STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455785	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Western Hills Nursing & Rehabilitation	512 Draper Dr Temple, TX 76504

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	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 interview, and record review, the facility failed to ensure that resident received adequate supervision to prevent accidents for 1 of 1 resident (Resident #2) reviewed for elopement.On 06/11/2025 Resident #2 eloped from the facility; On 06/25/2025 a Record Review of the Facility Incident report was completed. According to the Report, it was estimated that Resident #2 left the facility between 5:30PM and 6:00PM, was found on the grounds of a nearby apartment complex, and taken to the ER with an admission time around 7:10PM. The noncompliance was identified as PNC . The Immediate Jeopardy began on 6/11/25 and ended on 6/12/25. The facility had corrected the noncompliance before the survey began.This failure placed residents at risk of physical injury.Findings include: Review of Resident #2’s face sheet reflected he was a [AGE] year-old man admitted to the facility on [DATE]. Resident #2 was admitted with a diagnosis of secondary malignant neoplasm of the brain (cancer cells that have spread to the brain from a primary tumor in another part of the body). Review of the Wander Risk assessment dated [DATE] revealed Resident #2 scored at high risk for wandering. The facility reported this was the assessment that they used to determine if a person was at risk for elopement. Review of Resident #2’s Baseline Care Plan dated 06/11/2025 did not reflect any interventions for wandering or elopement. Review of Resident #2’s MDS initial assessment dated [DATE] reflected a BIMS score of 7 which indicated severe cognitive impairment. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Record Review of the Facility Incident Report dated 06/11/2025 reflected how Resident #2 was discovered missing and the immediate facility-wide response. The Report described that a facility -wide search was implemented and when Resident #2 was not found, EMS was notified at 8:50PM on 06/11/2025. The Report documentation reflected that the Administrator, DON, Resident Representative, and Medical Director were notified on 06/11/2025. Documentation in the Report described that Resident #2 was discovered to be in the local Emergency Room. The Facility Incident Report outlined the activities implemented in response to the elopement. According to the Report, the following was implemented:• Administrator immediately conducted a headcount of all residents in the facility and no other residents were found to be missing• DON and ADONs conducted an audit on all residents and updated all wandering risk assessments on the night of 06/11/2025. On 06/25/2025 Record Review of the audit was completed to verify the Wandering Risk Assessment were completed and Care Plans updated as needed.• Administrator audited elopement binder to ensure all resident at high risk of elopement was included.• Administrator immediately began in serving all staff on the policies and procedures o wandering and elopements. On 06/25/2025 Record Review of the in-service sign in sheets was conducted. Interviews were conducted with 10 staff beginning on 06/27/2025 and ending 07/02/2025 to assess receipt and understanding of the in-service material.• Ad-hoc QAPI was implemented on 06/12/2025. Record Review of the QAPI Sign in Sheet and minutes was conducted on 06/25/2025 to confirm.• Administrator and DON collected statement from all staff who proved direct care to Resident #2. Record Review of the statements was performed on 06/25/2025. • Daily monitoring and discussion in Morning Meeting were implemented to identify residents at risk for safety concerns. Record Review conducted of Daily Monitoring Form on 06/25/2025 Review of ER hospital records dated 6/11/2025 reflected Resident #2 was brought into the hospital for assessment and the chief complaint was that he had fallen while walking through some tall grass and had some bumps and bruises but nothing that warranted hospitalization. The records reflected that Resident #2 stated he lost his balance while walking. Vitals were stable. Resident had complaints of right collar bone pain and T6 (sixth thoracic vertebra) region pain. Xray results were negative. CT Head negative for any acute findings. CT Cervical-spine, and Lumbar -spine all negative. CTA chest negative for PE and acute findings. CT abdomen negative for acute findings. On 06/25/2025 at 2:35PM during an interview with the Administrator, he stated Resident #2 was admitted on [DATE] due to a significant decline in physical and cognitive function due to radiation. The Administrator further stated the facility received little clinical information on Resident #2 as he was admitted from home. The Administrator stated the nurse who did the wandering assessment stated Resident #2 was high risk because she observed him walking around the halls. The Administrator stated management was never notified of the high risk for elopement. On 06/25/2025 at 3:01PM during an interview the DON stated on 6/11/2025 she was notified by ADON A on duty that Resident #2 was missing. The DON stated the staff immediately started a search of the facility and they contacted LE at approximately 7:50PM on 06/11/2025 and reported Resident # 2 as missing. The DON stated upon admission, residents are assessed for the risk of elopement and the Wander Risk Assessment is documented in the electronic medical record. If the resident scored high based on the Wandering Risk Assessment, their process was to notify the Administrator and or DON. The DON stated she was not notified that Resident #2 scored high on the Wandering Risk Assessment. The DON stated there was no specific policy for follow up actions after a resident scored high on the risk assessment for elopement. The DON stated the facility process was to place at risk residents on one-to-one monitoring and the Administrator and DON should have been notified for further interventions. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/25/2025 at 3:41PM during an interview with MA A she stated she discovered Resident #2 missing when she went to his room to give him his night pills at about 6:50PM. MA A stated she notified ADON A that she could not find Resident #2 and then the staff searched the building attempting to locate the resident. MA A further stated she did observe the resident in the afternoon while he was in his room visiting with his family. She reported that she never observed any behaviors that gave her concern about him being at risk for wandering away from the facility. On 06/25/2025 at 3:51PM during an interview with ADON-A she stated on 6/11/2025 she observed Resident #2 as his family walked in the building around 5:30PM or 5:45 PM. ADON A then stated she did not see anything else of them. ADON A stated she was notified around 6:50PM, by MA A that Resident #2 was missing. ADON A stated she called Resident #2’s family member to see if the resident was with him. The Resident’s family member stated the resident was not with him. ADON A reported during the call the family was very apologetic and stated they neglected to tell the staff he had an issue with wandering. ADON A stated, “They knew and didn’t tell us.” ADON A stated the staff started their search of the building, called LE, and notified the DON and Administrator. On 06/27/2025 at 10:10AM during an interview with LVN A she stated she completed the original wandering assessment on 6/11/2025. LVN A stated she had observed Resident #2 wandering around but did not think that it was exit seeking behavior but rather attempting to get familiar with surroundings. LVN A stated she did not know how to score the assessment. LVN A stated “I wanted him to be on the radar for his safety. My concern was that we might find him in someone else’s room not because Resident #2 was a flight risk.” She stated she did not obtain any history from the family for this assessment. On 06/27/2025 at 2:49PM during a phone interview with Resident #2’s family member, she stated the nurses were fantastic and were very good. Everything was fine. She had no complaints or concerns about the resident’s care when he was in the facility. On 06/27/2025 at 4:14PM received an email from the Regional Clinical Director. She stated the process for prevention of elopement is the IDT convenes and identifies individualized interventions that are appropriate for that resident if a resident is identified as being at risk for wandering. Those would then be added to their care plan and/or physician's orders as indicated.On 07/01/2025 at 3:28PM a phone interview with LE. The detective reported that on 06/11/2025 they received a report from EMS indicating they had transported Resident #2 to the hospital for further assessment. LE reported the facility called in a missing person report at approximately 8:40PM on 06/11/2025. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Post event actions documented in the facility investigation and report detail the following completed 6/12/2025 prior to surveyor entrance on 06/25/2025• Administrator conducted a head count of all residents in the facility. No other residents were missing. This was confirmed per record review of the resident count documented on the resident roster and per interview with the Administrator on 06/25/2025 at 2:35PM.• The DON, ADONs, and other nurses conducted an audit on all Resident Wandering Risk Assessments. Completion of audit confirmed via Record Review of the audit documentation and per interview with the DON on 06/25/2025 at 3:01PM.• Administrator immediately began in-services to staff regarding policy/procedure of wandering/elopements. Confirmed by record review of the in-service sign in sheets, interview with the Administrator on 06/25/2025 at 2:35PM. Further confirmation obtained via individual staff interviews to include:• During an interview with RN A on 07/02/2025 at 11:46AM she stated she was shown on the computer how to assess the risk and how to complete the document. RN A also stated if someone was determined to be at high risk, they were to call Administrator and DON and monitor the resident. • During an interview with LVN A on 07/02/2025 at 11:51AM she stated on 06/12/2025 she was trained on how to complete the assessment and how to sign and save so the document automatically recorded the risk level. If the resident was identified at risk, they were to contact the Administrator and the DON immediately. • During an interview with LVN B on 07/02/2025 at 11:57AM she stated she was in serviced the day following the event. She verbally verified her signature on the Inservice sign in sheet. She stated she was trained on completing the assessments and what and how to do follow up for residents determined to be high risk. If at risk, they notify the DON and /or the Admin. There will be a determination of the intervention to be implemented such as a wander guard. LVN B stated if the resident was actively exiting seeking, they would be monitored on a one to one. • During an interview with ADON B on 07/02/2025 at 12:03PM she stated she received training the day of the event. She stated the training included a review of the wander assessments and how to score and document them properly. She stated the training also included what to do if a resident scored at high risk which was to notify Admin/DON. If the resident was exiting seeking, they would be placed on one-to-one monitoring. ADON B stated she keeps the resident with her for supervision while the calls are being made. • During an interview with RN B on 07/02/2025 at 12:10PM she stated she was in serviced the night of the event. The training included completion of the wandering risk assessment and what interventions to take depending on how the resident was scored. She stated if the resident scored high, the staff were to notify the Administrator/DON. • During an interview on 06/25/2025 at 3:43PM MA A stated she received training on responding to missing residents to include notifying the ADON and performing a search of the building and grounds. MA A’s signature is found on Record Review of the in-service sign in sheet dated 06/11/2025. • During an interview on 06/27/2025 at 3:16PM CNA A stated he recalled having had training on elopement and the training included instructions to respond with three step process. The staff were instructed to try to find the resident, perform a head count, and notify administration. Per Record Review on 06/25/2025 CNA A’s signature is located on the in-service sign in sheet dated 06/11/2025. • During an interview on 06/27/2025 at 3:24PM with CNA B he stated he received training on what to do if a resident seems to be missing. He stated the process was to check all rooms and do a head count and notify the administrator. He stated the training included to prevent elopements by making sure to visualize the residents every 2 hours and make sure no one was near those exit doors. Record Review of the in-service sign in sheet dated 06/11/2025 showed his signature. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	• During an interview on 06/27/2025 at 3:28PM with CNA C she stated she has been in serviced on the prevention of elopement. CNA C stated she received training on /6/11/2025 and also at new hire orientation to prevent elopements . The training included the use of alarms, performing head counts, and checking exit doors. • During an interview on 06/27/2025 at 3:34PM with CNA D she stated she received training by the Administrator, and it contained instructions on recognizing wandering or if a resident wanted to leave. She stated the training included the need to check on the residents and let the nurse know if a resident seemed to be wandering. Record Review of the in-service sign in sheet dated 06/11/2025 revealed CNA D’s signature. • On 06/12/2025 an Ad Hoc QAPI meeting was held to identify the process breakdown and how the facility could prevent a future incident. This was validated via record review of the QAPI sign in sheet and per interview with the Administrator on 06/25/2025 at 2:35PM. • The DON or designee implemented continuous monitoring via review of the 24-Hour Report daily during clinical meeting to identify residents at risk of safety concerns. Record Review of the audit tool was completed on 06/25/2025 and found to be completed to date.• Nurses were in serviced by the Administrator and DON regarding the elopement policy and procedures and the steps to take after a resident was deemed high for elopement risk. This was confirmed by record review of the in-service sign in sheets dated 06/11/2025 and confirmed during interviews conducted on 07/02/2025 with licensed nursing staff. During an interview with the DON on 07/02/2025 at 12:27PM she stated in order to make sure all staff were educated, the administrator helped in monitoring the in-service list and if it was identified that a staff was scheduled to work that had not had the in-service, the ADON would stay over or come in on the weekends to in-service those staff. Findings include: Review of Resident #2’s face sheet reflected he was a [AGE] year-old man admitted to the facility on [DATE]. Resident #2 was admitted with a diagnosis of secondary malignant neoplasm of the brain (cancer cells that have spread to the brain from a primary tumor in another part of the body). Review of the Wander Risk assessment dated [DATE] revealed Resident #2 scored at high risk for wandering. The facility reported this was the assessment that they used to determine if a person was at risk for elopement. Review of Resident #2’s Baseline Care Plan dated 06/11/2025 did not reflect any interventions for wandering or elopement. Review of Resident #2’s MDS initial assessment dated [DATE] reflected a BIMS score of 7 which indicated severe cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of the Facility Incident Report dated 06/11/2025 reflected how Resident #2 was discovered missing and the immediate facility-wide response. The Report described that a facility -wide search was implemented and when Resident #2 was not found, EMS was notified at 8:50PM on 06/11/2025. The Report documentation reflected that the Administrator, DON, Resident Representative, and Medical Director were notified on 06/11/2025. Documentation in the Report described that Resident #2 was discovered to be in the local Emergency Room. The Facility Incident Report outlined the activities implemented in response to the elopement. According to the Report, the following was implemented:• Administrator immediately conducted a headcount of all residents in the facility and no other residents were found to be missing• DON and ADONs conducted an audit on all residents and updated all wandering risk assessments on the night of 06/11/2025. On 06/25/2025 Record Review of the audit was completed to verify the Wandering Risk Assessment were completed and Care Plans updated as needed.• Administrator audited elopement binder to ensure all resident at high risk of elopement was included.• Administrator immediately began in serving all staff on the policies and procedures o wandering and elopements. On 06/25/2025 Record Review of the in-service sign in sheets was conducted. Interviews were conducted with 10 staff beginning on 06/27/2025 and ending 07/02/2025 to assess receipt and understanding of the in-service material.• Ad-hoc QAPI was implemented on 06/12/2025. Record Review of the QAPI Sign in Sheet and minutes was conducted on 06/25/2025 to confirm.• Administrator and DON collected statement from all staff who proved direct care to Resident #2. Record Review of the statements was performed on 06/25/2025. • Daily monitoring and discussion in Morning Meeting were implemented to identify residents at risk for safety concerns. Record Review conducted of Daily Monitoring Form on 06/25/2025 Review of ER hospital records dated 6/11/2025 reflected Resident #2 was brought into the hospital for assessment and the chief complaint was that he had fallen while walking through some tall grass and had some bumps and bruises but nothing that warranted hospitalization. The records reflected that Resident #2 stated he lost his balance while walking. Vitals were stable. Resident had complaints of right collar bone pain and T6 (sixth thoracic vertebra) region pain. Xray results were negative. CT Head negative for any acute findings. CT Cervical-spine, and Lumbar -spine all negative. CTA chest negative for PE and acute findings. CT abdomen negative for acute findings. On 06/25/2025 at 2:35PM during an interview with the Administrator, he stated Resident #2 was admitted on [DATE] due to a significant decline in physical and cognitive function due to radiation. The Administrator further stated the facility received little clinical information on Resident #2 as he was admitted from home. The Administrator stated the nurse who did the wandering assessment stated Resident #2 was high risk because she observed him walking around the halls. The Administrator stated management was never notified of the high risk for elopement. On 06/25/2025 at 3:01PM during an interview the DON stated on 6/11/2025 she was notified by ADON A on duty that Resident #2 was missing. The DON stated the staff immediately started a search of the facility and they contacted LE at approximately 7:50PM on 06/11/2025 and reported Resident # 2 as missing. The DON stated upon admission, residents are assessed for the risk of elopement and the Wander Risk Assessment is documented in the electronic medical record. If the resident scored high based on the Wandering Risk Assessment, their process was to notify the Administrator and or DON. The DON stated she was not notified that Resident #2 scored high on the Wandering Risk Assessment. The DON stated there was no specific policy for follow up actions after a resident scored high on the risk assessment for elopement. The DON stated the facility process was to place at risk residents on one-to-one monitoring and the Administrator and DON should have been notified for further interventions. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/25/2025 at 3:41PM during an interview with MA A she stated she discovered Resident #2 missing when she went to his room to give him his night pills at about 6:50PM. MA A stated she notified ADON A that she could not find Resident #2 and then the staff searched the building attempting to locate the resident. MA A further stated she did observe the resident in the afternoon while he was in his room visiting with his family. She reported that she never observed any behaviors that gave her concern about him being at risk for wandering away from the facility. On 06/25/2025 at 3:51PM during an interview with ADON-A she stated on 6/11/2025 she observed Resident #2 as his family walked in the building around 5:30PM or 5:45 PM. ADON A then stated she did not see anything else of them. ADON A stated she was notified around 6:50PM, by MA A that Resident #2 was missing. ADON A stated she called Resident #2’s family member to see if the resident was with him. The Resident’s family member stated the resident was not with him. ADON A reported during the call the family was very apologetic and stated they neglected to tell the staff he had an issue with wandering. ADON A stated, “They knew and didn’t tell us.” ADON A stated the staff started their search of the building, called LE, and notified the DON and Administrator. On 06/27/2025 at 10:10AM during an interview with LVN A she stated she completed the original wandering assessment on 6/11/2025. LVN A stated she had observed Resident #2 wandering around but did not think that it was exit seeking behavior but rather attempting to get familiar with surroundings. LVN A stated she did not know how to score the assessment. LVN A stated “I wanted him to be on the radar for his safety. My concern was that we might find him in someone else’s room not because Resident #2 was a flight risk.” She stated she did not obtain any history from the family for this assessment. On 06/27/2025 at 2:49PM during a phone interview with Resident #2’s family member, she stated the nurses were fantastic and were very good. Everything was fine. She had no complaints or concerns about the resident’s care when he was in the facility. On 06/27/2025 at 4:14PM received an email from the Regional Clinical Director. She stated the process for prevention of elopement is the IDT convenes and identifies individualized interventions that are appropriate for that resident if a resident is identified as being at risk for wandering. Those would then be added to their care plan and/or physician's orders as indicated.On 07/01/2025 at 3:28PM a phone interview with LE. The detective reported that on 06/11/2025 they received a report from EMS indicating they had transported Resident #2 to the hospital for further assessment. LE reported the facility called in a missing person report at approximately 8:40PM on 06/11/2025. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Post event actions documented in the facility investigation and report detail the following completed 6/12/2025 prior to surveyor entrance on 06/25/2025• Administrator conducted a head count of all residents in the facility. No other residents were missing. This was confirmed per record review of the resident count documented on the resident roster and per interview with the Administrator on 06/25/2025 at 2:35PM.• The DON, ADONs, and other nurses conducted an audit on all Resident Wandering Risk Assessments. Completion of audit confirmed via Record Review of the audit documentation and per interview with the DON on 06/25/2025 at 3:01PM.• Administrator immediately began in-services to staff regarding policy/procedure of wandering/elopements. Confirmed by record review of the in-service sign in sheets, interview with the Administrator on 06/25/2025 at 2:35PM. Further confirmation obtained via individual staff interviews to include:• During an interview with RN A on 07/02/2025 at 11:46AM she stated she was shown on the computer how to assess the risk and how to complete the document. RN A also stated if someone was determined to be at high risk, they were to call Administrator and DON and monitor the resident. • During an interview with LVN A on 07/02/2025 at 11:51AM she stated on 06/12/2025 she was trained on how to complete the assessment and how to sign and save so the document automatically recorded the risk level. If the resident was identified at risk, they were to contact the Administrator and the DON immediately. • During an interview with LVN B on 07/02/2025 at 11:57AM she stated she was in serviced the day following the event. She verbally verified her signature on the Inservice sign in sheet. She stated she was trained on completing the assessments and what and how to do follow up for residents determined to be high risk. If at risk, they notify the DON and /or the Admin. There will be a determination of the intervention to be implemented such as a wander guard. LVN B stated if the resident was actively exiting seeking, they would be monitored on a one to one. • During an interview with ADON B on 07/02/2025 at 12:03PM she stated she received training the day of the event. She stated the training included a review of the wander assessments and how to score and document them properly. She stated the training also included what to do if a resident scored at high risk which was to notify Admin/DON. If the resident was exiting seeking, they would be placed on one-to-one monitoring. ADON B stated she keeps the resident with her for supervision while the calls are being made. • During an interview with RN B on 07/02/2025 at 12:10PM she stated she was in serviced the night of the event. The training included completion of the wandering risk assessment and what interventions to take depending on how the resident was scored. She stated if the resident scored high, the staff were to notify the Administrator/DON. • During an interview on 06/25/2025 at 3:43PM MA A stated she received training on responding to missing residents to include notifying the ADON and performing a search of the building and grounds. MA A’s signature is found on Record Review of the in-service sign in sheet dated 06/11/2025. • During an interview on 06/27/2025 at 3:16PM CNA A stated he recalled having had training on elopement and the training included instructions to respond with three step process. The staff were instructed to try to find the resident, perform a head count, and notify administration. Per Record Review on 06/25/2025 CNA A’s signature is located on the in-service sign in sheet dated 06/11/2025. • During an interview on 06/27/2025 at 3:24PM with CNA B he stated he received training on what to do if a resident seems to be missing. He stated the process was to check all rooms and do a head count and notify the administrator. He stated the training included to prevent elopements by making sure to visualize the residents every 2 hours and make sure no one was near those exit doors. Record Review of the in-service sign in sheet dated 06/11/2025 showed his signature. (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	• During an interview on 06/27/2025 at 3:28PM with CNA C she stated she has been in serviced on the prevention of elopement. CNA C stated she received training on /6/11/2025 and also at new hire orientation to prevent elopements . The training included the use of alarms, performing head counts, and checking exit doors. • During an interview on 06/27/2025 at 3:34PM with CNA D she stated she received training by the Administrator, and it contained instructions on recognizing wandering or if a resident wanted to leave. She stated the training included the need to check on the residents and let the nurse know if a resident seemed to be wandering. Record Review of the in-service sign in sheet dated 06/11/2025 revealed CNA D’s signature. • On 06/12/2025 an Ad Hoc QAPI meeting was held to identify the process breakdown and how the facility could prevent a future incident. This was validated via record review of the QAPI sign in sheet and per interview with the Administrator on 06/25/2025 at 2:35PM. • The DON or designee implemented continuous monitoring via review of the 24-Hour Report daily during clinical meeting to identify residents at risk of safety concerns. Record Review of the audit tool was completed on 06/25/2025 and found to be completed to date.• Nurses were in serviced by the Administrator and DON regarding the elopement policy and procedures and the steps to take after a resident was deemed high for elopement risk. This was confirmed by record review of the in-service sign in sheets dated 06/11/2025 and confirmed during interviews conducted on 07/02/2025 with licensed nursing staff. During an interview with the DON on 07/02/2025 at 12:27PM she stated in order to make sure all staff were educated, the administrator helped in monitoring the in-service list and if it was identified that a staff was scheduled to work that had not had the in-service, the ADON would stay over or come in on the weekends to in-service those staff.