STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675834	A. Building B. Wing	03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Galleria	2929 Post Oak Blvd Houston, TX 77056

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 observations, interviews, and record review, the facility failed to ensure each resident received adequate supervision for 1 of 8 residents (Resident #1) reviewed for adequate supervision. The facility failed to ensure that Resident #1 received adequate supervision when Resident #1 was able to exit the facility at 1:00am and found by staff on a busy street. An Immediate Jeopardy (IJ) was identified on 3.20.2026. The IJ template was provided to the Administrator on 3.20.2026 at 5:48 p.m. On 3/21/26 at 8:15pm, the Administrator was notified that the IJ was removed; however, the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of isolated, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk for possible serious injuries, harm and deathThe Findings include:Record review of Resident #1's undated face sheet, revealed Resident #1 was a [AGE] year-old female, who admitted to the facility on [DATE] and discharged on 3/12/26, with a primary diagnosis of Cerebral Infraction (stroke). Upon admission, Resident #1's BIMS dated 3/12/26 revealed she had a score of 7 out of 15 indicating Resident #1 had severe cognitive impairment.Record review of Resident #1's care plan revealed the following:Focus: Resident #1 has an ADL Self Care performance Deficit r/t weakness, deconditioning from recent hospital stay (date initial: 3/9/26; Revision: 3/12/26)Goal: Resident #1 will improve in ADL functional status by the next review date (dated initiated: 3/9/26; target date: 6/7/26)Interventions/Task:Encourage the resident to participate to the extent possible with each interaction (dated initiated: 3/12/26)Encourage the resident to use call bell for assistance (dated initiated: 3/12/26)Explain all procedures/tasks (dated initiated: 3/12/26)Promote dignity by ensuring privacy (dated initiated: 3/12/26)PT OT evaluation and treatment as per MD orders (dated initiated: 3/9/26)Record review of Nursing notes dated 3/12/26 at 2:04 am by RN A stated, Making rounds at 11:00 PM, resident was observed on the bed sleeping. CNA took her vital signs without any changes. Then upon rounds at around 1:00 to 1:15 AM this writer noticed resident was not in bed, checked her bathroom and adjacent rooms, resident was not found, security was alerted writer went through the stairs door in front of her room to search the pool area in the backyard. Resident was not found. Then rider [writer] ran to the front of the building, spoke with one of the security guards who confirmed they let a woman out around 1:20 AM, thinking she's homeless. At that point everyone went to the streets, staff, security to look for resident. Resident was found walking on the road to the right side of the building on the pedestrian walkway. Then brought back into the building. Residents show writer how she walked out of the room through the stairs, to the pool area and a man let her out of the building. Assessment done, no injury observed, denies pain or discomfort. On call, administrator, DON, son and daughter were not notification. Resident is on one-on-one supervision.[sic]Record review of Security guard suspension report dated 3/12/26 revealed he was suspended and received in-sevice on abuse and neglect, elopement, emergency door monitoring, pool monitoring, and unfamiliar person protocol.Record review of Nursing notes dated 3/12/26 at 8:46am by RN A stated, Resident #1's FM voiced concerns that Resident #1 is a flight risk after RN A notified her of Resident#1's elopement (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
	675834	A. Building B. Wing	03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Galleria	2929 Post Oak Blvd Houston, TX 77056

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	incident.Record review of Occupational Therapy evaluation summary dated 3/11/26 revealed, a physical cognitive psychosocial impairment imbalance (a decline in bodily functions and problems with memory), fine motor coordination (loss of coordinated hand movement sometimes described as clumsiness), dexterity and mobility (unable to move around freely).Record review of the following In-Services completed between 3/21/26:Door Monitoring In-service revealed that the Facility has instituted immediate monitoring of the emergency exit doors leading outside to the pool and common areas. There is a staff person assigned at each door of egress, which leads outside near the pool area. There is also a sign in a sign out sheet and no resident visitor or staff shall be allowed to exit unless there is an event of an emergency. Staff who have been assigned to that area will be relieved for breaks and lunches and document on the assigned form.Staff exterior walking rounds and documentation In-service revealed staff hourly rounds in the dog park, pool, dog park gate secured, pool gate secured with staff initials.Walkie Talkie In-Service revealed walkie talkies are to be picked up by charge nurses and checked out at the beginning and returned at the end of each shift. This will enhance communication with security if needed.Emergency Exit and Fire Door Usage revealed that staff must not use these doors unless there is an emergency. Staff must investigate each time an alarm sounds for these doors.Elopement/Missing Resident revealed staff must alert other staff by calling a Code Yellow, skills check quiz for each employee, ensure the elopement Binders are located on the 1st and 2nd Floor nurses' station and at the front desk.Abuse and neglect and its definitions, types, reporting and the abuse coordinator.Unfamiliar person protocol Instant In-service to immediately remind staff of their obligations to identify all persons on the property.Elopement Risk assessment completed 3/12/26 on all residents in the facility.Incident/Accident Reporting Policy effective 03/2009 and last revised 06/2025 revealed the following:Complete an incident report for the following situations:ElopementRecord review of Impromptu QAPI dated 3/12/26 revealed an impromptu meeting regarding resident elopement & Binders, behavior monitoring, swimming pool concerns, and staff assigned at fire door, and egress monitoring 24/7.On 3/17/26 at 10:00 am in an interview with Admin, she said FM packed Resident #1 up the day before (3/11/26) so that she could go to a different rehab that the family felt was best for Resident #1. At 12:55 am rounds were made and at 1:02 am she went to the patio. She stated security spoke with Resident #1 at 1:06 am. She stated the RN was doing rounds while Resident #1 was speaking with Security A. The RN noticed Resident #1 was not in her room. RN A went to stairwell and didn't see anyone. RN came out of stairwell and notified other staff members that the resident was missing. The RN A, LVN A and CNA A, and CNA B proceeded to look in rooms, then to front desk to ask Security if he noticed a female resident in the area and he said, yes. Security stated that he opened the gate in the pool area, allowed Resident #1 inside the front of the building and then escorted her out of the facility. The Admin stated Resident #1 was not on property and was found by nursing staff on the sidewalk (street) walking. Admin stated Resident #1 was fully dressed. Admin stated all facility employees, including security personnel, received in-service training. Admin stated Security was suspended and received additional in-service training.On 3/17/26 at 11:30 am in an interview with Ombudsman who stated she was contacted by FM regarding Resident #1. The Ombudsman stated FM expressed concern that Resident 1 was able to leave the facility without notice at or around 1:30 am, especially when Resident 1 had a cognitive decline. She stated this was a concern and hoped no other residents would be able to get out of the facility without notice.On 3/19/26 at 9:40 am during a telephone interview with FM, she stated Resident 1 had a cognitive decline due to having a stroke and should not have been able to walk out of the facility without notice. FM stated the facility was negligent. FM stated she has been responsible for Resident 1's medical records and made all of her medical decisions since she had the stroke. FM stated the local hospital called her and told her that Resident 1 was a flight risk; however, she assumed this information was in the discharge paperwork from hospital to facility. She stated she was now aware that the local hospital did not add this information to the discharge instructions to the facility. FM stated due to having a stroke, Resident #1 could not order her own meals, make a phone (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675834	A. Building B. Wing	03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Galleria	2929 Post Oak Blvd Houston, TX 77056

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	call or get out of bed without assistance as a result of fall risk. FM stated she received a call from the facility at 1:45 am and was informed Resident #1 had eloped, but she was returned to the facility unharmed. FM also stated she was informed that Resident 1 was able to leave because the security guard thought she was homeless and had somehow gotten into the recreation area of the facility. FM stated Resident 1 was wearing a fall risk bracelet, and a stick on heart monitor where the cords were hanging out of the sleeve of her shirt and she should not have been mistaken for being homeless. FM also stated her mother could have drowned because she had full access to the pool and is unable to swim along with being in a dangerous situation on the streets at 1:00 am.On 3/19/26 at 10:13 am during an interview with Speech Therapist she stated according to the treatment notes, Resident 1 required verbal and instructional notes during the initial treatment consult. In other words, she stated Resident needed staff to repeat instructions multiple times and staff would even have to draw pictures. She stated Resident #1 understood verbal instructions 30% of the time and staff would have to repeat and draw pictures 70% of the time. She stated Resident 1 had a cognitive communication deficit. She stated Resident 1 was not always oriented to person, place and time. She stated Resident 1 could not tell you where home was, her address, the date or time.On 3/19/26 at 11:34 am during an interview with Health Information Specialist who stated he completed the admissions document agreement with Resident #1. Health Information Specialist stated he did not notice any altered mental status; however, noticed that all the questions were being answered by FM. Health Information Specialist stated after the end of the admissions interview, he did not ask questions to determine if Resident #11 was oriented to person, place and or time. He stated he just required an electronic signature, which he signed by receiving permission from FM. Health Information Specialist stated the next day after Resident #1 was admitted to the facility, he completed room rounds and spoke with Resident #1 to see if she had any concerns. Health Information Specialist stated he could not remember if Resident #1 had any concerns or complaints. On 3/19/26 at 11:45 am during a telephone interview with Security Guard, he stated he was doing rounds and noticed Resident 1 outside in the swimming pool area. He stated she approached the gate that has to be opened by a security guard to get to the bistro area, which will then allow her to exit the facility from the front door. Security Guard stated Resident 1 was unable to open the gate, so Security Guard opened the gate for her. Security Guard stated he asked how did she get to that area and Resident 1 responded, she came through the backdoor (which is in the garage area and where homeless people enter). Security Guard stated he was thinking Resident 1 was homeless, so he opened the gate and led her out of the facility. Security Guard stated Resident 1 never said anything else. Security Guard stated Resident 1 did not look confused. He stated he did not ask Resident 1 what her name was or any other identifying information. Security Guard stated he did not call any nursing staff on the residents' floor and ask or notify any staff members that a resident was in the area. Security Guard stated after leading Resident #1 out of the front door a CNA came to the front desk and asked if he had noticed a resident wearing a pink sweater in the area and he told CNA that a lady dressed like that just left out of the front door. The CNA informed him that that was a resident and not a homeless person. Security Guard stated he, another security guard, CNA and nurses ran out of the front door to locate Resident 1 and return her to the facility. Security Guard stated this event occurred around 1:10am - 1:15am. Security Guard stated Resident 1 did not have any identifying bracelets or clothing that would make him assume that she was a Resident. Security Guard stated since the incident, he believes he should have asked more questions. On 3/19/26 at 1:23 pm in a telephone interview with CNA A she stated she completed vitals on Resident #1 when she arrived on her shift around 11:00pm. She stated she went to supply room in the basement area around or close to 1:00 am to get supplies, which took approximately 5 minutes. She stated she then had to go to the 6th floor to get additional supplies, which was now a little after 1:00 am. CNA A stated once she returned to 1st floor she observed RN on the far end of the floor shouting, Code Yellow to inform them there was an issue with a resident not in their room. She stated she and CNA B immediately went to security and asked if they observed a resident exit the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675834	A. Building B. Wing	03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Galleria	2929 Post Oak Blvd Houston, TX 77056

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	building and was informed by Security Guard that a woman was wandering in the pool area, and she couldn't say what she was doing or where she was going so he escorted her out of the facility. CNA A stated the Security Guard stated Resident 1 looked like a homeless person and stated Resident 1 told him she was homeless. On 3/19/26 at 1:25 pm in a telephone interview with RN A who stated she made rounds at 11:00 pm and Resident #1 was in bed sleeping and shortly afterwards CNA A completed vitals and left the room. RN A stated around 1:05am while making rounds she noticed Resident 1 was not in bed. RN A stated she checked the bathroom in Resident 1's room and other resident rooms as well. RN A stated she checked everywhere on the floor. RN A stated she did not hear an alarm go off on the exit door to the stairwell, but she went to the stairwell and exited in the back area and didn't see Resident 1. RN A went to security and the security guard stated he escorted a lady, who was in the pool area, out the front door because she was homeless. RN A stated she told Security that lady was not homeless that was a resident. RN A stated at this time, she along with other nursing staff proceeded outside and located Resident 1 walking on the sidewalk on the side of the facility's building. RN A stated Resident 1 said she was going home. RN A stated she escorted Resident 1 back inside the facility and completed a head-to-toe assessment and placed Resident 1 on a 1:1 observation until the DON arrived at 8:00 am. She stated she alerted her Administrator, Medical Doctor, RP and DON.On 3/19/26 at 1:32 pm in a telephone interview with LVN A she stated she was on the first floor completing her charting at nurses' station when RN A told her Resident 1 was missing. She stated she immediately began to assist in locating Resident 1. LVN A stated she and other nursing staff went to the front of the building where they encountered Security Guard and was informed that he let a homeless woman out of the building because she was wandering in the pool area. LVN A stated nursing staff informed Security Guard that the woman he encountered was not homeless she was a Resident. On 3/19/26 at 1:40 pm in a telephone interview with CNA B he stated he worked 11pm-7pm. He along with CNA A was informed by RN A that a resident was missing and called Code Yellow (when someone is missing). CNA B stated he and CNA A looked in residents' rooms on the floor and then went to security guard where the two of them were informed there was a resident who he let out of the building because he thought she was homeless. He stated the two of them went outside and did not see Resident #1, then continued to look on the street and observed her walking.On 3/19/26 at 4:28 pm during a follow-up interview with Admin she stated there was an immediate Instant In-Service Training for all staff (nursing and others) including security. Admin stated there are 3 security guards that work 10pm - 6am only. Admin stated during the morning shift (6:00am-2:00pm) the front desk, and concierge personnel arrive in the facility. Admin stated that in-service training for nursing staff, including therapy and dietary, is conducted monthly or prior if there are any incidents. An Immediate Jeopardy (IJ) was identified on 3/20/26. The IJ template was provided to the Admin on 3/20/26 at 5:45 p.m. and a Plan of Removal was requested.The Plan of Removal was approved on 3.21.2026 at 4:50pmReview of the facility's Plan of Removal reflected:Date: 3/20/2026Plan to remove Immediate jeopardyF689- The facility failed to ensure the residents' environment remained free of accident hazards as is possible in residents receiving adequate supervision in the pool area.Upon Resident #1's return to the community a visual resident count was completed, confirming all residents on census were accounted for. RN completed a visual resident count, on 3/12/26, resident total census was referenced on 3/17/26 to compare visual count to assure all residents were accounted for. Resident #1's received a skin assessment with no areas of concern noted. The skin assessment was completed by RN on 3/12/26. RN notified Administrator, residents' physician, Medical Director (Administrator notified), resident's son was left a message, and resident's daughter was spoken to. RN completed skin assessment for Resident #1 with no concerns identified, BIMS reassessed and resident scored 7, elopement risk assessment completed and determined her to be high risk and Resident #1's placed on 1:1 monitor until her discharge to PAM at 3:29 pm. On 3/12/26. Resident #1's is no longer at this facility. Resident #1's care plan was updated to reflect new risks. In addition, all residents' elopement risks were reassessed and BIMSs were (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675834	A. Building B. Wing	03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Galleria	2929 Post Oak Blvd Houston, TX 77056

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	reassessed on 3/12/26 with no one identified at risk.On 3/20/2026, an impromptu Quality Assurance Performance Improvement Meeting was completed with the Healthcare Administrator, Executive Director, Medical Director, and Director of Resident Services via telephone. This meeting addressed security monitoring around the pool and dog park areas of the community. Additional actions to increase safety will include re-education to security/concierge staff on making hourly walking rounds on the pool area and the dog park area. Education and implementation of walking round forms to ensure accurate documentation completed on 3/20/26 by the Executive Director and the Healthcare Administrator.Facility's plan to ensure compliance:On 3/20/2026 Healthcare Administrator, and Executive Director begun education on Emergency Exit Usage and Alarm Investigation. No staff is permitted to use emergency exit doors unless there is an emergency. All staff are to investigate each time the alarm is triggered. All staff, not in-serviced on 03/20/2026, will be in-serviced prior to start of their next shift. This will be documented on an in-service sheet. Associates working in the following positions will receive this education, Nurses, nursing assistants, security, maintenance, concierge, administration, dietary servers, cooks, and dietary manager.On 03/20/2026 Healthcare Administrator and Executive Director completed education with all staff on the resident elopement/missing resident, search procedure, proper notification, resident assessments, and resident monitoring. All staff not reeducated 3/20/2026 will be reeducated before the start of their next shift by the Healthcare Administrator/ Executive Director. Skills test for elopement began with staff working 3/20/26. This will be documented on an in-service sheet.On 3/20/26 Healthcare Administrator/Executive Director begun education with all staff on Abuse and Neglect. Definition of abuse, abuse coordinator name, types of abuse, types of neglect, and the importance of timely notification reviewed with staff. Any staff not reeducated on 3/20/2026 will be reeducated before the start of their next shift by Healthcare Administrator/Executive Director. Skills test for abuse and neglect will be completed once per shift.On 3/20/26 Executive Director completed Instant Reeducation with security/concierge staff on initial contact and verification of wandering resident. Security will ask identifying questions (name, where do you live, how they got to the area, etc.), check for any identifying markers, call nurses' stations to verify if individual may have left assigned area, and refer to elopement binder. This will be documented on an in-service sheet. All security/concierge staff will be retrained prior to the start of their next scheduled shift and will not be able to return to duty until retrained.On 03/20/26 all night shift staff were educated by Healthcare Administrator/Executive Director on the following protocol as an additional method of communication between the nursing facility and the front desk, security. All nursing staff and security education will be completed prior to the start of associate's next shift. This will be documented on an in-service sheet:-Walkie talkies will be located and charged at the front concierge desk. On 03/20/26 all night shift staff were educated by Healthcare Administrator/Executive Director.-Walkie talkies are to be carried by at least one security associate and one direct care associate on each floor. On 03/20/26 all night shift staff were educated by Healthcare Administrator/Executive Director-Walkie talkie will be issued (1) to each floor, and signed out at that time, upon the end of shift walkie will be returned to the front concierge desk.On 03/20/26 all night shift staff were educated by Healthcare Administrator/Executive Director on security protocol, unfamiliar persons protocol, abuse and neglect.On 3/20/2026, the Executive Director and Healthcare Administrator provided immediate re-education to all security and concierge staff regarding required safety monitoring protocols. Training included: completion of hourly walking rounds in both the pool and dog park areas, continuous monitoring of the pool area via security cameras, ensuring the camera feed remains visible on the security desk monitor at all times, prompt reporting of any adverse findings or safety concerns to the Director of Resident Services, Executive Director, and Healthcare Administrator, accurate and timely documentation of all walking rounds and observations. This will be documented on an in-service sheet.On 3/20/2026 Executive Director reeducated Healthcare Administrator on the facility abuse policy, elopement policy.On 3/21/2026 Regional Director of Clinical services educated Executive (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675834	A. Building B. Wing	03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Galleria	2929 Post Oak Blvd Houston, TX 77056

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	Director and Health Care administrator on Missing resident policy and, swimming pool and spa policy.The Executive Director and Healthcare Administrator will provide ongoing oversight to ensure adherence to established protocols. Any deviations from required procedures will be addressed promptly through corrective action and additional staff training as needed.The facility will place a staff member at the emergency exit door between dog park and pool area to redirect anyone attempting to exit unless there is an active emergency. This staff member will remain in place 24 hours a day until the gate is reassessed on Monday 3/23/26 and an appropriate locking mechanism is in place to prevent access an identified and approved technology company is scheduled for a meeting at 12:00 pm on 3/23/26 with the Administrator, Director of Maintenance, and Executive Director to assess the appropriate locking mechanism for the gate between the dog park and the pool area. Security will complete 1 hour walking rounds on the pool and dog park area. Any adverse findings will be documented and reported to Director Residents Services, Executive Director, and Healthcare Administrator.The policy for the pool area was reviewed on 3/21/26 with no additional updates. Access to the pool area is restricted to Independent Living residents. Residents residing in skilled care are not allowed access to the pool area.Monitoring observations and interviews were conducted on 3/21/26 through 3/23/26 on all shifts. The Admin, and ED, verified the in-service training and competencies that had been conducted to validate the staff understanding of the information presented to them. Interviews with CNA A, CNA B, CNA C, CNA D, CNA E, CNA F, Health Info. Spl, RN A, RN B, RN C, Front Desk, LVN A, LVN B, all verified they received in-services training on door monitoring walking rounds around the pool and dog park with a checklist, checking emergency doorways fire doors and the alarm, missing and/or elopement residents skills checklists. Employees had to reenact a situation where management would identify a resident who has eloped and time to see if that resident could be located and what the protocol would be, in service training and including the abuse and neglect each staff member interview in this area were asked to identify three types of abuse in this area and most indicated physical verbal and financial; all employees identified the administrator as the abuse coordinator. All employees were asked about the in-service training regarding the unfamiliar person protocol. Each employee interviewed stated they all understood. They stated that if there is an unfamiliar person in the facility, you are required to ask questions to see if he or she is a resident and if there is a possibility that the unfamiliar person is a resident, then you must telephone the charge nurses on the units and request that they report to the area to identify the person and also, look in the protocol binder on each floor. The protocol binders on each floor have each residents face sheet to identify who the resident is and what floor the resident resides.On 3/23/26 at 10:00 am, observation and test were completed on the 2nd Floor with the emergency door. The emergency door was opened and closed quickly as to silence the door alarm. At 10:01am RN C and CNA G responded to the stairwell.On 3/23/26 at 4:41 pm telephone interview with MD - who stated that upon the admission of Resident 1 the facility was not advised that Resident 1 was an elopement risk. MD stated the local hospital did not advise the facility nor did they put it into the resident's discharge summary. She stated that the resident was not at the facility long maybe 36 hours so there was not a long history to measure with resident. She stated that this is a rehab facility and not a memory care facility and if they had known that Resident #1 had some cognitive deficiencies and was an elopement risk there's a high possibility she would not have been admitted to this facility. Since this incident, protocols have been updated, staff have been in-serviced, security have been in-serviced, there are checks and balances in the facility just in case there is a situation that may possibly occur in the future.On 3/21/26 at 8:15pm, the Administrator was notified that the IJ was removed; however, the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of isolated, due to the facility's need to evaluate the effectiveness of the corrective systems.