STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375431	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Park Health Care Center	7019 Northwest Cache Road Lawton, OK 73505

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 01/14/26, an IJ situation was determined to exist related to the facility's failure to ensure a comprehensive care plan was developed for Resident #9 to prevent an elopement on 07/27/25. Resident #9's cognition was severely impaired with a BIMS score of 2. Resident #9 had four elopement assessments which identified Resident #9 as a high risk for elopement. Resident #9 had several exit seeking attempts and elopements during a three-month period. After each elopement or attempted elopement, the resident was placed on one-on-one supervision. Resident #9's care plan was not updated with one-on-one supervision, and there was no documentation of one-on-one supervision was ongoing to prevent elopement. CNA #2 stated they did not know what was supposed to happen when a resident had multiple elopement events.On 01/14/26 at 5:52 p.m., the OSDH was notified and verified the existence of an IJ situation.On 01/14/26 at 6:12 p.m., the administrator, DON, and AIT were notified of the IJ situation and the IJ template was provided. On 01/15/26 at 2:30 p.m., an acceptable POR was approved by the OSDH. The POR, read in part, Resident #9 directly involved in this deficient practice is no longer in the facility at this time.Elopement Risk Assessments were completed on 100% of residents.Facility completed 100% audit of residents who were identified at risk for elopement.Facility developed and implemented care plans to address elopements for all residents identified as at risk for elopement.IDT received immediate education on reviewing, revising, developing and implementing care plans from the VP of Reimbursement or designee(s).IDT team has implemented appropriate monitoring sheet for our elopement risks residents.The IJ was lifted. effective 01/15/26, when all components of the POR were verified as corrected:a. Resident #9's discharge MDS, dated [DATE], showed they were discharged to another facility with a memory care unit,b. the facility's documentation showed all residents were reassessed for elopement risk. The assessments identified three residents were at risk for elopement, c. three residents care plans were reviewed. The care plans showed the residents had a focus and interventions to address the elopement risk,d. the elopement book was reviewed at the nurse's station. The elopement book contained pictures of the three identified resident at risk for elopement, their care plans, and a post elopement check list. The post elopement check list showed eight questions to ensure the resident was located, assessed, the proper individuals were notified, and the proper documentation was completed,e. the care plan monitoring tool document was reviewed. The document showed the time, location, and staff initials to monitor the care plans, f. in-service training documentation, dated 01/15/26, showed team members of the IDT were in-serviced by the VP of reimbursement over ensuring comprehensive care plans were revised after incidents, andg. members of the IDT team were interviewed. The IDT team members were able to communicate they understood the care plan should be updated to reflect interventions in place to prevent elopements after each incident or assessment.This deficient practice remained at an isolated with the potential for more than minimal harm. Based on record review and interview, the facility failed to ensure a resident's comprehensive care (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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	plan was implemented after exit seeking behaviors and elopements to ensure adequate supervision for 1 (#9) of 3 sampled residents reviewed for comprehensive care plans.The administrator identified 82 residents resided in the facility. Findings:A facility policy titled, Comprehensive Care Plans, dated 08/01/24, read in part, The comprehensive care plan will include measurable objectives, and time frames to meet the resident's need as identified in the resident comprehensive assessment. The objective will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. An Elopement Risk Assessment for Resident #9, dated 04/14/25, showed the resident was a high risk for elopement with a score of 10.An admission assessment for Resident #9, dated 04/20/25, showed the resident's cognition was severely impaired with a BIMS score of 2. The assessment showed they were admitted with diagnoses which included dementia and anxiety. The assessment showed Resident #9 had wandering behaviors for one to three days during the seven days look back period. The assessment showed Resident #9 ambulated and transferred independently. A care plan for Resident #9, date initiated 05/08/25, showed a focus for elopement. The care plan showed Resident #9 eloped from the facility on 07/11/25 and on 07/27/25. The care plan showed the following interventions to prevent elopement:a. distract the resident from wandering by offering diversions like food and activities initiated on 05/08/25 and cancelled on 08/06/25,b. identify a pattern of wandering and intervene as appropriate initiated on 07/28/25 and cancelled on 08/06/25, andc. provide structured activities like signs, memory boxes, and walking inside and outside initiated on 05/08/25 and cancelled on 08/06/25.The care plan initiated on 05/08/25 did not show interventions were added to the care plan after the elopement on 07/11/25.An Elopement Risk Assessment for Resident #9, dated 07/11/25, showed the resident was a high risk for elopement with a score of 10.A facility incident report, dated 07/11/25, showed Resident #9 was reported to exit the facility with visitors and was notified by visitors Resident #9 was outside the front door. The report showed Resident #9 was redirected back inside and the resident's care plan was updated to reflect the resident's current status.A facility document titled Resident One on One, dated 07/11/25, showed Resident #9 was on one-on-one supervision on 07/11/25 from 7:30 p.m. to 10:00 p.m. The one-on-one supervision intervention was not added to the care plan.A facility incident report, dated 07/24/25, showed Resident #9 was reported to have attempted to exit the facility when a visitor held the door for the resident. The report showed Resident #9 was redirected back inside and the resident's care plan was updated to reflect the resident's current status.A facility document titled Resident One on One, dated 07/24/25, showed Resident #9 was on one-on-one supervision on 07/24/25 from 1:30 p.m. to 10:00 p.m. The one-on-one supervision intervention was not added to the care plan.A nurse's note for Resident #9, dated 07/27/25, showed the resident was observed by staff walking in the parking lot near the next door storage facility. The note showed Resident #9 was agitated and hard to redirect. The note showed the resident continued to have exit seeking behaviors. A facility incident report, dated 07/28/25, showed Resident #9 was observed by staff on 07/27/25 walking in the parking lot by staff near a busy street and storage facility next door. The report showed the resident was redirected inside, assessed, and the care plan updated to reflect the resident's current status. An Elopement Risk Assessment for Resident #9, dated 08/18/25, showed the resident was a high risk for elopement with a score of 10.A facility incident report, dated 08/23/25, showed Resident #9 was observed by staff walking out the front door after someone entered into the facility. The report showed the resident was redirected inside, assessed, and the care plan updated to reflect the resident's current status. A facility document titled Resident One on One, dated 08/23/25, showed Resident #9 was one-on-one supervision on 08/23/25 from 12:00 p.m. to 10:00 p.m. The one-on-one supervision intervention was not added to the care plan.A facility incident report, (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	dated 09/04/25, showed Resident #9 was observed by staff walking out the front door by a family member. The report showed the staff was notified and the resident was redirected inside, assessed, and the care plan updated to reflect the resident's current status. The report showed alarms were placed on the doors to alert staff and signs were placed to alert visitors of wandering residents.A facility document titled Resident One on One, dated 09/04/25, showed Resident #9 was on one-on-one supervision on 09/04/25 from 10:00 a.m. to 9:00 p.m. The one-on-one supervision intervention was not added to the care plan.A facility incident report, dated 09/30/25, showed Resident #9 was observed by a visitor walking out the front door after they entered into the facility. The report showed the staff was notified and the resident was redirected inside, assessed, and the care plan updated to reflect the resident's current status. The report showed an alarm was placed on the doors to alert staff and signs were placed to alert visitors of wandering residents. A facility document titled Resident One on One, dated 09/30/25, showed Resident #9 was on one-on-one supervision on 09/30/25 from 4:00 p.m. to 10:00 p.m. The one-on-one supervision intervention was not added to the care plan.A care plan for Resident #9, revised 10/14/25, showed a focus related to elopement. The care plan showed Resident #9 was observed to pull on locked doors on 08/21/25. The care plan showed on 08/30/25, Resident #9 walked out of the facility following visitors. The care plan showed the following interventions:a. distract from wandering by offering pleasant diversions, activities, food, and conversations dated 08/19/25,b. observe for fatigue and weight loss dated 08/19/25,c. observe location in the community dated 08/19/25, andd. provide directional cues to reduce distractions dated 08/22/25.A care plan for Resident #9, revised 10/14/25, did not show previous elopements and interventions from Resident #9's care plan initiated on 05/08/25 and cancelled on 08/09/25. The care plan did not show the interventions were revised to include one-on-one supervisions after Resident #9's exit seeking behaviors and elopements on the following dates:a. on 07/11/25, Resident #9 eloped from the facility,b. on 07/24/25, Resident #9 had exit seeking behaviors,c. on 07/27/25, Resident #9 eloped from the facility,d. on 08/23/25, Resident #9 was had exit seeking behaviors,e. on 09/04/25, Resident #9 eloped from the facility, and f. on 09/30/25, Resident #9 eloped from the facility.On 01/14/26 at 1:30 p.m., CNA #2 stated interventions for a resident who was an elopement risk would be found in the care plan. CNA #2 stated they were unsure what to do when a resident had multiple elopement attempts and would report to the RN. They stated if a resident was confused, had dementia, or was always trying to go home, a resident would be at risk for elopement.On 01/14/26 at 1:36 p.m., LPN #2 stated interventions for residents at risk for elopement should be in the resident's care plan. LPN #2 stated Resident #9 eloped from the facility when a visitor let the resident out of the facility. They stated Resident #9 was found in the parking lot near the busy road. LPN #2 stated Resident #9 would shake the exit doors and try to open them. On 01/14/26 at 1:47 p.m., CNA #3 stated they could identify residents at risk for elopement by word of mouth or the care plan. CNA #3 stated there was an elopement book on the [NAME] hall, but they were not sure who checked or looked at the book. CNA #3 stated unless there was a person standing by the exit door twenty-four hours a day, they could not keep track of who was exiting the facility. CNA #3 stated there was a busy road outside the facility and there was a potential for harm if a resident eloped from the facility. On 01/14/26 at 1:47 p.m., ADON #1 stated residents with an elopement risk score on 10 or higher would be considered a high risk for elopement. The ADON stated Resident #9's care plan was revised on 7/15/25 after Resident #9 attempted to exit the facility with visitors on 7/11/25. The ADON stated Resident #9 attempted to exit the facility on 07/24/25 when a delivery driver was leaving. The ADON stated they identified residents at risk for elopement through in-service training, the elopement book with a green sheet, and reporting from nurses.On (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	01/14/26 at 2:17 p.m., the DON stated Resident #9 eloped from the facility on 07/27/25. The DON stated Resident #9 was found in the parking lot near a very busy street. The DON stated there was a potential for harm to Resident #9. The DON stated Resident #9 was placed on focused charting and on one-on-one supervision after an exit seeking attempt on 07/11/25. The DON stated the system failure was related to one-on-one forms to reflect the location of Resident #9, and the facility's lack of documentation in the care plan for the exit seeking and elopements of Resident #9. On 01/14/26 at 4:33 p.m., resident representative #1 stated they were never informed Resident #9 was placed on one-on-one supervision. They stated Resident #9 was moved to a different facility with a memory care because Resident #9 was not safe at the facility due to the residents exit seeking behaviors.

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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** On 01/14/26, an IJ situation was determined to exist related to the facility's failure to ensure Resident #9 had adequate supervision to prevent elopements on 07/11/25, 07/27/25, 09/04/25, and 09/30/25.Resident #9's cognition was severely impaired with a diagnosis of dementia. Resident #9 had three elopement assessments that placed them at high risk for elopement. Resident #9 had two episodes of exit seeking where staff redirected them and brought them back into the facility, and four additional elopements where staff were not aware the resident was gone from the facility. The facility failed to ensure adequate supervision to protect Resident #9 from elopement. Direct Care staff were not aware the resident was at risk for elopement, and stated there was a lack of communication and training. On 01/14/26 at 5:52 p.m., the OSDH was notified and verified the existence of an IJ situation.On 01/14/26 at 6:12 p.m., the administrator, DON, and AIT were notified of the IJ situation and provided the IJ template.On 01/15/26 at 2:30 p.m., an acceptable POR was approved by the OSDH. The POR, read in part, Resident #9 directly involved in this deficient practice is no longer in the facility at this time.Elopement Risk Assessments were completed on 100% of residents.Facility developed and implemented care plans to address elopements for all residents identified as at risk for elopement.An At-Risk Elopement Book with care plan was created and posted at the nurse's station, accessible only to staff, in accordance with HIPAA [Health Insurance Portability and Accountability Act] requirements.All nursing staff on all shifts received immediate education on wandering, elopement, and resident safety from the DON or designee(s).Elopement and wandering residents' policy was reviewed.Facility has implemented appropriate monitoring sheet for our elopement risks residents.An Elopement Response Drill schedule was implemented, with drills occurring quarterly on all shifts.The DON or designee will perform a daily audit of clinical data to ensure adequate supervision is in place and assigned when the attempt to exit seek of active wandering and triggered elopement residents occur.The IJ was lifted, effective 01/15/26, when all components of the POR were verified as corrected:a. Resident #9's discharge MDS, dated [DATE], showed they were discharged to another facility with a memory care unit,b. the facility's documentation showed all residents were reassessed for elopement risk. The assessments identified three residents were at risk for elopement, c. three residents' care plans were reviewed. The care plans showed the residents had a focus and interventions to address the elopement risk,d. the elopement book was reviewed at the nurse's station. The elopement book contained pictures of the three identified resident at risk for elopement, their care plans, and a post elopement check list,e. the care plan monitoring tool document was reviewed. The document showed the time, location, and staff initials to monitor the care plans, f. in-service training documentation, dated 01/15/26, showed forty-three staff members from multiple departments were in-serviced by the DON over elopements and elopement drills, andg. fifteen staff members from multiple departments and shifts were interviewed. All fifteen staff members interviewed were able to communicate how to identify residents at risk for elopement, how to identify interventions for residents at risk, and what to do in the event of an elopement. This deficient practice remained at an isolated level with the potential for more than minimal harm. Based on record review and interview, the facility failed to ensure adequate supervision to prevent elopement for 1 (#9) of 3 sampled residents reviewed for adequate supervision to prevent elopements. The administrator identified 82 residents resided in the facility and three residents who were identified at risk for elopements. Findings: A facility policy titled Elopement and Wandering resident, dated 04/14/24, read in part, This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to decrease the risk (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	of accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering/elopement risk.An Elopement Risk Assessment for Resident #9, dated 04/14/25, showed the resident was a high risk for elopement with a score of 10.An admission assessment for Resident #9, dated 04/20/25, showed the resident's cognition was severely impaired with a BIMS score of 2. The assessment showed they were admitted with diagnoses which included dementia and anxiety. The assessment showed Resident #9 had wandering behaviors for one to three days during the seven day look back period. The assessment showed Resident #9 ambulated and transferred independently. An Elopement Risk Assessment for Resident #9, dated 07/11/25, showed the resident was a high risk for elopement with a score of 10.A facility incident report, dated 07/11/25, showed Resident #9 exited the facility with visitors. The report showed Resident #9 was located outside the front door and was redirected by staff to re-enter the facility. The report showed the care plan of Resident #9 was updated to reflect the elopement. A nurse's note for Resident #9, dated 07/11/25, showed Resident #9 walked out of the front door with visitors. The note showed residents sitting near the door notified staff and Resident #9 was redirected inside. A facility document titled Resident One on One, dated 07/12/25, showed Resident #9 was on one-on-one supervision on 07/11/25 from 7:30 p.m. to 10:00 p.m. The document was not filled out with time intervals showing Resident #9 received the one-on-one supervision. The one-on-one supervisions were not added to the care plan to show increased supervision.A nurse's note for Resident #9, dated 07/12/25, showed the resident was on focused charting and was observed wandering through the facility aimlessly displaying exit seeking behaviors.A nurse's note for Resident #9, dated 07/24/25, showed the resident attempted to exit the facility after following a delivery driver out the door. The note showed family was notified about social services helping to find a locked unit for the resident.A facility incident report, dated 07/24/25, showed Resident #9 was reported to have attempted to exit the facility when a visitor held the door for the resident. The report showed Resident #9 was redirected back inside and the resident's care plan was updated to reflect the resident's current status.A facility document titled Resident One on One, dated 07/24/25, showed Resident #9 was on-one-on supervision on 07/24/25 from 1:30 p.m. to 10:00 p.m. The document was not filled out with time intervals showing Resident #9 received the one-on-one supervision. The one-on-one supervisions were not added to the care plan to show increased supervision.A nurse's note for Resident #9, dated 07/27/25, showed the resident was observed by staff walking toward the storage facility next door outside the facility and redirected to the facility. The note showed the resident was agitated, difficult to redirect, and continued to exit seek. A facility incident report, dated 07/28/25, showed on 07/27/25 Resident #9 was observed by staff walking in the parking lot by staff near a busy street and storage facility next door. The report showed the resident was redirected inside, assessed, and the care plan updated to reflect the resident's current status. An Elopement Risk Assessment for Resident #9, dated 08/18/25, showed the resident was a high risk for elopement with a score of 10.A nurse's note for Resident #9, dated 08/21/25, showed the resident was wandering in and outside the room throughout the shift. A facility incident report, dated 08/23/25, showed Resident #9 was observed by staff walking out the front door after someone entered into the facility. The report showed the resident was redirected inside, assessed, and the care plan updated to reflect the resident's current status.A nurse's note for Resident #9's, dated 08/23/25, showed the resident walked out of the facility following another resident. The note showed staff witnessed the resident leaving and redirected them back into the facility. A facility document titled Resident One on One, dated 08/23/25, showed Resident #9 was on one-on-one supervision on 07/24/25 from 12:00 p.m. to 10:00 p.m. The document was not filled out with time intervals showing Resident #9 received (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the one-on-one supervision. The one-on-one supervision intervention was not added to the care plan to show increased supervision.A facility incident report, dated 09/04/25, showed Resident #9 was observed by staff walking out the front door with a visitor. The report showed the staff were notified and the resident was redirected inside, assessed, and the care plan updated to reflect the resident's current status. The report showed alarms were placed on the doors to alert staff and signs were placed to alert visitors of wandering residents.A nurse's note for Resident #9, dated 09/04/25, showed another resident's family was leaving the facility when Resident #9 was observed outside. The note showed the exiting visitor notified the staff Resident #9 was by the curb outside the facility and returned to the facility by a staff members car. A facility document titled Resident One on One, dated 09/04/25, showed Resident #9 was on one-on-one supervision on 09/04/25 from 10:00 a.m. to 9:00 p.m. The document was not filled out with time intervals showing Resident #9 received the one-on one supervision. The one-on-one supervision intervention was not added to the care plan to show increased supervision.A nurse's note for Resident #9, dated 09/05/25, showed the resident was wandering the facility and walking up to the front doors. The note showed Resident #9 was redirected. A facility incident report, dated 09/30/25, showed Resident #9 was observed by a visitor walking out the front door after they entered into the facility. The report showed the staff was notified and the resident was redirected inside, assessed, and the care plan updated to reflect the resident's current status. The report showed an alarm was placed on the doors to alert staff and signs were placed to alert visitors of wandering residents. A nurse's note for Resident #9, dated 09/30/25, showed the resident exited the doors behind a visitor. The note showed Resident #9 was redirected back inside the facility. A facility document titled Resident One on One, dated 09/30/25, showed Resident #9 was on one-on-one supervision on 09/30/25 from 4:00 p.m. to 10:00 p.m. The document was not filled out with intervals showing Resident #9 received the one-on one supervision. The one-on-one supervision intervention was not added to the care plan.A care plan for Resident #9, revised 10/14/25, showed a focus related to elopement. The care plan showed Resident #9 was observed to pull on locked doors on 08/21/25. The care plan showed on 08/30/25 Resident #9 walked out of the facility following visitors. The care plan showed the following interventions:a. distract from wandering by offering pleasant diversions, activities, food, and conversations dated 08/19/25,b. observe for fatigue and weight loss dated 08/19/25,c. observe location in the community dated 08/19/25, andd. provide directional cues to reduce distractions dated 08/22/25.The care plan did not show interventions were updated to increase supervision after Resident #9's exit seeking and wandering on 07/24/25 and 08/23/25. The care plan did not show interventions for increased supervision after elopements on 07/11/25, 07/27/25, 09/04/25, and 09/30/25.On 01/14/26 at 1:30 p.m., CNA #2 stated interventions for a resident who was an elopement risk would be found in the care plan. CNA #2 stated they were unsure what to do when a resident had multiple elopement attempts and would report to the RN.On 01/14/26 at 1:36 p.m., LPN #2 stated Resident #9 eloped from the facility when a visitor let the resident out of the facility. LPN #2 stated Resident #9 would shake the exit doors and try to open them. On 01/14/26 at 1:47 p.m., CNA #3 stated they could identify residents at risk for elopement by word of mouth or the care plan. CNA #3 stated there was an elopement book on the [NAME] hall, but they were not sure who checked or looked at the book. CNA #3 stated unless there was a person standing by the exit door twenty-four hours a day, they could not keep track of who was exiting the facility. CNA #3 stated there was a busy road outside the facility and there was a potential for harm if a resident eloped from the facility. On 01/14/26 at 1:47 p.m., ADON #1 stated a resident with an elopement risk score on 10 or higher would be considered a high risk for elopement. On 01/14/26 at 2:17 p.m., the DON stated Resident #9 eloped from (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the facility on 07/27/25. The DON stated Resident #9 was found in the parking lot near a very busy street. The DON stated there was a potential for harm to Resident #9. The DON stated Resident #9 was placed on focused charting and on one-on-one supervision on 07/11/25 after an exit seeking attempt. The DON stated the system failure was related to one-on-one forms were not completed by staff to reflect the Resident #9's location in time intervals and there was no documentation the one-on-ones were added to Resident #9s care plan to ensure adequate supervision after elopements and exit seeking attempts on 07/11/25, 07/24/25, 07/27/25, 08/23/25, 09/04/25, and 09/30/25. The DON stated Resident #9 should have been on one-on-one supervision after the first exit seeking attempt on 07/11/25 to ensure adequate supervision.On 01/14/26 at 4:33 p.m., resident representative #1 stated they were never informed Resident #9 was placed on one-on-one supervision. They stated Resident #9 was moved to a different facility with a memory care because Resident #9 was not safe at the facility due to exit seeking attempts and elopements.