documents an intervention dated 2/25/26 that instructs staff to visualize R4 every fifteen minutes. R4's Behavior Tracking dated 2/24/26, 2/25/26, 2/28/26 and 3/3/26 documents R4 was exit seeking and/or attempting to elope. R4's Nurse Progress Note dated 2/11/26 at 2:06 AM documents R4 was wandering into other resident rooms. This same note documents R4 was agitated with redirection and expresses that he is upset. R4's Nurse Progress Note dated 2/27/26 at 5:17 AM documents R4 was yelling out curse words to his roommate, yelling at the staff, following the staff around, and physically punching staff a couple of times. This same note documents staff continued to try to redirect R4 without success. R4's Community Survival Skills Screen dated 3/5/26 documents R4 is not able to safely navigate on community streets. This same screen documents R4 is not aware of potentially dangerous situations such as straying into an alley or taking rides from strangers and is not capable of unsupervised outside pass privileges. R4's Discharge Quarterly progress note dated 3/5/26 at 11:37 AM documents R4 is forgetful and has safety concerns. This same note documents R4 has special care needs identified of requiring 24-hour supervision and/or monitoring. R4's Nurse Progress Note dated 3/13/26 at 3:32 PM documents (V4) Licensed Practical Nurse (LPN) was notified that R4 had exited the facility. (V4) and facility staff returned (R4) to the facility. (R4) was able to walk into the facility. (R4) has a contusion to his Right Knee and two abrasions to his Right Palm of his hand. (R4) was able to move all of his extremities. (R4) was alert and oriented to self only which is baseline. R4's Nurse Practitioner Progress Note dated 3/13/26 at (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2:49 PM documents staff notified V32 (Nurse Practitioner) of R4's incident. This same note documents R4 exited the building and sustained a fall outside. R4 was unable to give history of events due to R4's Dementia. R4 was noted to have blood on his pants at the area of his Right Knee. R4's Right Hand was wrapped with gauze and elastic bandage. Staff reports R4's fall was unwitnessed. R4 has limited ability of making his needs known. R4 is unable to follow commands without extreme focus which is his baseline. R4's Fall Risk Evaluation dated 3/13/26 documents R4 as a risk for falling. R4's AIM for Wellness Note dated 3/13/26 documents R4 eloped from the facility unsupervised obtaining two abrasions to his Right Palm and one contusion to his Right Knee. This same report documents a precursor to this event is that R4 wanders frequently. The environment was noisy and busy. R4's Skin Only Evaluation dated 3/13/26 documents R4 obtained a Right Palm abrasion measuring 4.0 centimeters (cm) long by 0.2 cm wide by 0.1 cm deep, a second Right Palm abrasion measuring 1.0 cm long by 0.5 cm wide by 0.1 cm deep and a Right Knee contusion measuring 1.0 cm long by 1.0 cm wide. R4's Nurse Progress Noted dated 3/18/26 at 11:51 PM documents (R4) awake, making his fist, asking to leave and attempted to use the bathroom here at the nurse's station. (R4) continues asking to leave. (R4) given snacks. (R4) asking for Certified Nurse Aides (CNA) to open the door so he can leave. Staff stated ?No', then (R4) makes a fist then grunts. (R4) then raises his hand pointing his Right Index finger at CNA. (R4) continues attempting to sit at nurse's desk. Multiple attempts to redirect (R4). On 3/19/25 at 1:05 PM R4 was sitting on the side of his bed mumbling incoherently to himself. R4 was not able to answer simple, direct questions such as What is your name?. On 3/19/26 at 2:50 PM V36 (Interim Maintenance Director) physically tested the alarms on the facility exit doors. V36 stated he has been doing exit door alarm checks daily since 3/13/26 by pushing on the alarm bar on the door but not pushing the door open. V36 stated he has been doing the exit door checks at 7:00 AM and did not want to wake up any residents that early by pushing the exit doors open to hear their alarm. V36 pushed onto the alarm bar of the exit door and an intermittent beep was heard seven times, then it changed to a continuous beep. There was no audible sound at the 200-hall nurse's desk. V36 pushed the 200-hall exit door open and no other alarm sounded. The facility 100-hall exit door was the same as the 200-hall door when V36 tested the door alarms. On 3/19/25 at 1:10 PM V27 (Licensed Practical Nurse/LPN) stated she did not know if the facility had folders or binders that showed which residents are at a high risk for eloping. V28 (Certified Nurse Aide/CNA) retrieved a binder that included a list of and face sheets for residents who are at a high risk for elopement. V27 (LPN) stated again she did not know there was such a thing. On 3/19/25 at 1:30 PM V28 (CNA) stated V14 (CNA) and V28 were working on R4's hall on 3/13/26. V28 stated there had been another CNA working with V14 and V28, but that employee had left prior to R4 eloping. V28 stated V14 and V28 were assisting another resident in a resident room with the door closed and did not hear any alarms sounding when R4 eloped from the facility. V28 stated V14 and V28 were the only staff on the hall at the time R4 eloped due to V4 (LPN) was in the dining room with the other residents who were still eating lunch. On 3/19/26 at 1:35 PM V4 (LPN) stated R4 was supposed to be on 15-minute visual checks but the staff were busy assisting other residents. V4 stated R4 was last seen around 12:15 PM when he was entering another resident's room. V4 stated V30 (CNA Supervisor) assisted R4 out of the other resident's room and guided R4 back to the nurse's station on his own hall. V4 stated she received a phone call from Emergency Medical Service (EMS) at 1:15 PM asking if R4 was a resident at the facility and if so, if he was accounted for. V4 stated she reported to EMS personnel that she was not aware of R4's whereabouts and would do a head check. V4 stated when the facility staff were unable to find R4, V4 and V29 (Social Service Director/SSD) used the facility van to drive to R4's location. V4 stated that would be eight or ten blocks away. V4 stated R4 would have to cross the railroad tracks to get to where he was found. On 3/19/26 at 1:40 PM V14 (CNA) stated V14 and V28 (CNA) were both in a resident room assisting another resident when R4 eloped from the facility. V14 stated she did not hear any alarms sounding. V14 stated she did not know how R4 eloped but that he was located by emergency medical services (EMS) in a neighborhood across (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the railroad tracks and across a busy street from the facility. V14 stated she knew R4 was in the dining room eating lunch but did not know how long R4 had been missing. V14 stated someone who lived in that neighborhood called 911 when they saw R4 wandering in their yard. V14 stated V4 (LPN) and V29 (SSD) drove the facility van over to the other neighborhood after EMS called the facility to inquire if R4 resided in the facility. V14 stated R4 was wearing a long sleeve shirt, pants and no skid socks with no shoes. V14 stated R4 told staff he was out looking for his lost dog. On 3/19/26 at 1:45 PM V31 (Human Resources Director) stated V31 and V21 (Business Office Manager) took turns monitoring the front door on 3/13/26 during lunch service. V31 stated she took her own lunch break leaving V21 to monitor the front door. V31 stated she did not hear any alarms sounding during the time she was by the front door. On 3/19/26 at 1:50 Pm V30 (CNA Supervisor) stated she saw R4 enter another resident room between 12:00 PM and 12:15 PM on 3/13/26. V30 stated she assisted R4 back to his nurse's station area and there were no staff present on the hall. V30 stated V14 (CNA) and V28 (CNA) were both busy in another resident's room and V4 (LPN) was still in the dining room monitoring other residents during lunch. V30 stated she was told R4 eloped unsupervised from the facility. V30 stated there are only two ways R4 could have gotten to where he was found. V30 stated R4 would have had to walk around the building to the back yard area or walk the sidewalk down the street, turn left on a very busy street and then turn left again on to the cul-de-sac street where he was found by a community member. V30 stated either way R4 went he would have to cross railroad tracks that are in use. V30 stated R4 could have fallen on the railroad tracks or on the sidewalk or on a road while crossing. V30 stated the facility does not know for sure which door R4 eloped from but believe R4 walked out the front door. V30 stated she did not hear any alarms sound during this time. V30 stated R4 was wearing a long sleeve shirt, pants, no skid socks with no shoes on and was not wearing a hat. V30 stated R4 was previously on 15-minute visual checks due to his high risk of elopement. V30 stated the staff did not complete the visual checks as were care planned. V30 stated R4 wanders ?all over the place' and is at high risk for eloping unsupervised due to his attempts to push on the exit doors and his poor cognition due to Dementia. On 3/19/26 at 2:00 PM V29 (SSD) stated she was not present during lunch on 3/13/26 because she was out doing some shopping for residents. V29 stated when she returned from the resident shopping trip, she was informed by V4 (LPN) that R4 had eloped. V29 stated V29 and V4 used the facility van to go pick up R4. V29 stated R4 probably walked out the front door and R4 would have had to walk around the back of the facility, or he would have followed the sidewalk down several blocks to a busy street to turn left again onto another street and then down a few more blocks to where he was located. V29 stated R4 would have had to cross railroad tracks and maneuver over several curbs, busy roads and steep decline/inclines on each side of the railroad tracks. On 3/20/26 at 9:40 AM V37 (R4's family member) stated the facility called her on 3/13/26 to inform her that R4 had escaped and was found by the staff. V37 stated she was told that R4 did not leave the facility property and was found by staff in the grassy area just beyond the resident smoking area. V37 stated R4 has attempted to elope twice before by pushing the exit doors open. V37 stated R4 attempted to exit the front door once, the alarm sounded, and the staff responded by redirecting R4 back into the facility. V37 stated R4 attempted to elope a second time on 3/18/26 after yelling and punching the staff. On 3/20/26 at 10:55 AM V22 (Regional Maintenance Director) stated all the facility exit doors have been tested and are functioning properly. V22 stated there was a 30 second delay on the front door that was changed to a ten second delay. V22 stated when the front door alarm bar was pushed its alarm sounded but the ?loud alarm' on the front door was set to 30 seconds which means the ?loud alarm' would not sound unless the door was opened for more than 30 seconds. V22 stated if no one were up by the front door to hear the alarm, a resident could pass through the front door within 30 seconds without anyone knowing. On 3/20/26 at 11:15 AM V32 (Nurse Practitioner/NP) stated she was in the facility on 3/13/26 when R4 eloped. V32 stated she was in a resident room when R4 followed V32 into the room. V32 stated V30 (CNA Supervisor) assisted R4 back to his nurse's station. V32 stated she was not certain of the time but stated it may (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	have been around 12:30 PM. V32 stated R4 was especially [NAME] on 3/13/26. V32 stated EMS was called by a community member from a local neighborhood due to R4 wandering around their yard/driveway. V32 stated EMS assessed R4 at the location where he was found and made the decision to not take R4 to the emergency room. V32 stated R4 did have an abrasion on his right knee and right palm from an unwitnessed fall. V32 stated she had not been notified of any other of R4's elopement attempts. V32 stated she was aware of only one incident which happened on 3/13/26. V32 stated the facility should have completed the 15-minute visual checks and followed R4's Care Plan to ensure his safety. On 3/20/26 at 1:50 PM V24 (LPN) stated she was R4's nurse on the early morning of 2/27/26 when R4 did have multiple behaviors. V24 stated R4 was stalking the staff up and down the hall, trapped staff behind the nurse's station and was menacing to staff. V24 stated R4 was walking up and down the halls and repeatedly attempted to exit the facility but staff intervened before R4 was able to exit the facility. V24 stated R4 was overly aggressive, menacing and hollered at staff Let's go! Open the door!. On 3/20/26 at 3:15 PM V23 (LPN) stated 3/18/26 was her first night working at this facility and remembers R4 well. V23 stated R4 was very agitated. V23 stated R4 walked around the corner of the nurse's station where V23 was and yelled I need the door. I need the door. V23 stated R4 raised his fist at staff threatening to hit staff. V23 stated staff did try non-pharmacological interventions such as providing snacks. V23 stated R4 did not exit the facility but did need to be redirected away from the exit doors multiple times. The Immediate Jeopardy that began on 3/13/26 and the immediacy was removed on 4/1/26 when the facility took the following actions. 1. R4 was assessed on 3/13/26 by V4 (Licensed Practical Nurse /LPN) at the location R4 was found by the concerned citizen and again at the facility by V32 (Nurse Practitioner). 2. V41 (MDS/Care Plan LPN) stated she reviewed R4's care plan on 3/13/26. V1 (Administrator) stated V1, V2 (Director of Nursing/DON) and V17 (Assistant Director of Nursing/ADON) all in-serviced staff on R4's elopement interventions on 3/13/26. 3. On 3/20/26 at 10:55 AM V22 (Regional Maintenance Director) stated there was a 30-second delay with the front door that was changed to a ten second delay on 3/20/26. 4. On 3/31/26 the facility exit door alarms produced a ringing sound that were heard by V42 (CNA) and V43 (Social Service Assistant/SSA) when they were inside a resident room. Staff were observed rushing to the sounding door alarms. 5. On 3/17/26 upon entry for survey there was a notice posted on the doors. V1 (Administrator) stated she is monitoring the door notices during the audit period and will continue to visualize the door signs ongoing after the audit has concluded. 6. V2 (DON) stated R4 was on continual observation from 3/13/26-3/16/26 and then reinstated to the 15-minute visuals after the conclusion of the three days of continual observations. V2 stated staff were in-serviced on R4's individual elopement interventions on 3/13/26. General staff In-services on Safety and Elopement are dated 3/16/26 and 3/17/26. 7. V41 (MDS/Care Plan LPN) stated she started the review of care plans of residents who are at high risk for elopement on 3/13/16. V41 stated this review is ongoing and she has not been through the entire list yet. V41 stated she added R37, R39 and R40's elopement care plan on 3/30/26. V1 (Administrator) stated the facility reviewed all of the resident care plans who are at high risk for elopement on 3/13/26 and V41 then found that none of the residents listed as high risk had an elopement care plan. V1 stated a thorough review of all residents at any level of risk of elopement was completed on 4/1/26. V1 stated all residents at risk for elopement have elopement care plans in place as of 3/30/26 but the facility was not certain of this until 4/1/26. V1 stated a care plan for resident wandering is not the same as an elopement care plan. 8. V1 (Administrator) confirmed all residents at any level of risk for elopement have the potential to be affected. 9. In-services on Missing Resident Policy and Safety/Supervision Policy were conducted on 3/16/26 and 3/17/26 by V1 (Administrator) and V2 (DON) for all staff. V8 (Regional Director of Operations) stated the facility uses one agency for staffing needs. V8 stated the agency has been notified and provided two separate in-services for any agency staff to complete prior to picking up a shift. 10. V31 (Human Resources) stated she provides education on elopement/safety for all newly hired staff. V31 stated this is an ongoing process. 11. V1 (Administrator) stated V17 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(ADON) reviewed the elopement binders on all halls. V1 Administrator stated the elopement binder on each hallway was updated on 4/1/26. 12. V1 Administrator stated the elopement drills were conducted on 3/16/26 and 3/17/26 which included 100% of their staff either on site or by phone. 13. V2 (DON) stated any residents on 15-minute visuals were monitored. V2 stated the staff were educated on monitoring residents on 15-minute visuals and documenting the visual observations every 15 minutes. Facility audit initiated on 3/16/26. 14. V36 (Maintenance Director) stated the door alarm checks began 3/13/26. V36 stated he has checked the door alarms every day by pressing on the cross bar of each exit door without pushing the door open. V36 stated he began checking the exit door alarms by pushing the cross bar and pushing the door open on 3/20/26. V1 (Administrator) stated the facility has a new QA nurse who starts next week (4/6/26) who will work every weekend and be responsible for checking the alarms and has already been instructed on how to check door alarms and documenting the door alarm checks are to be completed. 15. V1 (Administrator) stated the facility had an ad hoc Quality Assurance Performance Improvement (QAPI) meeting on 3/13/26. V1 stated the facility has not had another QAPI meeting but plans to discuss Missing Resident/Safety and Supervision and Elopement Policies, in-services and audits completed and/or in progress to ensure the safety of the residents. 16. V1 (Administrator) stated elopement drills are ongoing. V1 stated the last drill was completed on 3/16/26 and 3/17/26 and will be due again ?around' 4/16/26. 17. On 4/1/26 at 1:25 PM V1 (Administrator) stated IDT meets daily Monday through Friday. V1 and V2 (DON) stated the IDT discussed any new residents who were assessed to be an elopement risk and any changes in behaviors for established residents. V1 stated they were not aware that the initial list of residents at risk for elopement had not been reviewed until 4/1/26.