STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455390	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Vida Nursing and Rehab-San Antonio	5027 Pecan Grove San Antonio, TX 78222

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 - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident to meet a resident's medical, nursing, and mental and psychosocial needs for 4 of 11 residents (Residents #1, #2, #3, and #4) reviewed for comprehensive care planning. The facility failed to develop and implement comprehensive care planning for assessed elopement risks of Residents #1, #2, #3, and #4. This failure could lead to residents not receiving necessary care and decreased quality of life. Findings included: 1.Record review of Resident #1's admission Record, dated 1/13/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included dementia (a progressive disorder that affects memory, reasoning, and other cognitive processes), adjustment disorder (emotional or behavioral reactions to stressful life events), alcohol abuse, and psychosis (a loss of contact with reality). Record review of Resident #1's quarterly MDS, submitted 12/3/2025, reflected a BIMS score of 06, which indicated severely impaired cognition. Section E0900 of the MDS reflected Resident #1 did not exhibit wandering behavior during the assessment period. Record review of Resident #1's Care Plan Report, undated/printed 1/13/2025, revealed the following:Resident wants to go across the street to visit his friend. Resident left facility without notifying staff to corner store [sic]. (Date initiated: 9/05/2025, revision on 9/08/2025)SW/Staff will remind resident of safety concerns (date initiated 9/08/2025, revision on 9/08/2025)Resident sent to [Psychiatric Facility] in [location] for review of medications due to his increased anxiety and agitation in relation to missing his friend placed at another facility (date initiated 9/08/2025, revision on 9/08/2025)Further record review of Resident #1's care plan report did not reveal care planning related to the ongoing risk of elopement. Record review of Resident #1's Elopement Risk Assessment- V 6 revealed the following:assessment dated [DATE], score of 24- elopement riskassessment dated [DATE], score of 19- elopement riskassessment dated [DATE], score of 17- elopement riskNo additional Elopement Risk Assessments were documented between 9/22/2025 and survey entrance on 1/13/2026. Record review of the facility incident reported dated 1/13/2025 reflected Resident #1 eloped from the facility on 9/05/2025 at 6:45 PM. In an observation and interview on 1/14/2026 at 9:44 AM, Resident #1 was observed ambulating independently in the first-floor common area of the facility. Resident #1 could not recall the elopement incident, nor could he state what the facility procedure was for leaving the premises. Resident #1 stated if he wanted to leave the facility, he would walk out of the front door. He was unsure if he should tell staff prior to leaving. 2.Record review of Resident #2's admission Record, dated 1/15/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included psychotic disorder with delusions (a loss of contact with reality with firmly held false beliefs). Record review of Resident #2's annual MDS, submitted 12/16/2025, reflected a BIMS score of 06, which indicated severely impaired cognition. Section E0900 of the MDS reflected Resident #2 did not exhibit wandering behavior during the (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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessment period. Record review of Resident #2's Elopement Risk Assessment V 6 reflected the most recent assessment was dated 10/15/2025 and scored 12, which indicated elopement risk. Record review of Resident #2's Care Plan Report, undated/printed 1/15/2026, did not reveal care planning related to elopement risk. In an observation and interview on 1/15/2026 at 10:08 AM, Resident #2 was observed in the common area of the second floor, interacting with staff. While conversational, Resident #2 was unable to participate in the interview in a meaningful way due to her mental status. Resident #2 did not answer interview questions and only wanted to discuss her personal history. 3.Record review of Resident #3's admission Record, dated 1/15/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included herpesviral [sic] encephalitis (severe inflammation of the brain caused by a viral infection that can result in confusion and personality changes). Record review of Resident #3's admission MDS, submitted 11/04/2025, reflected a BIMS score of 15, which indicated intact cognition. Section E0900 of the MDS reflected Resident #3 did not exhibit wandering behavior during the assessment period. Record review of Resident #3's Elopement Risk Assessment V 6 reflected the most recent assessment was dated 10/28/2025 and scored 23, which indicated elopement risk. Record review of Resident #3's Care Plan Report, undated/printed 1/15/2026, did not reveal care planning related to elopement risk. In an interview and observation of Resident #3 on 1/14/2026 at 3:10 PM, Resident #3 was observed in an unoccupied wing on the first floor of the facility. Resident #3 was inspecting a handrail on the wall. No staff were present in the hallway. Resident #3 stated he has never attempted to leave the facility, and he then ended the interview to return to his room. 4.Record review of Resident #4's admission Record, dated 1/15/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included dementia. Record review of Resident #4's annual MDS, submitted 10/03/2025, reflected a BIMS score of 01, which indicated severely impaired cognition. Section E0900 of the MDS reflected Resident #4 exhibited wandering behavior daily during the assessment period. Record review of Resident #4's Elopement Risk Assessment V 6 reflected the most recent assessment was dated 12/15/2025 and scored 21, which indicated elopement risk. Record review of Resident #4's Care Plan Report, undated/printed 1/15/2026, did not reveal care planning related to elopement risk. In an observation and attempted interview of Resident #4 on 1/15/2026 at 10:10 AM, Resident #4 was observed sleeping in his bed. Resident #4 awoke upon surveyor entry to the room but declined to participate in the interview. In an interview with the RCN on 1/14/2026 at 9:50 AM, she said the facility underwent a leadership change in October 2025, including the Admin, DON, and MDS/care plan nurse. She said care plans were being overseen by the current DON, but that she was new to the role and had not yet reviewed every care plan from the former administration. In an interview with the ADO on 1/15/2026 at 12:23 PM, she said she felt comfortable speaking about the care plan process for the facility as she was involved in the daily functions during the administration transition period. She said the facility utilizes Elopement Risk Assessments to alert the IDT of a resident's potential for elopement, and the IDT will then determine specific risks and interventions for each resident and discuss possible placement in a secured unit for safety. She was unaware the care plans for Residents #1-4 did not contain planning for elopement risks, and she said the care plans should contain what is discussed during IDT. Record review of the facility policy titled Comprehensive Care Planning, undated/printed 1/15/2026, revealed the following: When developing the comprehensive care plan, facility staff will, at a minimum, use the [MDS] to assess the resident's clinical condition, cognitive and functional status, and use of services there may be times when a resident risk, weakness or need is identified within the context of the MDS assessment but may not cause a CAA to trigger. The facility will address these areas and will document the assessment of these (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	risks, weaknesses, or needs in the medical record and determine whether or not to develop a care plan and interventions to address the area .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident receives adequate supervision to prevent accidents for 1 of 11 residents (Resident #1) reviewed for accidents and hazards. The facility failed to ensure Resident #1 received adequate supervision and did not elope from the facility on 9/05/2025 at approximately 6:15 PM until he was returned to the facility by a visitor at 6:45 PM. The noncompliance was identified as PNC. The IJ began on 9/05/2025 at approximately 6:15 PM and ended on 9/06/2025 at 5:30 PM. The facility had corrected the noncompliance before the survey began. The failure could place residents at-risk of injury or death due to not being adequately supervised. Findings included: Record review of Resident #1's admission Record, dated 1/13/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included dementia (a progressive disorder that affects memory, reasoning, and other cognitive processes), adjustment disorder (emotional or behavioral reactions to stressful life events), alcohol abuse, and psychosis (a loss of contact with reality). Record review of Resident #1's quarterly MDS, submitted 12/3/2025, reflected a BIMS score of 06, which indicated severely impaired cognition. Section E0900 of the MDS reflected Resident #1 did not exhibit wandering behavior during the assessment period. Resident #1's prior MDS, submitted 9/1/2025, also reflected a BIMS score of 06, but indicated in section E0900 that Resident #1 exhibited wander behavior daily. Section GG0115 reflected no impairment of Resident #1's upper or lower limbs, and section GG0120 indicated Resident #1 did not require a mobility device for ambulation. Record review of Resident #1's Care Plan Report, undated/printed 1/13/2025, revealed the following: Resident wants to go across the street to visit his friend. Resident left facility without notifying staff to corner store [sic]. (Date initiated: 9/05/2025, revision on 9/08/2025)SW/Staff will remind resident of safety concerns (date initiated 9/08/2025, revision on 9/08/2025)Resident sent to [Psychiatric Facility] in [location] for review of medications due to his increased anxiety and agitation in relation to missing his friend placed at another facility (date initiated 9/08/2025, revision on 9/08/2025)Further record review of Resident #1's care plan report did not reveal care planning related to the ongoing risk of elopement. Record review of Resident #1's Elopement Risk Assessment- V 6 revealed the following:assessment dated [DATE], score of 24- elopement riskassessment dated [DATE], score of 19- elopement riskassessment dated [DATE], score of 17- elopement risk Record review of Resident's #1's progress notes revealed the following:Progress note dated 9/3/2025 11:37 AM by DON C: Resident expressed that he wanted to leave and go see his friend [friend] who no longer resides here. Resident was informed that his friend is in [other city]. He stated that he wants to walk there. He was redirected and taken by social worker to call [friend].Progress note dated 9/3/2025 6:19 PM by DON C: Resident has given consent to move rooms in the secured unit. After spending some time in the unit. resident expressed that he does not want to be back there. He is his own responsible party. Nursing to observe for elopement or exit seeking behaviors.Progress note dated 9/03/2025 10:53 PM by RN B: Noted patient is anxious and agitated. Place patient under 15 minute monitoring during shift. At this time resident is at his bedroom sleeping. Will give report to night nurseProgress note dated 9/04/2025 6:23 PM by LVN A: Resident is pacing in front of the door to exit the building in the main lobby. He is intently focusing on the door sign that indicates how to open after 15 secs of pushing. He sat down in the chair when this nurse approached and said, I just want out. [Friend] is out there and I want to see her. This nurse asked if a call with her would be nice he said no he wanted to leave again. This nurse stayed with the resident in the front for 25 min. The resident went back to the 2nd floor and came down. ADON and Administrator notified of the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	behavior.Progress note dated 9/05/2025 4:37 AM by LVN A: Pacing up and down the hall and taking the elevator to go to first floor, continues to go from second to first floor. Interventions: Q15 minute monitoring, [sic]Progress note dated 9/05/2025 1:07 PM by DON C: On 8/29/2025, [Resident #1] was involved in a resident-to-resident altercation. Immediately afterward, he was placed on 1:1 monitoring until cleared by the psychiatrist. The resident continued to experience increased anxiety and expressed a desire to leave the facility to be with a former resident friend. On 9/2/25, he had a consultation with [Telehealth Company] and was advised to find ways to communicate with the former patient. The Activity Director contacted the other facility and arranged video calls between the resident and the former resident. The psychiatrist also increased Depakote dosage. Staff have monitored him for further agitation and anxiety, with ongoing signs of nervousness and a short temper with staff. During the IDT review with [NP], he recommended sending the patient to a higher level of care for medication adjustment. Patient referral sent to [inpatient psychiatric hospital] for review.Progress note dated 9/05/2025 6:45 PM by DON C: Called [inpatient psychiatric hospital] to find out if resident was accepted. Spoke to [hospital staff] and did a nurse to nurse report. He was accepted for admission. Pending transportationProgress note dated 9/05/2025 6:45 PM by DON C: LATE ENTRY [sic] Note text: Event-Elopement/Attempted . Door Exited: Front door / How long missing: approx 30 min / Where was the resident discovered: Resident was at the convenience store / Resident alert and oriented x 4 resident was aware that [sic] he should not have left without notifying the staff that he was leaving / Injuries: No / Cognition / Behavior at Time of Event: Oriented / no problem, / Resident returned to the facility on 9/5/2025 at approximately 6:40 pm after he had left the facility for approximately 30 minutes. Staff were not aware that resident had left the facility as resident did not properly sign himself out. Head to toe assessment was completed upon his return, resident did not have injuries and was not in any emotional or physical distress. Resident is A&O x4 and stated that he should not have left and not tell the staff that he was leaving / Initial Treatment/New Orders: n/a / Resident Statement: I know i [sic] know i [sic] wanted to see [friend] didn't think it was that far. I know i [sic] should have told yall i [sic] was going . / Interventions: 1 on 1 supervision, educated resident on the sign out processProgress note dated 9/05/2025 10:14 PM by RN B: Patient was high risk for elopement. Patient was place [sic] on every 15 minutes monitoring. During meal time [sic] nurse was checking the tray patient [sic] was still at the hallway. CNA asked patient if he will join the other residents in the dining room. [sic] while nurse is watching the dining room and feeding residents at the second floor. Resident went downstairs and managed to come out of the front door at the first floor. Administrator, DON, ADON where [sic] at the first floor at that time. ADON brought the patient back to the second floor. Received patient with drink on]sic] his hand and asked how he got out. Patient stated i [sic]pushed the door because it did not close completely and i [sic] got out but i [sic] came back. Nurse assessed the patient, V/S are within normal limit [sic]. Also stated I been requesting to visit my friend but they always says NO [sic]. nurse [sic] offered patient to go to his room so he can rest and cool down. Nurse kept monitoring patient and offered water to drink. DON arranged for the patient to be transferred to [inpatient psychiatric hospital] for his behavior. Transportation arrived and nurse handed all the paper works [sic] to EMT including 2 t shirts, 2 pants and 2 under wears [sic]. Patient Transferred [sic] from bed to stretcher safely and wheeled to the ambulance a little after 10 pm [sic]. Reported to Night shift nurse. [sic]Further record review of Resident #1's progress notes reflected Resident #1 readmitted to the facility on [DATE]. No documentation regarding additional elopements, actual or attempted, was documented from 9/22/2025 through 1/13/2026. Record review of Resident #1's Kardex dated 1/15/2026 reflected the following: If the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident has physical behaviors toward another resident, immediately intervene to protect the residents involved and call for assistance. [Resident #1] will be monitor/record [sic] occurrence of for target behavior symptoms pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others and document per facility protocol. Record review of the facility document titled Incidents By Incident Type date range 8/1/2025 to 1/13/2026 reflected one elopement or attempt incident on 9/05/2025 at 6:45 PM for Resident #1. There were no additional incidents in this category listed on the report. Record review of the facility document titled Self-Reporting Protocol/Ad Hoc QAPI- Missing Resident or Elopement dated 9/05/2025 revealed the facility began investigating Resident #1's elopement incident on 9/05/2025. This investigation included assessment of Resident #1 on 9/05/2025 and a review and update of the care plan for Resident #1, reassessments of all residents in the facility for elopement risks, and updated care plans for any resident who has been assessed to be a high risk for elopement. Additionally, the document reflected an in-service for facility staff was initiated on 9/05/2025 regarding elopement; resident rights, signage was placed at the front door to remind visitors to be mindful of residents attempting to exit the facility on 9/05/2025, and the security code for the door was changed on 9/05/2025. Record review of a written statement from RN B dated 9/05/2025 revealed RN B observed Resident #1 in the hallway of the second floor of the facility prior to dinner. RN B then assisted with the dinner service in the dining room and did not observe Resident #1 during the meal. RN B was providing care for other residents after dinner when the ADON brought Resident #1 to the second floor, at which time she performed an assessment and found no injuries. Resident #1 left the facility for the inpatient psychiatric hospital between 10:00 and 10:30 PM. Record review of the facility document titled 1:1 Observation Form dated 9/05/2025 reflected 1:1 observation was initiated for Resident #1 on 9/05/2025 at 6:40 PM and ended 9/05/2025 (no time documented). Record review of the facility document titled Coaching Form dated 9/05/2025 revealed RN B received verbal and written coaching/education for the documented situation of [Resident #1] was on 15 min [sic] checks related to aggressive behaviors. Nurse failed to monitor resident appropriately at dinner time. Record review of the facility document titled Monitoring for Door Locking/Alarm function Properly reflected the facility made daily checks of the front door from 9/05/2025 to 9/12/2025. Record review of the facility document titled Record of Departmental In Service [sic] and Meetings reflected the facility conducted elopement drills for staff on 9/08/2025 at 11:00 PM, 9/10/2025 at 8:00 AM, and 9/12/2025 at 3:30 (time of day not documented). Record review of the facility document titled Elopement Drill or Actual Elopement Guide revealed additional elopement drills were conducted on 11/10/2025 at 3:05 PM and 12/18/2025 at 5:15 AM. Record review of the facility document titled Missing Resident Elopement Monitoring revealed the facility performed observations of front door entry/exit on 9/08/2025, 9/09/2025, 9/10/2025, 9/11/2025, and 9/12/2025. The locking mechanism and alarm function were tested daily 9/05/2025 through 9/09/2025, and elopement drills were conducted as previously notated. Record review of the facility document titled Actual/Alleged Abuse Monitoring revealed two staff members were interviewed about abuse/neglect procedures on 9/08/2025 through 9/11/2025, and 5 total residents were interviewed about potential abuse/neglect from 9/05/2025 to 9/10/2025. Record review of facility document titled Task List Report dated 1/15/2026 revealed behavior monitoring assigned to all residents for staff documentation daily on every shift. Record review of the facility document titled In-Service Program Attendance Record reflected training for elopement prevention and elopement response was conducted on 9/05/2025. A staff roster attached to the document reflected all staff had received the in-service. In an observation on 1/13/2026 at 10:00 AM, signage was observed on the front door of the facility directing visitors to not allow (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	residents to exit without first notifying staff. A receptionist was seated at a desk facing the front door of the facility. The desk had an unobstructed view of the front lobby. The front door was locked, and the pressure bar initiated an alarm when pushed. In an observation on 1/3/2026 at 4:00 PM, a gas station was observed directly across a two lane street from the facility, approximately 25 yards away. The facility and the gas station were observed to be on opposite sides of a four-way stop, and the traffic was minimal. Observed vehicles were traveling at low speeds, approximately 30 miles per hour. In an observation and interview on 1/14/2026 at 9:44 AM, Resident #1 was observed ambulating independently in the first-floor common area of the facility. Resident #1 could not recall the elopement incident, nor could he state what the facility procedure was for leaving the premises. Resident #1 stated if he wanted to leave the facility, he would walk out of the front door. He was unsure if he should tell staff prior to leaving. RN B did not respond to a request for interview left by voicemail on 1/14/2026 at 9:03 AM. In an interview with the RCN on 1/14/2026 at 9:50 AM, she said the Admin and DON employed by the facility at the time of Resident #1's elopement incident were no longer employees. She said Resident #1 eloped from the facility after a staff member failed to ensure the door was closed after entering the facility for the scheduled shift. She said Resident #1 was discovered by a former employee at the gas station who recognized Resident #1. The former employee notified the RCN of Resident #1's elopement, and she returned Resident #1 to the facility. She said Resident #1 should have been visualized by the staff every fifteen minutes, as ordered by the NP, but RN B failed to ensure the observations were conducted. She said RN B received written and verbal counseling for the incident. She said in response to the investigation, the facility also hired a receptionist to monitor the front lobby during the daytime hours, placed signage directing visitors and staff to not allow residents to exit, and performed multiple elopement drills. She said that in-services about elopements, including door entrance safety, were given to all staff members, and a new procedure for new employees was introduced to include elopement training. She reported no additional elopement attempts from any residents, and she said Resident #1's medications were adjusted while he was at the inpatient psychiatric facility, and he had not exhibited any negative behaviors since readmission. In an interview on 1/14/2026 at 2:13 PM, the Admin stated all staff received on-the-spot in-servicing regarding procedures and expectations of 1:1 observations at the time the staff member is assigned to service as the 1:1 observer. She said the facility policy was to maintain visual observation of the resident at all times during 1:1 observation, and a resident requiring 15 minute observations would be visualized every fifteen minutes to ensure location and safety. She said LVN A was on medical leave at the time of survey. In an interview on 1/15/2026 at 12:23 PM, the ADO said Resident #1 had been stable since readmission. She said all residents are monitored for wandering and elopement through assigned behavior monitoring by all clinical staff and the results are reviewed during the daily meeting. She said that all staff at the facility have been in-serviced about elopement procedures, including the risk of exit from the front door. The following staff interviews were conducted regarding elopement training:NA K was interviewed on 1/13/2026 at 12:50 PM. She said she had received training about abuse, neglect, and elopements from the facility and would report any issues to the nurse and administrator. NA L was interviewed on 1/13/2026 at 3:18 PM. She said she had received training from the facility about elopements and had participated in an elopement drill. NA M was interviewed on 1/13//2026 at 2:32 PM. She said she had received in-service training about elopements and frequent monitoring for residents who were at risk for elopements. NA N was interviewed on 1/14/2026 at 2:24 PM. She said she had received the elopement training from the facility and would notify her nurse to initiate the missing resident procedure if she could not locate a resident. NA O was (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	interviewed on 1/15/2026 at 4:30 PM. She said she had received training about elopements from the facility, and she would notify the nurse if a resident was missing. NA D was interviewed on 1/16/2026 at 8:50 AM. She said she had received training about elopements from the facility, as well as abuse/neglect and 1:1 observations. RN E was interviewed on 1/13/2026 at 2:35 PM. He said he had received training from the facility about elopement procedures and the process for locating a missing resident. LVN F was interviewed on 1/13/2026 at 3:11 PM. She said she had participated in an elopement drill and had training about elopements. LVN G was interviewed on 1/14/2026 at 2:39 PM. She said she had participated in an elopement drill and had training about elopements. LVN H was interviewed on 1/15/2026 at 4:15 PM. She said she had training from the facility about 1:1s and elopements. LVN I was interviewed on 1/16/2026 at 8:40 AM. He said he had received training from the facility about elopements. Receptionist P was interviewed on 1/14/2026 at 8:15 AM. She said she had received training about elopements and making sure residents do not exit from the front door without notifying staff. The noncompliance was identified as PNC. The IJ began on 9/05/2025 at approximately 6:15 PM and ended on 9/06/2025 at 5:30 PM. The facility had corrected the noncompliance before the survey began.