STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Oaks Nursing & Rehab LLC	201 Shady Lane Drive Wadena, MN 56482

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	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** 43367 Based on observation, interview and document review the facility failed to implement interventions to provide adequate monitoring and supervision for 2 of 3 residents (R1, R2) who reside on a memory care unit. R1 and R2 identified with wandering, elopement behaviors, and left the facility without staff being aware of where they were. Findings included: R1's elopement risk assessment completed on 1/5/25, identified he was ambulatory, had a history of wandering/elopement/exit seeking, dementia, wandered within the home without leaving grounds, and experienced sundowners (increased confusion, difficulty sleeping, anxiety, agitation, hallucinations, pacing and disorientation people living with dementia may experience from dusk throughout the night). He scored 10 on the assessment (0-8 low risk, 9-10 at risk to wander, 11-above high risk to wander) and was at risk to wander. R1's care plan dated 1/6/25, identified activity of daily living (ADL) self-care deficit and high risk for falls related to weakness, blind in right eye, hearing difficulty, and impaired cognition. He was independent with straight care (walker per DON) in halls, room, and transfers and required guidance for orientation. He was an elopement risk/wanderer/at risk to leave facility without notice/unauthorized related to dementia. Staff were directed to monitor for exit seeking, wandering, talking about leaving facility, document episodes, and offer activities for distraction, toileting, walking inside/outside, call family, structured activities, food, conversation, television, and books. He lived in the special care/secured unit and staff were directed to monitor for tailgating when visitors were in the building and provide a safe and secure environment. R1's Cognitive Performance Test (CPT) (a standardized occupational therapy (OT) assessment initially developed as a research instrument to assess cognition in daily tasks performance and change over time with Alzheimer's disease) dated 1/8/25, identified and an average CPT score of 4/4 out of 5/6 and indicated the need for 24-hour supervision. (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: 245581	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's admission Minimum Data Set (MDS) dated [DATE], identified continent of bowel and bladder. His diagnoses included congestive heart failure (CHF), kidney failure, diabetes mellitus (DM), dementia, anxiety, and no falls. admitted to facility on 1/3/25, from a hospital. He had moderately impaired cognition, no behaviors, and sometimes socially isolated himself. He required set-up/clean up assistance with toileting hygiene, supervision/cues for eating, independent with oral hygiene, dressing himself, sit to stand, all transfers, ambulated up to 150 feet in corridor, walking on uneven surface and steps/curbs not attempted due to medical condition or safety concerns, used a walker for mobility. His medications included antipsychotic, antidepressant, diuretic, opioid antiplatelet, and hypoglycemic (lowers blood sugar). A wander guard or alarm system was not used. R1's OT evaluation dated 2/7/25, identified he had demonstrated a physical decline and OT services would be restarted to improve activities of daily living (ADLs) participation and safety. History included legally blind right side, high risk for falls, moderate/severe cognitive performance, moderately impaired decision making, and impaired safety awareness. He moved slowly and demonstrated impaired balance at evaluation. OT was started three times a week with a duration of 30 days. R1's physical therapy (PT) evaluation dated 2/7/25, identified he had difficulty this week with sit to standing and order was placed for evaluation to be completed. Medical history identified gait abnormalities, unsteadiness on feet, and dementia with behavior disturbances. PT was started three time a week with a duration of 30 days. R1's progress notes from 2/26/25 through 2/27/25, identified: -On 2/26/25 at 9:54 a.m. R1 stated to writer his legs were not working and needed help getting up. He was able to get up out of bed with assist of two. Once he was up out of bed was able to ambulate and used front wheeled walker, gait belt, and standby assist. Hard of hearing (HOH) wore hearing aids in both ears and refused to wear . continued to work the physical/occupational therapy during the week. -On 2/27/25 at 6:51 p.m. nurse noticed R1's walker at the end of the hallway. This nurse started to look for him and alerted other staff to search for him. When this nurse came up towards the nurse's station the phone rang, answered phone and the caller stated I believe I have one of your residents here (she was from the apartments next door). This nurse immediately sent a staff member over to the apartments to bring him back to the facility. Once he was back into the facility, this nurse asked him how and where he ended up outside. He stated he pressed the numbers, and it turned green, so opened the door and went out. This nurse asked him where he was going and he replied I do not know, nowhere. Skin was checked for injuries, none noted. Maintenance still here in the building and changed the code on the door. He was placed on 15-minute checks until further notice. Director of nursing (DON) was updated via phone call. This nurse called guardian (phone message stated she was on vacation). Did attempt to call the stand in guardian, unable to reach her. Will attempt to reach her tomorrow. Physician will be updated via fax. -On 2/27/25 at 9:32 p.m. R1 had been started on 15-minute checks this earning. He has been wandering the hallways with his walker and sitting in recliner chairs in a variety of areas. When he was seen going down to the east hallway with the walker, staff had asked him to go to the lounge area or his room to get his mind off going towards the door at the end of the hallway. He has been closely monitored by staff of his whereabouts. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's PT evaluation dated 7/22/24, identified was discharged from PT a few months ago, placed on walking program with caregivers assist of one and front wheeled walker (FWW), had not been walking anymore and had declined in his mobility. He required supervision or touching assistance with ambulation up to 50 feet and unable to attempt 150 feet due to medical conditions or safety concerns. His gait pattern included a very short and shuffling steps where his feet caught on each other, walked very narrow base of support (BOS), and flexed knees. R2's OT evaluation dated 12/11/24, identified moderately impaired decision making, impaired safety awareness, and muscle weakness. He had fallen once in the past year and felt unsteady when he walked. R2's care plan dated 1/2/25, identified limited physical mobility, unsteady gait, weakness, and other abnormalities of gait and mobility. Staff were instructed to have provide assistance of one with ambulation/locomotion and independent with wheelchair-based pivot transfers in room. R2 had purpose driven wandering and tried to get outside to smoke. Staff were directed to monitor for exit seeking or wandering behaviors, attempting to push on doors, type numbers into mag lock, and threatening to leave. Additionally, staff were directed to redirect, assess for needs, take outside for a walk as able, and offer food/drink. R2 had a history of delusions of needing to go to court and wandering/exit seeking increased when someone visited and then left. R2 lived in the special care unit that was secured and staff were directed to monitor for tailgating when visitors were in the building, identify when pattern of wandering was purposeful, aimless, or escapist and intervene as appropriate. R2 had impaired cognition function related to dementia and short-term memory loss. Staff were directed to cue, reorient, and supervise as needed. R2 benefited/required a secure memory care unit due to impaired cognition, dementia with psychotic disturbances, and behaviors. Staff were directed to monitor for changes in behaviors and provide a safe environment. R2's CPT dated 1/8/25, identified an average CPT score of 4.0/5.6 and indicated moderate cognitive impairment and the need for 24-hour supervision and assistance. R2's quarterly MDS dated [DATE], identified admitted to facility on 10/4/22. from a hospital. He had severely impaired cognition, sometimes socially isolates self, rejection of care happened 4 to 6 days out of 7 during look back period, and delusions (misconceptions or beliefs that are firmly held, contrary to reality). He had bilateral lower extremity impairment and used a wheelchair for mobility. He required supervision/touching with toileting hygiene, upper, lower body dressing, sit to stand, and all transfers, wheel 150 feet once seated in wheelchair in corridor or similar space, set-up or clean-up for personal hygiene, and walk at least 10 feet once standing was not attempted due to medical condition or safety concerns. He was frequently incontinent of bladder and always continent of bowel. R2's diagnoses included cancer, dementia, and psychotic disorder. Medications included antipsychotic antiplatelet, and no falls. A wander guard or alarm system was not used. R2's elopement risk assessment completed on 2/12/25, identified he could move without assistance while in wheelchair, had a history of wandering/elopement/exit seeking (past hospitalization or history from resident/family), dementia diagnosis and severely impaired cognition, several times a week making statements of leaving for [NAME], Montana wheeling self in wheelchair to the exits. He scored seven on the assessment and identified at low risk to wander. R2's progress notes from 2/24/25 through 3/4/25, identified: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 2/24/25 at 11:13 a.m. activities brought him up to the main floor for church services in the chapel. He did fine during the service, when it was time to go back downstairs, he had behaviors. He wanted to go down the stairs to go outside and leave. He did not want to go on the elevator, activity director (AD) said Well, we will go up, she pressed the lower floor button, and he noticed that they were going down and not up. He swore at the AD and tried to get out of wheelchair. AD got him off elevator and blocked the elevator until it shut. He wanted to go back up; AD told him that she did not remember the code. He got upset, swore at the staff member again and AD walked away. -On 2/26/25 at 1:36 p.m. he came up to nurse's station several times this shift wanted to speak with business office and call was made per his request. He stated he needed money to get to [NAME], Montana to pick up his car parked in [NAME], and he was going to need gas money. -On 2/27/25 at 5:54 p.m. at approximately 4:57 p.m. AD stated to this nurse R2 was outside. This nurse alerted staff and two staff went to bring him back into the facility. At 5:04 p.m. R2 and staff are back into the facility, and he was asked where and how her got out. He replied he knew the code to the door and opened the door and went out. He stated I was going to the sheriff's office to go report his care missing. This nurse checked skin for injuries, none noted. He was placed on 15-minute checks. Door code was changed by maintenance . DON updated via phone. -On 2/27/25 at 9:14 p.m. he was on 15-minute checks this evening (p.m.) shift. He had been in his room playing cards, watching television (TV) and up to nurse's station for pop several times. he told the nurse he was on his way to [NAME], Montana to go get his car and just stopped here for the night to get some rest, did not think he would be arrested. The nurse stated he was not under arrest this was not a jail, and he was in the nursing home. He stated you could have fooled me this is not a jail; then why could he not have left earlier like he did. Those two girls ran right towards him, and he did not know what he was going on. The nurse stated again he was not in jail or under arrest they brought you back so you could eat supper. He was ok with this explanation and continued his card game. -On 3/4/25 at 9:18 p.m. He had his all belongings packed in a suitcase in his room. He stated he was going to [NAME], MT in the morning. He was going to check out the casinos there and get his car. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25, at 12:13 p.m. licensed practical nurse (LPN)-A stated she had worked 2/27/25 day shift, gave report, and left for the day. She returned to facility at approximately 4:45 p.m. and entered the memory care unit through the east hallway door located at the end of the hallway. R1 stood at the end of the hallway with his walker by the exit door when she entered, dressed in a flannel shirt, jeans, shoes, and was legally blind in one eye. He frequently told staff he wanted to go home and tried to exit the facility. R2 was in the hallway by the nurse's station in his wheelchair, was delusional, frequently asked for his car, wanted to leave the facility, and told us he was going to [NAME], Montana. No wander guards were used in the memory care unit. Two NAs were at the nurse's station and the evening nurse was in the medication room located across from the nurse's station. She entered the medication room, talked with the nurse, and signed some papers for a total of about 15 minutes. She walked down to the exit door located at the end of the east hallway and R1 remained standing with his walker by the exit door. She stood in front of the exit door and located on the wall on the left side of the door was a code pad. R1 stood approximately seven feet behind her. She used her left hand, covered the code pad, punched in the numbers with her right hand, the light on the pad turned green, pushed the door open, entered the stairwell. The door sounded like it latched, kept walking, did not look back to see where R1 was located, opened the outside exit door, and walked out of the building in two seconds, and did not see a resident. She did not look through the window located in the inside door before she left, the door closed and latched, and she thought it was locked. She was unaware the door had taken up to three to five seconds to be locked. The east end hallway exit door was not a designated employee entrance/exit door. She was in a hurry, had parked close to that door, and ran in and out quickly. The exit door was not to be used by staff or visitors after the incident on 2/27/25. She heard R1 had caught the door before it locked, placed his foot, and held it while he flagged down R2. R1 and R2 exited the facility together and when they were found and brought back to the facility and placed on every 15-minute checks for at least five days. She was aware R1 and R2 had talked about leaving and tried to exit the memory care unit. The east hallway and exit door were not visible from the nurse's station. The staff would be expected to monitor and keep the resident within site so that they were kept safe. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 12:33 p.m. nursing assistant (NA)-B stated the memory care unit was a locked unit and when a resident indicated they wanted to leave they would be monitored frequently every 15 to 30 minutes. R1 was admitted to the memory care unit not too long ago, paced the hallways and talked about leaving. Recently R1 talked more about leaving and pushed on exit doors. R2 was admitted quite a while ago and stated frequently, he did not have to be there, was held against his will, and had not signed any papers to be there. R2 talked almost daily about leaving. On 2/27/25 R1 was restless at 2:45 p.m. and provided a snack. Just after 3:45 p.m. R2 requested to go outside to smoke and was informed by LPN-B he no longer smoked. NA-A had asked LPN-B if R 1 was able to go outside. LPN-B stated R1 could not go outside alone. At 4:15 p.m. NA-A went on a short break, and she completed cares with a resident from 4:15 p.m. to 4:30 p.m. NA-A returned to the memory care unit at 4:30 p.m. and along with her walked back to nurse's station. She stated the last time she saw had R2 was between 4:00 p.m. and 4:30 p.m. Between 4:30 p.m. and 4:45 p.m. AD informed us R2 had gotten out of the building. NA-B along with NA-A immediately went outside to get R2. We found R2 in the front of the building by the archway off the side of the road stuck in a mud puddle in his wheelchair. R2 was angry, fought staff, stated he planned on calling the police station to get his keys to his truck, and had taken three staff to get him back to the building. R2 was unable to walk. We arrived back to the building at about 5:00 p.m. LPN-A had received a phone call from the apartments located on campus approximately 200 feet away. NA-A and NA-B stood in the apartment entry way with two female residents without his walker. R1 had poor vision, could only see out of one eye, unsteady gait, would fallen if he had taken a wrong step, and required the assistance of a walker when ambulating. R1 would not be safe out in the community by himself, had dementia, and a poor memory. The double doors were closed earlier in the shift, tried to redirect him, he had placed hand sanitizer on his hands, and attempted to put a code in to open the exit door. There could have been more supervision of the residents during that time on 2/27/25. The nurse that exited the door at the end of the east hallway should have checked the door prior when she left the building. Staff needed to be more aware of their surroundings to keep the residents safe in the memory care unit. We are not able to see the exit door in the east hallway from the nurse's station. During an interview/observation on 3/6/25 at 1:17 p.m. R2 sat in his wheelchair in his room, well groomed, fully dressed in shoes, and television and radio on. He played cards by himself on a small desk. He stated he had waited for the sheriff to come and visit, trying to get out of here. He stated he stopped in here about one year ago and did not get sent here. He had parked his car here, was stolen, someone rolled it and got wrecked. They changed the combination on the door at the end of the hallway and he was unable to get out of the building. During an interview on 3/6/25 at 3:54 p.m. NA-D stated R1 ambulated independently with a walker and staff were expected to redirect him if he showed signs and/or talked about exit seeking. Today R1 told me he did not want to be here and tried to get out through the locked 1/2 door located at the entrance of the memory care unit, redirection was provided. Staff were expected to monitor R1 at least every 20 minutes when he walked the hallways and/or sat down by the exit door to keep him safe. R1 was at risk for elopement, falls, frequently confused, and would have not been safe outside, in a parking lot or ambulating on uneven ground by himself. R2 frequently talked about wanting to leave the building. We were expected to redirect him with snacks and acknowledge his whereabouts, both usually worked. She checked on him at least every hour and he often visited the nurse's station. She had seen him frequently down at the end of the east hallway by the exit door. R2 attempted self-transfers, unable to walk independently, used a wheelchair for mobility, refused assistance with cares, and required help with hygiene. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/7/25 at 9:15 a.m. activity director (AD) stated she clocked out for the day between 4:50 p.m. and 5:00 p.m. She left the facility building, got into her car, drove north to leave the parking lot, and when she went around the corner saw R2. He was located between the front and the east parking lot on the side of the road in his wheelchair approximately 100 feet from the building. He had pushed himself backwards with his feet going north. R2 wore a coat, tennis shoes, pants, and a shirt. She did not talk to him, re-entered the facility building and once she reached the memory care unit she saw LPN-B, NA-A and NA-B located in the nurse's station. She informed the staff R2 was outside, and they stated were surprised and unaware he had been missing. NA-A and NA-B ran down to the end of the east hallway and out the exit door. R2 had pushed himself 100 more feet down the road when she arrived back outside. R2 resisted and refused to come back inside the building, locked his feet down on the ground, one shoe came off, and staff pushed him back to the facility. Earlier in the week he had talked about going to [NAME], Montana to get his car, was frequently confused, and at risk for elopement. Once they returned to the memory care unit, LPN-B stated she had received a phone call from the apartments located approximately 300 feet away, R1 had left the memory care unit also and walked over there. Along with NA-A and NA-B, she walked over to the apartments and assisted the staff. The NA's stood on each side of R1, placed their arm underneath his arm pits and walked him back to the facility. During an interview on 3/7/25 at 9:49 a.m. administrator stated she was notified on 2/27/25 at 4:50 p.m. by DON R2 was located outside of the building. She received another phone call shortly after that and R1 was located at the apartment building next door. R1 and R2 were appropriately dressed, outside temperature was around 45 degrees and both were outside for approximately 12 minutes. She had reviewed the video recording of the incident and LPN-A exited the east hallway door, R1 stood close by, door looked closed but slightly gaped/open. R1 reached for the door may have caught it before it latched (took three seconds to lock). R1 was a pacer and walked the hallways frequently but she was unaware he had exiting seeing behaviors prior to this incident. Three staff had worked the shift on the memory care unit, NA was on a short break, nurse and NA were on the floor. Staff were unaware R1 and R2 were missing or when they were seen last. Staff provided sufficient supervision on 2/27/25 and continued to. She was unsure whether staff were able to see residents from the nurse's station in the east hallway. Her focus was on how the residents got out of the facility. Staff would be expected to monitor residents with an elopement risk located by an exit door with staff entered and exited the door. There should have been increased supervision prior to this incident when R1 was located by the east hallway exit door. R1 would have not been safe outside by himself, walking on uneven ground, and was at risk for falls. Review of a camera recording on 3/7/25 at 10:39 a.m. with human resource director (HRD) of the facility memory care unit recorded on 2/27/25, from 4:33 p.m. to 5:03 p.m. identified: -At 4:33 p.m. LPN-A and LPN-B were in the medication room across from the nurse's station and both exited the room. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Oaks Nursing & Rehab LLC	201 Shady Lane Drive Wadena, MN 56482

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	-At 4:42 p.m. activity director (AD) walked outside to her van located in the parking lot. NA-A and NA-B entered nurse's station together. LPN-B sat in a chair by a computer. NA-A sat in a chair and NA-B prepared ice and water for residents, both located in the nurse's station. HRD stated staff are unable to see residents in the east hallway while the staff where in the nurse's station. -At 4:45 p.m. LPN-B, NA-A and NA-B were in the nurse's station and AD approached them (per HRD was when AD informed staff she had found R2 located outside in his wheelchair). NA-A and NA-B ran down the east hallway and left the building through the exit door. LPN-A walked out of the nurse's station, down the east hallway, looked in R2's room, and to the exit door at the end of the hallway. LPN-A lifted a walker (R1's, confirmed by HRD) located by the exit door, moved it aside then sat down on the couch located below the large window, and looked outside. -At 4:48 p.m. LPN-B stood up from the couch, walked quickly down the hallway towards the nurse's station. -At 4:50 p.m. LPN-B turned around in hallway, walked back down to the end of the east hallway and looked in the last room located on the right side of the hallway across from the exit door. She walked back down the east hallway to the other end, turned left then right into the nurse's station. She looked through the open window located between the nurse's station and the lounge/dining room/commons area. At 4:51 p.m. she sat down in front of computer in the nurse's station on the telephone. -At 4:54 p.m. staff pushed R2 in a wheelchair back into the facility building through the exit door located at the end of the east hallway. R2's right foot did not have a shoe on it. -At 4:56 p.m. LPN-B was located at the nurse's station hung up phone and NA-A and NA-B ran back out of building through the east hallway exit door. LPN-B stood in east hallway next to R2 located just outside his room in his wheelchair. -At 4:57 p.m. LPN-B walked back to nurse's station -At 4:49 p.m. LPN-B walked down to the end of the east hallway, gave the door a push, did not open, and sat down on the couch located underneath the window at the end of the hallway. -At 5:00 p.m. NA-C approached the outside exit door located at the east end of the hallway, unable to enter building, LPN-B opened inside and outside exit doors and allowed NA-C entrance. LPN-B pulled the exit doors closed and sat back down on the couch. -At 5:02 p.m. LPN-B pushed R1's walker down the hallway from the end of the east hallway located by the exit door towards the nurse's station. R1 entered the memory care unit escorted by five staff without a walker. An unidentified female staff held his left hand while he walked down the hallway towards his room. -At 5:03 p.m. LPN-B, NA-A, and NA-B were at the nurse's station. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025

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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 - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/7/25 at 2:15 p.m. NA-A stated the memory care unit was a locked unit and staff were expected to have checked on residents at least every 15 to 20 minutes. There were at least three residents in the unit that were at risk for elopement. R1 and R2 sat together at the end of the east hallway and had conversations. She had noticed R1 pressed numbers on the code pad by the exit door many times located at the end of the east hallway days prior to the incident on 2/27/25. She informed the nurse and closely watched R1 and R2 when they talked about leaving the facility. R2 talked about leaving the facility at least two to three times a shift, wanted to get his car back. R1 had told her he thought he was in jail and wanted fresh air. R1 and R2 move around the unit frequently and when they saw someone leaving, one of them, tried opening the door. She stated the day of the 2/27/25 incident, R1 had approached her and asked to be let outside, continued to walk the hallways, sat at the end of the east hallway by the exit door. She updated LPN-A and was informed R1 was not allowed go outside by himself, and staff would be expected to stay with him in the courtyard. R2 had a visitor/volunteer and had requested to go outside and smoke. LPN-A informed the volunteer he no longer smoked. R2 would not be safe outside by himself, was frequently forgetful, unable to walk independently, and dependent upon a wheelchair for mobility. At approximately 4:20 p.m. she informed LPN-A and NA-B she was taking a quick break, left the floor, and returned approximately 4:30 p.m. LPN-A sat at the nurse's station and AD stopped by the memory care unit and yelled out R2 was outside. Prior to her break R2 was in his room visiting with a volunteer. NA-A and NA-B ran down the east hallway and left the building through the exit door located at the end of the hallway. She located R2 at the front of the building in his wheelchair off the side of the road stuck in the snow. R2 was upset, refused to go with back inside building, spit on her, and stated he was a grown person, did not have to stay, and wanted to go. Just after 4:30 p.m. R2 was brought back to the facility and entered the building through the east hallway exit door. R1's walker was left at the end of the hallway. LPN-A was on the phone and informed her and NA-B R1 was out of the building also and found at the apartments next door. Along with NA-B she ran back down the hallway and exited the building through the east hallway exit door. R1 was walked back to the facility and all residents in the memory care unit were checked on. She was not aware R1 and R2 were missing. During an interview/observation on 3/7/25 at 2:30 p.m. maintenance (M) stated and demonstrated on the end of the east hallway exit door when the code was entered into the code pad located on the wall right side of the inside exit door at eye level, the button turned green, within three seconds the button turned red and the door latched and locked. M pushed on door and demonstrated the door locked within three seconds. M verified all the codes were changed on 2/27/25 immediately after the incident with R1 and[TRUNCAT