STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195380	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Guest House Skilled Nursing Rehabilitation	9225 Normandie Drive Shreveport, LA 71118

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40193 Based on record reviews and interviews, the facility failed to ensure an alleged violation involving neglect was reported to the State Survey and Certification Agency for 1 (#1) of 6 (#1, #2, #3, #4, #5, #6) sampled residents reviewed for elopement. Findings: Review of the facility's Abuse Investigation and Reporting (Revised October 15, 2022) revealed: Policy Statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management .Reporting: 4. The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident . Review of Resident #1's medical records revealed an admitted [DATE] with the following diagnoses, in part, including: chronic obstructive pulmonary disease/unspecified, heart failure/unspecified, depression/unspecified, insomnia/unspecified, problems related to living alone, and history of falling. Review of Resident #1's progress notes revealed a late entry on 04/07/2024 at 3:18 a.m. read in part, at approximately 2:50 a.m. staff nurse received a phone call from Resident #1's S9 Responsible Party, stating Resident #1 was found at a gas station. Staff on shift had previously observed resident or what appeared to be the resident asleep in the bed. Upon further inspection, it was noted by staff that the bed was stuffed with pillows and blankets to resemble a body asleep in bed. Upon searching by staff, resident was not found anywhere in the building. The window in Resident #1's room was observed by staff to be raised open, which leads to the outside of the building area. At approximately 3:30 a.m. resident was returned to the facility via S9 Responsible Party . (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 09/19/2024 at 3:50 p.m. S9 Responsible Party of Resident #1, reported resident has dementia and was transferred to a memory care unit. S9 Responsible Party further reported she thought staff were supposed to be doing checks every 2 hours on the residents. S9 Responsible Party confirmed on 04/07/2024 at approximately 3:00 a.m. a gas station clerk notified her Resident #1 was wandering in the parking lot. S9 Responsible Party reported on 04/07/2024 she picked up Resident #1 from the gas station and returned her to the facility at approximately 3:30 a.m. S9 Responsible Party further reported on the way back to the facility she contacted the facility and requested staff check on Resident #1. S9 Responsible Party reported staff confirmed Resident #1 was not in her room. During a telephone interview on 09/23/2024 at 11:45 a.m. S8 Licensed Practical Nurse (LPN) confirmed she worked on 04/07/2024 when Resident #1 eloped. S8 LPN confirmed the night of 04/07/2024 Resident #1's S9 Responsible Party called and told staff she was on her way to pick up Resident #1 at the gas station. S8 LPN reported Resident #1 left out the window in her room. Review of facility's incident investigation reports failed to reveal documentation for Resident #1's elopement from the facility on 04/07/2024. During a telephone interview on 09/23/2024 at 1:29 p.m. S1 Administrator acknowledged Resident #1 eloped from the facility on 04/07/2024 and an incident investigation was not completed and should have been.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 40193 Based on record reviews and interviews, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are thoroughly investigated for 1 (#3) of 6 (#1, #2, #3, #4, #5, #6) sampled residents reviewed for elopement. Findings: Review of the facility's Abuse Investigation and Reporting (Revised October 15, 2022) revealed: Policy Statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management .Role of the Investigator: 1. The individual conducting the investigation will, at a minimum: a. Review the completed documentation forms; b. Review the resident's medical record to determine events leading up to the incident; c. Interview the person (s) reporting the incident; d. Interview any witnesses to the incident; e. Interview the resident (medical appropriate); f. Interview the resident's attending physician as needed to determine the resident's current level of cognitive function and medical condition; g. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; h. Interview the resident's roommate, family members, and visitors; j. Review all events leading up to the alleged incident. 4. Upon conclusion of the investigation, the investigator will record the results of the investigation and provide the completed documentation to the Administrator. Review of facility's Routine Resident Checks Policy Statement (no date) revealed: Staff shall make routine resident checks to help maintain resident safety and well-being. Policy Interpretation and Implementation: 1. to ensure the safety and well-being of our residents, nursing staff shall make a routine resident check on each unit at least four times per each 8-hour shift. 2. Routine resident checks involve entering the resident's room and/or identifying the resident elsewhere on the unit to determine if the resident's needs are being met, identify any change in the resident's condition, identify whether the resident has any concerns, and see if the resident is sleeping, needs toileting assistance, etc. 3. The person conducting routine check shall report promptly to the Nurse Supervisor/Charge Nurse any changes in the resident's condition and medical needs. Review of Resident #1's progress notes revealed a late entry on 04/07/2024 at 3:18 a.m. read in part, at approximately 2:50 a.m. staff nurse received a phone call from Resident #1's S9 Responsible Party, stating Resident #1 was found at a gas station. Staff on shift had previously observed resident or what appeared to be the resident asleep in the bed. Upon further inspection, it was noted by staff that the bed was stuffed with pillows and blankets to resemble a body asleep in bed. Upon searching by staff, resident was not found anywhere in the building. The window in Resident #1's room was observed by staff to be raised open, which leads to the outside of the building area. At approximately 3:30 a.m. resident was returned to the facility via S9 Responsible Party . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 09/19/2024 at 3:50 p.m. S9 Responsible Party of Resident #1, reported resident has dementia and was transferred to a memory care unit. S9 Responsible Party further reported she thought staff were supposed to be doing checks every 2 hours on the residents. S9 Responsible Party confirmed on 04/07/2024 at approximately 3:00 a.m. a gas station clerk notified her Resident #1 was wandering in the parking lot. S9 Responsible Party reported on 04/07/2024 she picked up Resident #1 from the gas station and returned her to the facility at approximately 3:30 a.m. S9 Responsible Party further reported on the way back to the facility she contacted the facility and requested staff check on Resident #1. S9 Responsible Party reported staff confirmed Resident #1 was not in her room. During a telephone interview on 09/23/2024 at 11:45 a.m. S8 Licensed Practical Nurse (LPN) confirmed she worked on 04/07/2024 when Resident #1 eloped. S8 LPN confirmed the night of 04/07/2024 Resident #1's S9 Responsible Party called and told staff she was on her way to pick up Resident #1 at the gas station. S8 LPN reported Resident #1 left out the window in her room. During an interview on 09/23/204 at 1:20 p.m. S4 Director of Nursing (DON) reported on 04/08/2024 she was notified of Resident #1 leaving the facility on 04/07/2024. S4 DON acknowledged she did not know if an investigation was completed. During a telephone interview on 09/23/2024 at 1:29 p.m. S1 Administrator reported he was notified of Resident #1's elopement on 04/07/2024. S1 Administrator acknowledged an investigation was not completed and should have been.

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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** 40193 Based on record reviews, video review, and interviews the facility failed to supervise cognitively impaired residents who were high risk for elopement. Resident #1 exited the facility and Residents #5 and #6 remained at high risk for elopement, 3 (#1, #5, #6) of 6 (#1, #2, #3, #4, #5, #6) sampled residents reviewed for elopement. This deficient practice resulted in an Immediate Jeopardy (IJ) on 04/07/2024 at 2:50 a.m. when Resident #1, a moderately cognitively impaired resident who ambulated with a walker, was unsupervised and eloped from the facility. Resident #1 crawled out of the window in her room and exited the facility. Staff did not realize Resident #1 eloped from the facility until staff received a phone call from the S9 Responsible, reporting the Resident #1 was found at a gas station approximately one mile from the facility. Resident #1 walked down a dark single lane highway and a 4 lane divided highway during the night. Resident #1 was returned to the facility on [DATE] at approximately 3:30 a.m. by S9 Responsible Party. The IJ continued as a review of facility video surveillance from 09/19/2024 from 11:18 p.m. until 5:18 a.m. revealed staff were not performing visual checks on remaining residents (Resident #5 and Resident #6) who resided on Hall A and were identified at risk for elopement. The facility's system to adequately supervise residents every two hours according to the facility's routine resident checks policy is deficient. S3 Assistant Administrator and S2 Corporate Nurse were notified of the Immediate Jeopardy on 09/24/2024 at 5:20 p.m. This deficient practice had the likelihood to cause more than minimal harm to the remaining ten residents at risk for elopement residing in the facility. The Immediate Jeopardy was removed on 09/25/2024 at 10:18 a.m. when it was determined the facility had implemented an acceptable Plan of Removal as confirmed through onsite interviews, observations, and record reviews prior to exit. Findings: Review of facility's Wandering and Elopements Policy and Procedure (revised November 15, 2023) revealed in part: Policy: The facility will identify residents who are at risk of unsafe wandering and implement appropriate protective measures to help guard against a resident wandering from the facility. The facility strives to prevent harm while maintaining the least restrictive environment for residents. Identifying residents at risk: 2. if identified as a risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Wandering and elopement protocols: 1. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the charge nurse or Director of Nursing (DON). 2.Instruct another staff member to inform charge nurse or DON that a resident has left the premises. 3. When the resident returns to the facility, the DON or charge nurse shall: examine the resident for injuries, notify the attending physician and report findings .complete and file report of incident/accident, document the event in the resident's medical record and notify regulatory agencies per state guidelines as indicated. Review of facility's Routine Resident Checks Policy Statement (no date) revealed in part: Staff shall make routine resident checks to help maintain resident safety and well-being. Policy Interpretation and Implementation: 1. to ensure the safety and well-being of our residents, nursing staff shall make a routine resident check on each resident at least four times per each 8-hour shift. 2. Routine resident checks involve entering the resident's room and/or identifying the resident elsewhere on the unit to determine if the resident's needs are being met, identify any change in the resident's condition, identify whether the resident has any concerns, and see if the resident is sleeping, needs toileting assistance, etc. 3. The person conducting routine check shall report promptly to the Nurse Supervisor/Charge Nurse any changes in the resident's condition and medical needs. Review of the Resident #1's medical record revealed an admitted [DATE] with diagnoses including but not limited to: chronic obstructive pulmonary disease/unspecified, heart failure/unspecified, chronic kidney disease/unspecified, depression/unspecified, insomnia/unspecified, problems related to living alone, at risk for elopement and history of falling. Review of Resident #1's Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed Resident #1 had a BIMS score of 10, indicating moderate cognitive impairment. Review of Resident #1's Elopement assessment dated [DATE] revealed an elopement score of 3.0 indicating resident is at risk. (Score > = 1 = At Risk for Elopement). Review of an internet mapping site revealed Resident #1 was located approximately 1 mile from the facility and had to walk down a single lane highway and a 4 lane divided highway at night. Review of Resident #1's Physician's orders revealed an order dated 04/04/2024 to perform visual census checks, resident at risk for wandering, exit seeking behaviors, and elopement every 2 hours for elopement risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's progress notes revealed an entry on 04/04/2024 at 5:53 p.m. read in part, Resident #1 sitting near front door crying with bags packed. When asked what was wrong, resident stated she wants to go home, she is not going back to her room . Will notify all staff to monitor res closely. Further review revealed a late entry on 04/07/2024 at 3:18 a.m. read in part, at approximately 2:50 a.m. staff nurse received a phone call from Resident #1's S9 Responsible Party, stating Resident #1 was found at a gas station. Staff on shift had previously observed resident or what appeared to be the resident asleep in the bed. Upon further inspection, it was noted by staff that the bed was stuffed with pillows and blankets to resemble a body asleep in bed. Upon searching by staff, resident was not found anywhere in the building. The window in Resident #1's room was observed by staff to be raised open, which leads to the outside of the building area. At approximately 3:30 a.m. resident was returned to the facility via S9 Responsible Party . Will continue to monitor and maintain safety measures while on shift. During a telephone interview on 09/19/2024 at 3:50 p.m. S9 Responsible Party of Resident #1, reported resident has dementia and was transferred to a memory care unit. S9 Responsible Party further reported she thought staff were supposed to be doing checks every 2 hours on the residents. S9 Responsible Party confirmed on 04/07/2024 at approximately 3:00 a.m. a gas station clerk notified her Resident #1 was wandering in the parking lot. S9 Responsible Party reported on 04/07/2024 she picked up Resident #1 from the gas station and returned her to the facility at approximately 3:30 a.m. S9 Responsible Party further reported on the way back to the facility she contacted the facility and requested staff check on Resident #1. S9 Responsible Party reported staff confirmed Resident #1 was not in her room. During an interview on 09/23/2024 at 10:10 a.m. S5 Receptionist reported she had witnessed Resident #1 following visitors and/staff out of the locked double doors to the front entrance of the facility prior to 04/07/2024. S5 Receptionist further reported she witnessed Resident #1 during the week of 04/01/2024 walking out behind someone and noticed her walking down the street not realizing she was a resident. S5 Receptionist reported staff was notified and Resident #1 was brought back to the facility. During a telephone interview on 09/23/2024 at 11:45 a.m. S8 Licensed Practical Nurse (LPN) confirmed she worked on 04/07/2024 when Resident #1 eloped. S8 LPN confirmed the night of 04/07/2024 Resident #1's S9 Responsible Party called and told staff she was on her way to pick up Resident #1 at the gas station. S8 LPN reported Resident #1 left out the window in her room. During an interview on 09/23/2024 at 12:15 p.m. S10 Business Office reported Resident #1 would see her put her purse on and follow her to the front door, wanting to leave. During a telephone interview on 09/23/2024 at 11:38 a.m. S6 Former Assistant Director of Nursing (ADON) reported Resident #1 had behaviors of wanting to leave the facility. During an interview on 09/23/2024 at 1:20 p.m. S4 DON reported Resident #1 always had her bag packed and had exhibited exit seeking behaviors. During an interview on 09/23/2024 at 2:20 p.m. S2 Corporate Nurse reported Resident #1 had been exhibiting exit seeking behaviors. S2 Corporate Nurse further reported Resident #1 would carry her bags around wanting to go home. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review on 09/24/2024 at 11:55 a.m. of the facility's video surveillance of Hall A dated 09/19/2024 from 11:18 p.m. until 5:18 a.m. during the night shift with S2 Corporate Nurse and S3 Assistant Administrator revealed staff failed to perform visual checks every 2 hours on residents. Resident #5 and Resident #6 resided on Hall A and were identified at risk for elopement. Review of Resident #5's medical records revealed an admitted [DATE] with diagnoses including but not limited to: cognitive communication deficit, dementia in other diseases classified elsewhere/moderate with anxiety, insomnia/unspecified, schizoaffective disorder/bipolar type, and major depressive disorder/recurrent/moderate. Review of Resident #5's MDS assessment dated [DATE] revealed a BIMS score of 1 (severely cognitively impaired). Review of Resident #5's Elopement Risk Evaluation dated 09/23/2024 revealed a score of 1.0 (Score > = 1 = At Risk for Elopement) indicating at risk for elopement. Review of Resident #5's Physician's orders revealed an order dated 08/23/2024 to perform visual census checks, resident at risk for wandering, exit seeking behaviors, elopement every 2 hours. Review of Resident #6's medical records revealed an admitted [DATE] with diagnoses including but not limited to: unspecified dementia/unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of Resident #6's MDS assessment dated [DATE] revealed a BIMS score of 00 (severely cognitively impaired). Review of Resident #6's Elopement Risk Evaluation dated 09/23/2024 revealed a score of 1.0 (Score > = 1 = At Risk for Elopement) indicating at risk for elopement. Review of Resident #6's Physician's orders revealed an order dated 08/23/2024 to perform visual census checks, resident at risk for wandering, exit seeking behaviors, elopement every 2 hours. During an interview on 09/24/2024 at 12:25 p.m. S2 Corporate Nurse acknowledged video surveillance of the Hall A on 09/19/2024 from 11:18 p.m. until 5:18 a.m. during the night shift revealed rounding was not completed every 2 hours and should have been done. S2 Corporate Nurse further acknowledged the nurse on duty did not enter the rooms to perform visual checks on the residents, including Resident #5 and Resident #6 identified at risk for elopement, every 2 hours according to facility policy. S2 Corporate Nurse acknowledged the lack of supervision had the potential to adversely affect the remaining ten residents identified at risk for elopement. During an interview on 09/24/2024 at 12:25 p.m. S3 Assistant Administrator acknowledged video surveillance of Hall A on 09/19/2024 from 11:18 p.m. until 5:18 a.m. during the night shift revealed rounding was not completed every 2 hours and should have been done. S3 Assistant Administrator further acknowledged the nurse on duty did not enter the rooms to perform visual checks on the residents. Observation on 09/24/2024 at 9:20 a.m. revealed Resident #5 walking around nursing station and staff were redirecting her. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 09/24/2024 at 9:20 a.m. revealed Resident #6 self-propelling her wheelchair down the hallway. Observation on 09/25/2024 at 9:45 a.m. revealed Resident #5 pushing her wheelchair in the hallway being redirected by staff.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40193 Based on record review, video review, an interviews, the facility failed to be administered in a manner that enabled its resources to be used effectively and efficiently by failing to have an adequate system in place to ensure 3 (#1, #5, #6) of 6 (#1, #2, #3, #4, #5, #6) sampled residents who were at risk for elopement were adequately supervised to prevent elopement from the facility. The lack of administrative oversight resulted in an Immediate Jeopardy on 04/07/2024 at 2:50 a.m. when Resident #1, a moderately cognitively impaired resident who ambulated with a walker, was unsupervised and eloped from the facility. Resident #1 crawled out of the window in her room and exited the facility. Staff did not realize Resident #1 eloped from the facility until staff received a phone call from S9 Responsible Party, reporting the Resident #1 was found at a gas station. Resident #1 was located at a gas station approximately one mile from the facility, Resident #1 walked down a dark single lane highway and a 4 lane divided highway during the night. Resident #1 was returned to the facility on [DATE] at approximately 3:30 a.m. by S9 Responsible Party. Resident #1 was assessed on 04/04/2024 as at risk for elopement and protective measures had not been put into place related to Resident #1's recent documented history of exit seeking behaviors. Review of facility video surveillance from 09/19/2024 from 11:18 p.m. until 5:18 a.m. revealed staff were not performing visual checks on remaining residents (Resident #5 and Resident #6) who resided on Hall A and were identified at risk for elopement. The facility's system to adequately supervise residents every two hours according to the facility's routine resident checks policy is deficient. S3 Assistant Administrator and S2 Corporate Nurse were notified of the Immediate Jeopardy on 09/24/2024 at 5:20 p.m. This deficient practice had the likelihood to cause more than minimal harm to the remaining ten residents at risk for elopement residing in the facility. The Immediate Jeopardy was removed on 09/25/2024 at 10:18 a.m. when it was determined the facility had implemented an acceptable Plan of Removal as confirmed through onsite interviews, observations, and record reviews prior to exit. Findings: Cross Reference F689 Review of facility's Wandering and Elopements Policy and Procedure (revised November 15, 2023) revealed in part: Policy: The facility will identify residents who are at risk of unsafe wandering and implement appropriate protective measures to help guard against a resident wandering from the facility. (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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of facility's Routine Resident Checks Policy Statement (09/23/2024) revealed in part: Staff shall make routine resident checks to help maintain resident safety and well-being. Policy Interpretation and Implementation: 1. to ensure the safety and well-being of our residents, nursing staff shall make a routine resident check on each resident at least four times per each 8-hour shift. 2. Routine resident checks involve entering the resident's room and/or identifying the resident elsewhere on the unit to determine if the resident's needs are being met, identify any change in the resident's condition, identify whether the resident has any concerns, and see if the resident is sleeping, needs toileting assistance, etc. 3. The person conducting routine check shall report promptly to the Nurse Supervisor/Charge Nurse any changes in the resident's condition and medical needs. During a review on 09/24/2024 at 11:55 a.m. of the facility's video surveillance on the Hall A dated 09/19/2024 from 11:18 p.m. until 5:18 a.m. during the night shift with S2 Corporate Nurse and S3 Assistant Administrator revealed staff failed to perform visual checks every 2 hours on residents. Resident #5 and Resident #6 resided on Hall A and were identified at risk for elopement. During an interview on 09/24/2024 at 12:25 p.m. S2 Corporate Nurse acknowledged video surveillance of the Hall A on 09/19/2024 from 11:18 p.m. until 5:18 a.m. during the night shift revealed rounding was not completed every 2 hours and should have been done. S2 Corporate Nurse further acknowledged the nurse on duty did not enter the rooms to perform visual checks on the residents every 2 hours according to facility policy. S2 Corporate Nurse acknowledged the lack of supervision had the potential to adversely affect the remaining ten residents identified at risk for elopement. S2 Corporate Nurse acknowledged the facility failed to ensure nurses were performing visual checks and CNAs were rounding every two hours. S2 Corporate Nurse reported administration should be monitoring the night shifts to ensure monitoring every two hours is being completed. During an interview on 09/24/2024 at 12:25 p.m. S3 Assistant Administrator acknowledged video surveillance of the Hall A on 09/19/2024 from 11:18 p.m. until 5:18 a.m. during the night shift revealed rounding was not completed every 2 hours and should have been done. S3 Assistant Administrator further acknowledged the nurse on duty did not enter the rooms to perform visual checks on the residents.