STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455497	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Terrace Rehabilitation	1555 Powell Avenue Belton, TX 76513

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records review the facility failed to ensure each resident Quarterly Review Assessment A was completed not less frequently than once every 3 months for one (Resident #1) three residents review for assessment in that:The facility failed to complete Resident #1's quarterly MDS assessment and elopement assessment for more than 3 months. This deficient practice placed Residents at risk for not getting right interventions, risk for harm and hospitalizationFindings included:Review of Resident #1's face sheet printed 06/07/2026 revealed a [AGE] year-old male with admission date of 01/15/2026 and readmission date of 06/07/2026, diagnoses include unspecified Dementia (decline in mental abilities severe enough to interfere with daily life, with unknown underlying cause), Anxiety disorder (a group of treatable mental health conditions characterized by persistent, excessive, and uncontrollable fear or worry in non-threatening situations), Psychotic disorder with delusions due to known physiological condition (a condition where false, fixed beliefs (delusions) are directly caused by a physical illness or neurological disorder rather than a primary mental illness). Review of Resident #1's quarterly minimum data set (MDS) assessment dated [DATE] revealed a brief interview for mental status (BIMS) score of 06, severely impaired. No risk for elopement. There were no other MDS assessments completed for Resident #1 after 02/18/2026 which was over 3 months since the last assessment. Review of R#1's progress notes dated 04/21/2026 at 11:26 pm reflected Resident #1 had exit seeking behavior. Review of Resident #1's Care Plan initiated 4/22/2026 revealed Resident #1 had Behavioral Symptoms [Resident#1] wanders through out the facility, is a risk for 1. Elopement 2. exit seeking behavior 3. fall risk. Related to diagnosis of Dementia. Resident verbalizes wanting to smoke. Resident #1's care plan also reflected Resident #1 had documented wandering in nurse's station and he was at risk for complications. It reflected Resident #1 required assistance with his ADLs 2/2 muscle weakness, lack of coordination, need for assistance with his ADLs, intake of anti-anxiety medication. Review of Resident #1's Elopement assessments reflected an elopement assessment was completed for Resident #1 on 01/15/2026 upon admission and on 06/07/2026 after the incident. The was no elopement assessment completed for Resident # 1 on 04/21/2026 when he had exit seeking behavior. There was no quarterly elopement assessment completed for Resident #1 after the initial assessment post admission. During an interview on 06/07/2026 at 5:13 pm the DON stated if there was a quarterly MDS done in 2/18/2026 for Resident #1, he should have had the next assessment done in May 2026 along with elopement assessment. The DON stated MDS assessments and elopement assessments were done quarterly and as needed when there were changes. The DON stated the staff were supposed to complete an elopement assessment for Resident #1 in April of 2026 when he had an exit seeking behavior. During an interview on 06/07/2026 at 5:30 pm the Administrator stated elopement risk assessment was done on admission and quarterly. The Administrator stated it was important to do quarterly assessment to identify any other risk. The Administrator stated when Resident #1 had exit seeking behavior sometimes in April 2026, the facility should have completed elopement assessment. During an interview on 06/07/2026 at 5:44 pm, MDS Nurse A stated MDS assessments were done upon admission and quarterly. MDS Nurse A stated Resident #1's last quarterly MDS assessment was (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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	done 2/18/2026, there should have been another quarterly MDS assessment completed on 05/18/2026. MDS Nurse A stated MDS Nurse B was responsible to complete Resident #1's quarterly MDS assessments. During an interview on 06/08/2026 at 09:58 am, MDS Nurse B stated she was responsible to complete Resident #1's MDS assessments. MDS Nurse B stated MDS assessments were done every 92 days to be in compliance. MDS Nurse B stated if Resident #1's last MDS assessment was completed on 02/18/2026, there should have been another assessment on 05/18/2026. MDS Nurse B stated that was a missed assessment and it would be completed by the end of the day. MDS Nurse B stated the floor nurses were responsible for completing elopement assessments. MDS Nurse B stated elopement assessment should be done if a resident had risk or history of elopement. MDS Nurse B stated the elopement assessment would indicate that the residents needed more observation and to bring awareness to the staff. MDS Nurse B stated elopement assessment should be done with every MDS assessment and as needed. Review of facility's policy titled NURSING POLICIES AND PROCEDURES- MINIMUM DATA SET (MDS) with revision date of 09/28/2023 reflected:Policy:A licensed nurse will conduct or coordinate each assessment with the interdisciplinary team. An MOS, which is a comprehensive, accurate, standardized reproducible assessment will be completed for each resident, using the RAI process. Facility staff complete a comprehensive assessment of each resident's needs, strengths, goals, life history, and preferences, and offer guidance for further assessment once problems have been identified. The comprehensive assessment is completed initially and periodically.Quarterly and Significant Change assessments are completed as required, following the RAI specific guidelines. State-specific versions of such assessments are completed within the required timeframes according to applicable law and regulations. The Facility uses the RAI specified by CMS {which includes the MOS, utilization guidelines and the CAAs) to assess each resident and develop a comprehensive care plan. The facility is responsible for addressing all the needs and strengths of each resident. Each staff member will note their liability for the accuracy of the data recorded by signing {electronically) their name and identifying the MOS sections and questions to which they provided responses. A registered nurse (RN) must sign and certify that the assessment is completed. Procedures:Each assessment must represent an accurate picture of the resident's status during the observation period of the MOS. When the MOS is completed, onlythose occurrences during the observation period will be captured on the assessment. If it did not occur during the observation period, it is not coded on the MOS.A quarterly review assessment is completed using the standardized Quarterly review assessment tool specified by the State and approved by CMS no less than once every 3 months between comprehensive assessments. The quarterly MOS does not require the completion of CAAs, however the resident's care plan must be reviewed and revised by the interdisciplinary team after each assessment.

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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 residents' environment remained as free of accident hazards as possible and ensure each resident received adequate supervision and assistance devices to prevent accidents for one of three residents (Resident #1) reviewed for accidents and hazards. The facility failed to prevent Resident #1 from eloping from the facility. Resident #1 eloped from the facility and was found by local PD on a nearby highway with a speed limit of 70 mph on a sunny day with outside temperatures ranging from 88 to 89 degrees on 06/06/2026 at about 3:30 pm to 4:40 pm. The noncompliance was identified as PNC. The IJ began on 06/06/2026 and ended on 06/07/2026. The facility had corrected the noncompliance before the survey began. This deficient practice placed residents at risk for unsafe elopements, falls, injuries, and hospitalization.Findings included: Review of Resident #1's face sheet printed 06/07/2026 revealed a [AGE] year-old male with admission date of 01/15/2026 and readmission date of 06/07/2026, diagnoses include unspecified Dementia (decline in mental abilities severe enough to interfere with daily life, with unknown underlying cause), Anxiety disorder (a group of treatable mental health conditions characterized by persistent, excessive, and uncontrollable fear or worry in non-threatening situations), Psychotic disorder with delusions due to known physiological condition (a condition where false, fixed beliefs (delusions) are directly caused by a physical illness or neurological disorder rather than a primary mental illness). Review of Resident #1's quarterly minimum data set (MDS) assessment dated [DATE] revealed a brief interview for mental status (BIMS) score of 06, severely impaired. No risk for elopement. Review of R#1's progress notes dated 04/21/2026 at 11:26 pm reflected Resident #1 had exit seeking behavior. Review of Resident #1's Care Plan initiated 4/22/2026 after the exit seeking behavior revealed Resident #1 had Behavioral Symptoms [R#1] wanders through out the facility, is a risk for 1. Elopement 2. exit seeking behavior 3. fall risk. Related to diagnosis of Dementia. Residents verbalize wanting to smoke. Resident #1's care plan also reflected Resident #1 had documented wandering in nurse's station and he was at risk for complications. It reflected Resident #1 required assistance with his ADLs 2/2 muscle weakness, lack of coordination, need for assistance with his ADLs, intake of anti-anxiety medication. Review of Resident #1's progress notes dated 04/21/2026 at 11:26 pm reflected: At 6pm this nurse was given report that the resident had had an episode of attempting to leave the facility. Resident was observed by this nurse wandering through the halls. After report this nurse went to speak to resident and resident stated, All I want to do is go outside and smoke a cigarette. Resident did not appear agitated and was calmly stating why he was attempting to go outside the facility. This nurse explained to resident that the facility was a non smoking campus. I also explained to him that we do not have cigarettes available. Resident stayed on his [NAME] to go outside to smoke without a tangible way to even carry this out, being he has no cigarette or lighter to smoke with even if he did go outside. This nurse stayed with the resident as he was wandering through the halls. Resident would wander to an exit door and look through the window. Resident did appear to attempt to press the code key pad at one point but was easily redirected. Resident was given fresh ice water per his request. This nurse asked resident if he would like a nicotine patch and resident refused. Per policy the DON was notified and the on call provider was called. New orders were received for CBC, CMP, UA, U/C&S and for Nicotine patch. Orders entered. Resident was closely monitored by this nurse. Resident went to his room and got ready for bed at 8:15pm and has been in his bed resting quietly with no complaints since then. Resident has fresh fluids and snacks and call light in reach. Review of Resident #1's progress notes from 04/22/2026 through 04/28/2026 reflected Resident #1 was being monitored for exit seeking behaviors and there were none noted. Review of Resident #1's hospital records dated 06/06/2026 reflected the following:Temperature of 102.7 degrees at 05:04 pm, chest x-ray (is a quick, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	painless imaging test that passes a small amount of electromagnetic radiation through your body) reflected no evidence of acute cardiopulmonary (refers to the body's interrelated heart (cardio) and lungs (pulmonary).) abnormality, no pleural effusion or pneumothorax (occurs when air leaks into the space between your lung and your chest wall), CT scan(is an advanced imaging test that combines a series of X-ray views taken from various angles to create detailed, cross-sectional slices of bones, organs, and soft tissues)of the head reflected no acute intercranial abnormality. Resident #1 was given IV lactated Ringers 1,000 mL bolus at 5:32 pm and 5:52 pm respectively. Review of Resident #1's Elopement assessments reflected an elopement assessment was completed for Resident #1 on 01/15/2026 upon admission and on 06/07/2026 after the incident. Reviewed of Resident #1's progress notes dated 06/07/2026 at 2:46 pm written by the Social Worker reflected: submitted MCU referral to [another facility]. RP updated on referral and LMSW will follow up with RP with any further updates in transfer process. RP in agreement and appreciates call. LMSW to continue to assist and support in transfer process. Review of Resident #1's progress notes dated 06/08/2026 at 11:00 am written by the Social Worker reflected: Resident was accepted to transfer to [another facility] memory Care Placement. Resident is scheduled to transfer today around 12:30 pm. RP was notified and agrees with transfer. No further questions or concerns were verbalized. LMSW to complete DC letter and DC planning. During an observation and interview on 06/07/2026 at 2:37 pm, Resident #1 was noted in his room, lying in bed with door open. CNA C was noted sitting next to Resident #1's door. Resident #1 denied leaving the facility, being found by the local PD or being transferred to the ER. During an interview on 06/07/2026 at 2:44 pm, CNA C stated she was assigned to do a 1:1 monitoring for Resident #1 at the beginning of her shift at 2:00 pm. CNA C stated she was in-serviced on elopement at the beginning of her shift. CNA C stated she was told to report immediately to the nurses once a resident is showing signs of elopement, like wanting to go home. CNA C stated, if a resident assigned to her could not be found, she would report to the charge nurse, they would start to search for the resident within the facility and then to the immediate surroundings. CNA C stated the Administrator, DON, ADON and all authorities would be notified. During an interview on 06/07/2026 at 2:55 pm, CNA D stated she was the CNA assigned to Resident #1 on 06/06/2026 when he eloped. CNA D stated she last saw Resident #1 at about 3:00pm and he was on the 100-hall with other residents. CNA D stated at about 4:40 pm, she took Resident #1's dinner tray and noticed he was not in his room. CNA D stated just about the time she was going to look for Resident #1 for him to eat, the nurse on the hall was coming from the front and told her what had happened. CNA D stated they immediately stopped what they were doing and started to account for all other residents in the facility. CNA D stated she gave verbal statement as to when last she saw Resident #1. CNA D stated the Maintenance Director in-serviced staff on abuse and neglect, elopement, fire safety, who to notify when a resident was missing and an elopement drill was conducted. CNA D stated usually Resident #1 was walking around the facility, so it was not out of the ordinary not seeing in his room at the time. CNA D stated Resident #1 was now on a 1:1 monitoring since he got back from the hospital. During an interview on 06/07/2026 at about 3:10 pm, CNA E stated she was in-serviced on abuse and neglect on 06/06/2026 by LVN F. CNA E stated she was also in-serviced today 06/07/2026 by the Maintenance Director on elopement, when a resident left the facility or was missing, what to do, and an elopement drill was conducted. CNA E stated they were told when a resident was missing to search every room, if the resident was not found, to look around the premises, contact the Administrator, DON and ADON. CNA E stated Resident #1 was assigned to her on 06/06/2026 during the morning shift and he did not show sign of elopement like pushing on the door or talking about wanting to go home. CNA E stated Resident #1 was on 1:1 monitoring due to the incident. During an interview on 06/07/2026 at about 3:35 pm, LVN G stated she was Resident #1's charge nurse, she worked at the facility PRN. LVN G stated her shift started by 12:00 pm and she was in-serviced by LVN F prior to her shift on elopement. LVN G stated she was also told Resident #1 was on a 1:1 monitoring due his elopement on 06/06/2026. LVN G stated, if a resident was missing, they had to look in every room in the facility, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	restrooms and call code white. If the resident is not found within the facility, look in the perimeter of the building, notify everyone. LVN G stated, risk of elopement included exit seeking behavior, wanting to get out, finding ways to escape, pushing the door. During an interview on 06/07/2026 at 3:45 pm, LVN H/wound care nurse stated she was not in the facility when Resident #1 eloped. LVN H stated she was made aware that the Maintenance Director was in the facility on 06/06/2026 checking all the exit doors and today 6/07/2026, he was here checking all the windows. LVN H stated she was in-serviced today 06/07/2026 by the ADON on how to prevent elopement, ensuring room rounds and checking on residents. LVN H stated if you cannot see a resident, try to locate them, if not, let the charge nurses, ADON, DON and Administrator know. Extend to the outside perimeter. LVN H stated risk for elopement, were constantly wandering, wanting to go outside, possible agitation. LVN H stated Resident #1 had been on 1:1 all day. He has not attempted to leave the facility, he walks around but going to activities, I have not seen him pressing on doors. During an interview on 06/07/2026 at 05:05 pm, the Maintenance Director stated he was informed that Resident #1 had gotten out of the facility. The Maintenance Director stated he immediately came to the facility to check all the exit doors to see if they were working properly and alarming, when he checked, all doors were functioning well. He stated all the exit doors had keypad and you have to have the code to get out of the facility. He also stated he usually checks all doors once a week, on Wednesdays and his last check before the incident was 06/03/2026. The Maintenance Director stated he initiated elopement in-service; he conducted elopement drilled with the 2-10 shift. The Maintenance Director stated he did another elopement drill on 06/07/2026 on the 6am to 2 pm shift. The Maintenance Director stated Resident #1's CNA on the morning of 06/07/2026 stated she felt breeze coming in Resident #1's room from the window, when she checked, the screen was pushed back. The Maintenance Director stated he checked all the windows and screens in the facility, all other windows were intact except for Resident #1's, his window screen was pushed back. The Maintenance Director stated he adjusted Resident #1's window and fixed the screen. During an interview on 06/07/2026 at 5:13 pm the DON stated Resident #1 had exit seeking behavior in April 2026, he was assessed, care plan was updated, he was monitored for few days and there were no more behaviors. The DON stated Resident #1 wanted to smoke a cigarette, that is why he wanted to go out but the facility was a non-smoking facility, so the provider ordered a Nicotine patch to help. The DON stated MDS Nurse A was the MOD on 06/06/2026, she received a call from the local PD that Resident #1 was found near a local church close to a major highway. The DON stated Resident #1 was found about 2 miles away from the facility and was at risk of being out in the street, risks of walking along a busy highway, injury and getting lost. The DON stated the facility put elopement mitigation in place right after they found out about the incident. The DON stated on the morning of 06/07/2026, Resident #1's CNA noticed that Resident #1's window screen was pushed back, and they think Resident #1 must have eloped through his room window because no one heard the doors alarm going off. The DON stated, after they got the information of window screen being pushed back, the Maintenance Director checked all windows and screens in the facility and they were intact. During an interview on 06/07/2026 at 5:30 pm the Administrator stated she found out about Resident #1's elopement on 6/6/2026 at about 4:45 pm. The ADM stated she got a call from the manager on duty/MDS Nurse A. The ADM stated MDS Nurse A told her that she had just gotten a call from the local PD that Resident #1 was found near a local church, not too far from a major highway, about 2 miles away from the facility. The ADM stated the local PD sent Resident #1 to the local hospital to rule out heat exhaustion. The Administrator stated Resident #1 was at risk of dehydration, it was hot, a vehicle could have hit him. The Administrator stated Resident #1 wandered but was easily redirect, he went to activities and meal service. The Administrator stated they learned Resident #1's window screen was pushed back on the morning of 06/07/2026 and the Maintenance Director came up to the facility to check all window screens in the building; they were all intact except for Resident #1's. The ADM stated the facility had an AD HOC (doing something for a specific, immediate purpose rather than planning it in (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	advance), completed elopement assessment for Resident #1 and all other residents in the facility, all exit doors and windows were checked by the Maintenance direct to ensure they were intact and functioning, elopement drill completed on 06/06/2026 and 06/07/2026, staff were in-serviced/ re-educated on elopement, Abuse and Neglect and staff would continue to be in-service before the start shift, Resident was placed on 1:1 monitoring and would continue until his placement to a MCU facility. During an interview on 06/07/2026 at 5:44 pm, MDS Nurse A stated she was the MOD on 06/06/2026 and she got a call at about 4:40 pm from the local PD wanting to confirm Resident #1 was a Resident at the facility. The MDS Nurse A stated the Local PD stated Resident #1 was found near a local church close to a major highway and was being sent to the local ER for evaluation for heat exhaustion. The MDS Nurse A stated right after the call, she reported to the Administrator, went to the nurse's station to notify Resident #1's charge nurse. MDS Nurse A stated the Administrator had instructed her to ensure all residents were accounted for, she initiated a count of all residents, and all residents were present except Resident #1. MDS Nurse A stated she checked all exit doors to make sure they were working because she did not hear any alarm go off, all doors were working after she checked. The MDS Nurse stated she was sitting at the receptionist desk in the front, she did not see Resident #1 exit through the front door and the alarm to the other exit doors did not alarm. During an interview on 06/08/2026 at 12:23 pm the Social Worker stated she was in-serviced by the Maintenance Director on 06/08/2026 on elopement and there was an elopement drill as well. The Social Worker they talked about what to do when a resident left the facility, who to contact, what were the signs of elopement risk. The Social Worker said she got a referral for Resident #1 to be transferred to a facility with MCU, she sent the referral and the facility was waiting for pick up later today 6/08/2026. The Social Worker stated she spoke with Resident #1's family regarding the referral and the transfer and they were ok with it. During an interview on 06/08/2026 from 09:58 am to 12:23 pm, MDS Nurse B, LVN I, RN J, CNA K, CNA L, CNA M and CNA N all stated they were in-serviced prior to their shift on abuse and neglect, elopement risks, what to do when a resident left the facility, who to report to and the steps to take. The facility immediately implemented the following actions to immediately address Resident #l's elopement incident on 06/06/2026:Elopement Mitigation Plan initiated 6/6/2026 PD sent Resident #1 to the local hospital.MD notified on 6/6/2026Elopement assessment for Resident #1 completed on 6/6/2026 at about 4:40 pm.Doors and alarm checks on 6/6/26 at 6:20 pm.In-services initiated by DON/ Maintenance Director 06/06/2026 on elopementAll residents in the facility elopement assessment completed from 06/06/2026 through 06/07/2026Elopement Drill completed by the Maintenance Director on 6/06/2026 and 06/07/2026Skin assessment completed for Resident #1 on 6/7/2026 when he got back from the hospital, superficial skin tear noted to both hands.Resident #1 was placed on 1:1 monitoring until he got placed at an MCU facility.All window screens in the facility checked by Maintenance Director on 06/07/2026AD HOC meeting with IDT team completed on 06/07/2026Progress notes and care plan dated 6/7/2026 reflected referred to MCU facility Record review of facility's Elopement Mitigation plan reflected: Date of event: 06/06/2026---What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident was transferred to the hospital by police department and currently receiving care at the hospital.Upon return, resident elopement risk evaluation will be repeated and appropriate interventions implemented with care plan & profile updates.MD/RP notified. Each exit door was assessed by the Maintenance Director on 6/6/26 to validate doors were working properly. An elopement drill was completed on 6/6/26 by the Maintenance Director --- How other residents who have the potential to be affected by the alleged deficient practice are identified: Residents at risk of elopement have the potential to be affected.Elopement risk evaluations done in the past 90 days on current residents in facility will be reviewed by nursing managers for accuracy. Residents identified at risk will be reviewed for appropriate interventions with care plans and profiles updated. ---How the corrective action will be monitored to ensure the deficient practice will not recur: Licensed nurses will be re-educated on the (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	elopement risk assessment process/accuracy and putting interventions in place based on the risks identified. Facility staff will be reeducated on identification of exit seeking behaviors and implementing interventions immediately.This education will be completed on 6/7/26.Any member of target audience not receiving this by this date will receive prior to next scheduled shift New admissions will be reviewed in morning meeting daily Monday thru Friday as part of the clinical morning meeting process. Elopement risks assessments will be reviewed for accuracy and interventions validated if indicated. Quarterly assessments will be reviewed as part of the MDS/Care planning process The Director of Nursing will randomly audit a minimum of 5 elopement assessments weekly for 4 weeks then monthly for 2 additional months to validate accuracy The maintenance director will inspect facility doors 3 times weekly for 4 weeks then weekly for 2 additional months The administrator will make rounds weekly for 4 weeks then monthly for 2 additional months with maintenance director to validate that doors are functioning properly ---What quality assurance program will be put into place: Ad hoc QAPI held on 6/7/26 Medical Director was notified of the incident and plan for improvement on 6/6/26This process will be reviewed in QAPI for a minimum of 3 months Review of facility's in-service initiated 06/06/2026 provided by the DON reflected: Topics:Elopement, Elopement risk1. Staff must report any behaviors that indicate an increased risk for elopement such as; wandering, more confused, trying to go out the door, resident stating I want to go home. Etc. This must be reported immediately to the charge nurse and resident must not be left unattended until the nurse is aware.2. Charge nurses must report any increased signs of elopement risk to DON for further guidance and intervention.3. Staff do not assist residents outside.4. When residents leave on pass, they must sign out and this must be communicated to oncoming shifts5. Wandering and elopement assessments/Care plan should be updated quarterly and when elopement risks are identified. Please see below for steps to take in the event a resident is missing to include.Notify ADMIN/DONNotify employees of missing resident on the overhead paging systemObtain missing resident profile from elopement book Searching the facility and facility grounds within 30 minutes.If the search fails after 30 minutes the DON/ADMIN will notify appropriate agenciesAfter 30 min the search will continue and extend 2 miles around the facility-DON/ADMIN will coordinateIf resident is found, nurse must complete assessment immediately to include head to toe assessment, VS, skin, hydration and pain. RP/Provider notification RVP & CSD notification. Record review of facility's elopement drill reflected a drill was conducted on 06/06/2026 at 6:35 pm during the 2pm to 10 pm shift and 06/07/2026 at 09:08 am during the 6:00 am to 2:pm shift Review of facility's document titled Equipment and Utilities Management Program dated 06/06/2026 reflected that all nine (9) exit doors were checked on 06/06/2026 at 06:20 pm.Review of facility's document titled Screens in the facility dated 06/07/2026 reflected all window screens in the facility were checked. Record review of investigation document reflected an Ad hoc was held on 06/07/2026 --ADHOC Meeting held with IDT Team on 6/7/2026 to discuss incident regarding Resident#1's Elopement on 6/6/2026 and mitigation plan, investigation and interventions, presented by the Administrator and the DON. Reviewed of facility's elopement policy reflected: The Facility will assess all patients/residents for elopement potential.1. All patients/residents are assessed on admission by a licensed nurse for elopement risk utilizing an elopement risk assessment form. 2. All patients/residents are re-assessed for elopement potential by the MDS Nurse/Social Service or designee periodically throughout a patient's/resident's stay and with a significant change. The noncompliance was identified as PNC. The IJ began on 06/06/2026 and ended on 06/07/2026. The facility had corrected the noncompliance before the survey began.