STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375427	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Fellowship Home for Senior Citizens, Inc	605 East State Road Fairview, OK 73737

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure careplan's were reviewed or revised for 2 (#1 and #6) of 3 sampled residents reviewed for care plan revisions. The DON identified 75 residents resided in the facility. Findings: The facility's policy titled Resident Safety- Wandering/Elopement, revised 10/2023, read in part, The director of nursing will evaluate each resident upon admission and every three months thereafter for need of the wonder dash guard system. The evaluation will utilize information input from the family or legal guardian of the resident, the resident physician, and when possible, the resident. Additionally, residents will be evaluated for the wonder guard system when they: Seem confused or disoriented Pack belongings Have a history of wondering Verbalize a desire to leave Attempt to leave the facility Residents who are mobile enough to wonder and exhibit one or more of the above behaviors will be recommended for wonder guard. The facility's policy titled MDS (minimum data set) and Care Plan Process, reviewed 02/18/25, read in part, Care plan schedule and requirements: A complete care review will identify any changes in care, or any goals met. It will identify any changes needed to help each resident obtain their goals. It is designed to help each staff member provide the assistance and care for each resident on an individual basis.The careplan will be reviewed and updated quarterly .each care plan is to be accurate in identifying individualized approaches from each discipline to assist in providing care to each resident. (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

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident #1's admission record, dated 11/01/24, showed the resident was admitted with diagnoses which included unspecified dementia and displaced intertrochanteric fracture of the left femur. Resident #1's significant change assessment, dated 02/13/25, showed they had severe cognitive impairment for decision making with a BIMS score of 7. The assessment showed the resident used a wheelchair to ambulate and had no wandering behaviors. Resident #1's assessment titled Wandering Risk Survey, dated 11/01/24, showed they were a low risk for wandering with a score of 4. Resident #1's nurses notes showed exit seeking behaviors and redirection attempts on the following dates; a. On 03/11/25, the resident was exit seeking with their spouse (Resident #6) on hall 2 looking for their house keys; b. on 03/19/25, Resident #1 and Resident #6 were found on hall 2 at the exit. The residents were redirected and Resident #1 had increased confusion; c. on 03/21/25, Resident #1 stated they were leaving in the morning. They tried to reorient the resident, but the resident continued to say their truck was being pulled up by hall 2 door; d. on 04/07/25, Resident #1 and Resident #6 were exit seeking and successfully exited through the North doors. They were brought back in and continued to push on the doors looking for a way out. They tried redirection and it was ineffective; e. on 04/07/25, hourly location checks were initiated; f. on 04/08/25, Resident #1 remained on hourly location checks; g. on 04/22/25, Resident #1 had increased confusion and continued to wander the facility looking for their children and belongings. The resident was unable to be redirected. h. on 05/02/25, Resident #1 was walking without their wheelchair stating they were leaving and had packed their personal items. The resident was redirected multiple times. i. on 05/03/25 at 1:51 p.m., Resident #1 was going up and down the halls shaking the doors and stating they were going to kick the doors down. The resident was redirected multiple times by staff. j. on 05/03/25 at 3:36 p.m., Resident #1 was found outside the laundry room, behind the building where employees enter, and in front of the trash cans laying on the ground. The resident had an abrasion to their right eye with bleeding noted. The resident was taken to the emergency room. A facility form titled 1 hour Location check, dated 04/07/25, showed they placed Resident #1 and Resident #6 on one hour location checks from 04/07/25 at 6:00 p.m., through 04/09/25 at 4:00 p.m. The one hour location checks were not documented in the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Oklahoma State Department of Health incident report form 283, dated 05/03/25, read in part, Nurse called at [2:00 p.m.] by CMA going to lunch that resident had fallen, upon arrival resident was found on the ground outside of the laundry door. [They] were assessed, and an abrasion is noted to rt(right) eyebrow with bleeding noted. taken to [name of hospital withheld] ER (emergency room).[They] have been exit seeking this shift and remains a high risk for falls. Resident #1's emergency room hospital record titled After Visit Summary, dated 05/03/24, showed they were treated at the emergency room and had a diagnosis of laceration of the right eyebrow due to a small right front scalp hematoma with intact skull. Resident #1's care plan for wandering, dated 03/11/25, read in part, I am redirected by staff frequently. Date initiated 05/03/25.Wander guard placed on right ankle, however when we checked on 05/05/25, it was found in resident's closet. Will attempt to place on wheelchair when [they] arrive back from hospital. Date initiated 05/03/25. Resident #1's care plan did not have any interventions to prevent elopement prior to 05/03/25. 2. Resident #6 's admission record, dated 11/01/24, showed they were admitted with diagnoses which included Alzheimer's disease and type 2 diabetes. Resident #6's quarterly assessment, dated 02/13/25, showed their cognition was severely impaired and with a BIMS score of 3. The assessment showed they did not wander. Resident #6's assessment titled Wandering Risk Survey, dated 11/01/24, showed they were a moderate risk for wandering with a score of 10. Resident #6's nurses notes showed exit seeking behaviors and wandering on the following dates; a. on 03/06/25; b. on 04/06/25; c. on 04/07/25; d. on 04/28/25; e. on 05/02/25; f. on 05/03/25; and g. on 05/04/25. Resident #6 was not assessed for wandering or elopement after the above exit seeking dates. Resident #6's care plan, revised 05/08/25, read in part, focus- I reside in the secure care unit due to being an elopement risk/wanderer. Date initiated 05/08/25.Interventions - Provide structured activities: toileting, walking inside and outside, reorientation strategies. Date Initiated: 05/22/2025.Wandering risk assessment per policy. Date Initiated: 05/22/2025. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan did not have a focus for elopement prevention in Resident #6's care plan prior to 05/08/25. On 05/21/25 at 1:10 p.m., CMA #1 stated Resident #1 and Resident #6 had been trying to leave the facility. CMA #1 stated they were redirected continuously. CMA #1 stated Resident #1 eloped from the facility and fell outside resulting in a cut to their right eye. On 05/21/25 at 1:36 p.m., CMA #2 stated Resident #1 and Resident #6 had been trying to elope from the facility since admission date of 11/01/24. CMA #2 stated the residents were placed on hourly checks for a while, but a nurse stated the resident was fine and they did not have to do them anymore. The CMA stated redirection and hourly checks for a couple days were the only interventions they had in the care plan to prevent elopement for Resident #1 and Resident #6. CMA #2 stated Resident #1 eloped from the facility out a backdoor through the laundry room door and fell off a 12-inch-high concrete patio in their wheelchair and was found on the ground with a cut on their head. On 05/21/25 at 1:55 p.m., CMA #3 stated Resident #1 was trying to get out and asked to leave frequently. CMA #3 stated Resident #1 and Resident #6 started exit seeking a few months after admission on [DATE]. CMA #3 was asked what interventions were used to prevent Resident #1 and Resident #6 from eloping. CMA #3 stated, they did one hour location checks for a couple days but those were stopped. On 05/21/25 at 2:06 p.m., LPN #1 stated Resident #1 and Resident #6 started exit seeking, trying the doors, and looking for personal items. LPN #1 stated Resident #1 and Resident #6 would be redirected, would become more forceful, and then reattempted exiting the facility. LPN #1 stated there was not a new intervention added to the care plan until 05/03/25 when Resident #1 received a new order for a wander guard. LPN #1 was asked what other interventions were in place to prevent elopement. They stated Resident #1 and Resident #6 were placed on 1 hour location checks on 04/07/25 through 04/09/25. LPN #1 stated they were unsure why they were doing the checks and they would redirect the residents. LPN #1 stated there were no interventions in Resident #6's care plan to prevent elopement before 05/08/25 when the residents were moved to memory care. On 05/21/25 at 3:00 p.m., the DON stated Resident #1 and Resident #6 had been seeking exit for a couple months. The DON was asked what interventions were in place to prevent elopement. The DON stated they had redirection only and did not add any interventions to the care plan to prevent elopement prior to 05/03/25 for Resident #1 and never had elopement interventions for Resident #6. The DON stated they moved Resident #6 and Resident #1 to memory care on 05/08/25 and updated the care plans. The DON stated Resident #1 eloped from the facility through a laundry room door that was supposed to be locked and fell from their wheelchair outside the facility resulting in a cut over their right eye. The DON was asked if there was a system failure. The DON stated Resident #1 and Resident #6 were not reassessed for wandering risk after 11/01/24 upon admission. The DON stated they did not care plan interventions to prevent the elopement after the facility identified exit seeking behaviors. The DON stated, they did not reassess Resident #1 and Resident #6 for wandering per their policy for the use of wander guard and the staff could not identify which residents were at risk for elopement. The DON stated residents who elope could be seriously harmed or result in death. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/22/25 at 12:23 p.m., the administrator was asked about the incident involving Resident #1 on 05/03/25. The administrator stated Resident #1 was able to open a door in the laundry room that was supposed to be locked and exit out the back door where they fell off a 12-inch-high concrete patio in their wheelchair resulting in a cut over their right eye. The administrator was asked to identify the system failure involving the elopement on 05/03/25. They stated, We knew [they] were exit seeking and we did not assess, monitor and intervene timely. The family meeting we set up was too little too late, we failed to ensure the door was secured.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** On 05/22/25 at 1:40 p.m., the Oklahoma State Department of Health was notified and verified the existence of an immediate jeopardy (IJ) situation related to the facility's failure to provide adequate supervision to prevent elopement from the facility. 1. Resident #1's admission record, dated 11/01/24, showed the resident was admitted with diagnoses which included unspecified dementia and displaced intertrochanteric fracture of the left femur. A Wander risk assessment, dated 11/01/24, showed Resident #1 was a low risk for elopement with a score of 4. A care plan, last revised 05/08/25, showed the resident was exit seeking on the following dates; a. 03/19/25; b. 04/11/25; c. 04/15/25; d. 04/07/25; e. 04/08/25; and f. 05/03/25. The care plan, revised 05/08/25, showed Resident #1 was moved to the memory care unit on 05/08/25. There were no additional documented interventions to address the wandering and exit seeking other than redirection. Resident #1's progress notes showed exit seeking behaviors and attempts to redirect on the following dates: a. On 03/11/25, resident and spouse were exit seeking; b. on 03/19/25, resident and spouse found on hall 2 trying to exit. Redirection was unsuccessful; c. on 03/21/25, resident stated they were leaving and the staff tried to reorient the resident; d. on 04/07/25, resident and spouse successfully exited through the front doors and was brought back in. Redirection was ineffective and the resident continued to exit seek; e. on 04/22/25, resident wandering and concerned about their house; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	f. on 04/27/25, resident tried to leave through the door, intervention of taking resident for walk was ineffective; g. on 04/28/25, resident was exit seeking with spouse to find their children; h. on 05/02/25, resident stated they were leaving and packed personal items, resident was redirected; i. on 05/03/25 at 1:51 p.m., resident was exit seeking. The resident was redirected but immediately began to exit seek. The resident shook all the doors and stated they were going to kick the doors down; and j. on 05/03/25 at 3:56 p.m., the resident was found on the ground outside the laundry room and in front of the trash cans behind the building. They had an abrasion to their right eyebrow with bleeding noted. On 05/22/25 at 1:50 p.m., the administrator and DON were notified of the immediate jeopardy (IJ) situation and provided the IJ template. On 05/23/25 at 11:23 a.m., an amended plan of removal was accepted by the Oklahoma State Department of Health. The plan of removal read in part, 1:1 supervision; assign 1:1 staffing to the resident 24/7 until further evaluation is complete .Secure the environment; move the resident to a locked or secure unit if available and appropriate .Door alarms and monitoring; ensure all doors are alarmed and functional, check surveillance system .Place a WanderGuard on resident .All residents will have a wandering risk evaluation completed by 5/23/25 . .Wandering risk will be done on new admission, re-admission, significant change, quarterly, and annually. .Reassess wandering risk evaluations; conduct a full interdisciplinary team to review including: .Care plan update; modify the residents care plan immediately to reflect: Elopement interventions Environmental changes Staffing changes. .Emergency In-service training on 5/22/25: Provide all staff with immediate re-education on: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	.Elopement protocols .Door alarm response procedures .Missing resident protocols .Immediate jeopardy awareness and CMS requirements .Document training: record date/time, attendance, trainer and materials used .Door alarms (functioning logs) .The Elopement Book will be implemented using current resident picture, face sheet, and working interventions. .Signage will be placed on the front and back of any door that has a regress to outside. On 05/23/25, the facility staff were interviewed in person and by phone regarding in-services completed on elopement. Staff interviewed were able to communicate elopement prevention strategies, identify residents at risk for elopement, and elopement response policies and procedures. All residents' electronic health records were reviewed and verified they had current wandering risk assessments. Twenty-six residents were assessed as a wondering risk. Their care plans were reviewed and verified to have elopement interventions. All exterior egress doors with locks were observed and verified to be in working order. Signage on doors were verified in place. Staff were observed ensuring all doors with locks latch when going through them. An elopement book containing a comprehensive list of all residents at risk for wandering was observed at all nurse stations. The elopement book contained a list of all residents at risk for wandering, a picture of each resident at risk, and care plan interventions to protect at risk residents. On 05/23/25, after interviews with staff, review of resident elopement wander risk assessments and care plans, posted signage, and in-services, the administrator was notified the immediacy was lifted effective 05/23/25 at 1:00 p.m. The deficient practice remained at a pattern for more than minimal harm. Based on record review and interview, the facility failed to: a. provide adequate supervision to prevent elopement for 1 (#1) of 3 sampled residents reviewed for elopement; and b. failed to ensure residents were assessed for wandering for 2 (#1 and #6) of 3 sampled residents reviewed for wandering assessments. The DON identified 26 residents were at risk for elopement. Findings: (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's policy titled Resident Safety- Wandering/Elopement, revised 10/2023, read in part, The director of nursing will evaluate each resident upon admission in every three months thereafter for need of the wonder dash guard system. The evaluation will utilize information input from the family or legal guardian of the resident, the resident physician, and when possible, the resident. Additionally, residents will be evaluated for the Wander-Guard System when they: Seem confused or disoriented Pack belongings Have a history of wondering Verbalize a desire to leave Attempt to leave the facility Residents who are mobile enough to wonder and exhibit one or more of the above behaviors will be recommended for wonder guard. 1. Resident #1's admission record, dated 11/01/24, showed the resident was admitted with diagnoses which included unspecified dementia and displaced intertrochanteric fracture of the left femur. Resident #1's significant change assessment, dated 02/13/25, showed they had severe cognitive impairment for decision making with a BIMS score of 7. The assessment showed Resident #1 used a wheelchair to ambulate and had no wandering behaviors. Resident #1's assessment titled Wandering Risk Survey, dated 11/01/24, showed they were a low risk for wandering with a score of 4. Resident #1's nurses notes showed exit seeking behaviors and redirection attempts on the following dates; a. on 03/11/25, the resident was exit seeking with their spouse (Resident #6) on hall 2 looking for their house keys; b. on 03/19/25, Resident #1 and Resident #6 were found on hall 2 at the exit. The residents were redirected and Resident #1 had increased confusion; c. on 03/21/25, Resident #1 stated they were leaving in the morning. They tried to reorient the resident, but the resident continued to say their truck was being pulled up by hall 2 door; d. on 04/07/25, Resident #1 and Resident #6 were exit seeking and successfully exited through the North doors. They were brought back in and continued to push on the doors looking for a way out. They tried redirection and it was ineffective; e. on 04/07/25, hourly location checks were initiated; f. on 04/08/25, Resident #1 remained on hourly location checks; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	g. on 04/22/25, Resident #1 had increased confusion and continued to wander the facility looking for their children and belongings. The resident was unable to be redirected. h. on 05/02/25, Resident #1 walked without their wheelchair stating they were leaving and had packed their personal items. The resident was redirected multiple times. i. on 05/03/25 at 1:51 p.m., Resident #1 was going up and down the halls shaking the doors and stating they were going to kick the doors down. The resident was redirected multiple times by staff. j. on 05/03/25 at 3:36 p.m., Resident #1 was found outside the laundry room and in front of the trash cans. The resident had an abrasion to their right eye with bleeding noted. The resident was taken to the emergency room. A facility form titled 1 hour Location check, dated 04/07/25, showed they placed Resident #1 and Resident #6 on one hour location checks from 04/07/25 at 6:00 p.m., through 04/09/25 at 4:00 p.m. The one hour location checks were not documented in the care plan. An Oklahoma State department of Health incident report, Form 283, dated 05/03/25, read in part, Nurse called at [2:00 p.m.] by CMA going to lunch that resident had fallen, upon arrival resident was found on the ground outside of the laundry door. [They] were assessed, and an abrasion is noted to rt(right) eyebrow with bleeding noted. taken to [name of hospital withheld] ER (emergency room. [They] have been exit seeking this shift and remains a high risk for falls. Resident #1's emergency room hospital record titled After Visit Summary, dated 05/03/24 showed they were treated at the emergency room and had a diagnosis of laceration of the right eyebrow due to a small right front scalp hematoma with intact skull. Resident #1's care plan for wandering, dated 03/11/25, read in part, I am redirected by staff frequently. Date initiated 05/03/25.Wander guard placed on right ankle, however when we checked on 05/05/25, it was found in resident's closet. Will attempt to place on wheelchair when [they] arrive back from hospital. Date initiated 05/03/25. Resident #1's care plan did not have any interventions to prevent elopement prior to 05/03/25. 2. Resident #6 's admission record, dated 11/01/24, showed they were admitted with diagnoses which included Alzheimer's disease and type 2 diabetes. Resident #6's quarterly assessment, dated 02/13/25, showed their cognition was severely impaired with a BIMS score of 3. The assessment showed they did not wander. Resident #6's assessment titled Wandering Risk Survey, dated 11/01/24, showed they were a moderate risk for wandering with a score of 10. There was no documentation Resident #6 was reassessed for wandering after 11/01/24. Resident #6's nurses notes showed exit seeking behaviors and wandering on the following dates; (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	a. on 03/06/25; b. on 04/06/25; c. on 04/07/25; d. on 04/28/25; e. on 05/02/25; f. on 05/03/25; and g. on 05/04/25. Resident #6's care plan for wandering, revised 05/08/25, read in part, focus- I reside in the secure care unit due to being an elopement risk/wanderer. Date initiated 05/08/25.Interventions - Provide structured activities: toileting, walking inside and outside, reorientation strategies. Date Initiated: 05/22/2025.Wandering risk assessment per policy. Date Initiated: 05/22/2025. The care plan did not have a focus for elopement prevention in Resident #6's care plan prior to 05/08/25. On 05/21/25 at 1:10 p.m., CMA #1 stated Resident #1 and Resident #6 has been trying to leave the facility. CMA #1 stated they were redirected continuously but it was not effective. CMA #1 stated Resident #1 eloped from the facility and fell outside resulting in a cut to their right eye. The CMA stated they did not know how to identify residents at risk for wandering or elopement. On 05/21/25 at 1:36 p.m., CMA #2 stated Resident #1 and Resident #6 had been trying to elope from the facility since admission date of 11/01/24. CMA #2 stated the residents were placed on hourly checks for a while, but a nurse (name unknown) said the resident was fine and they did not have to do them anymore. The CMA stated redirection and hourly checks for a couple days were the only interventions they had in the care plan to prevent elopement for Resident #1 and Resident #6. CMA #2 stated Resident #1 eloped from the facility out a backdoor through the laundry room door and fell off a 12-inch-high concrete patio in their wheelchair and was found on the ground with a cut on their head. On 05/21/25 at 1:55 p.m., CMA #3 stated Resident #1 was trying to get out and ask to leave frequently. They stated Resident #1 and Resident #6 started exit seeking started a few months after admission on [DATE]. CMA #3 was asked what interventions were used to prevent Resident #1 and Resident #6 from eloping. CMA #3 stated, they did one hour location checks for a couple days but those were stopped. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375427	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Fellowship Home for Senior Citizens, Inc	605 East State Road Fairview, OK 73737

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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 - Some	On 05/21/25 at 2:06 p.m., LPN #1 stated Resident #1 and Resident #6 started exit seeking, trying the doors, and looking for personal items. LPN #1 stated the residents would be redirected, would become more forceful, and then reattempted to exit the facility. LPN #1 stated there was not a new intervention added to the care plan until 05/03/25 when Resident #1 received a new order for a wander guard. LPN #1 was asked what other interventions were in place to prevent elopement. They stated Resident #1 and Resident #6 were placed on one hour location checks on 04/07/25 through 04/09/25. LPN #1 stated they were unsure why they were doing the checks and they would redirect the residents. LPN #1 stated there were no interventions in Resident #6's care plan to prevent elopement before 05/08/25 when the residents were moved to memory care. On 05/21/25 at 3:00 p.m., the DON stated Resident #1 and Resident #6 had been seeking exit for a couple months. The DON was asked what interventions were in place to prevent elopement. The DON stated they had redirection only and did not add any interventions to the care plan to prevent elopement prior to 05/03/25 for Resident #1 and never had elopement interventions for Resident #6. The DON stated they moved Resident #6 and Resident #1 to the memory care on 05/08/25 and updated the care plans. The DON stated Resident #1 eloped from the facility through a laundry room door that was supposed to be locked and fell from their wheelchair outside the facility resulting in a cut over their right eye. The DON stated Resident #1 and Resident #6 were not reassessed for wandering risk after 11/01/24 upon admission. The DON was asked if their system failure. The DON stated they did not care plan interventions to prevent the elopement after the facility identified exit seeking behaviors, they did not reassess the residents for wandering per their policy for the use of wander guard, and the staff could not identify residents at risk for elopement. The DON stated residents who elope could be seriously harmed or result in death. On 05/22/25 at 12:23 p.m., the administrator was asked about the incident involving Resident #1 on 05/03/25. The administrator stated Resident #1 was able to open a door in the laundry room that was supposed to be locked and exit out the back door where they fell off a 12-inch-high concrete patio in their wheelchair resulting in a cut over their right eye. The administrator was asked to identify the system failure involving the elopement on 05/03/25. They stated, We knew [they] were exit seeking and we did not assess, monitor and intervene timely. The family meeting we set up was too little too late, we failed to ensure the door was secured. On 05/22/25 at 1:00 p.m., maintenance #1 stated they were asked to evaluate the laundry room doors had a lock with a keypad. They stated they could not figure out how the resident got the door open to the laundry room.