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L 000	INITIAL COMMENTS A licensure and complaint investigation survey was conducted from 10/14/2025 to 10/15/2025. Event ID# JTHX11. The following intakes were investigated NC00221051. 1 of 6 complaint allegations resulted in deficiency. Intake NC00221051 resulted in a Past Corrected Type A2 violation. The Type A2 violation was identified at 10A NCAC 13D .2208(e). The violation began on 7/25/2024 and was removed on 7/31/2024.	L 000		
L 039	.2208(E) SAFETY 10A-13D.2208 (e) The facility shall ensure that: (1) the patients' environment remains as free of accident hazards as possible; and (2) each patient receives adequate supervision and assistance to prevent accidents. This Rule is not met as evidenced by: Based on observation, record review, and family, staff, and Medical Director interviews, the facility failed to supervise Resident #1, who was identified as cognitively impaired, had a diagnosis of Alzheimer's disease, had exit seeking behavior, and was identified as at risk for	L 039		

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elopement, from exiting the facility without supervision and staff knowledge. On Thursday, 7/25/2024, around 7:00 PM, Resident #1 had an unsupervised exit out of the facility through the back door of the memory care unit. Resident #1 was found in a parking lot outside of the facility located by a different section of the facility. Resident #1 ambulated down a driveway which did not have a sidewalk, at one point passed approximately 90 feet away from a 4-lane road with a posted speed limit of 35 miles per hour (MPH). Resident #1 was found in a parking lot which was approximately 250 feet away from a 2-lane road with a posted speed limit of 45 MPH. Due to the resident's unsupervised status, cognitive impairment, and being in an area with multiple hazards, Resident #1 was at a substantial risk for serious physical harm or death. The deficient practice was for 1 of 4 residents reviewed for safety (Resident #1).

The findings included:

Resident #1 was admitted directly from home to the secure memory care unit at the facility on 7/24/2024. The resident's diagnoses included Alzheimer's disease, diabetes, and glaucoma.

During an interview on 10/14/2025 at 12:06 PM Resident #1's family member stated Resident #1 had Alzheimer's disease and was admitted to the facility because it had become difficult for the family member to take care of Resident #1. The family member stated, at home Resident #1 lived on a horse farm with hills, fields, and a barn. She stated Resident #1 would wander around the property and to the barn frequently, and she would accompany him.

Review of the nursing admission assessment

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dated 7/24/2024 completed by the Memory Care Coordinator (MCC), who was a nurse, indicated Resident #1 was oriented to person with short- and long-term memory impairment, ambulatory, and full weight bearing with good balance.

Review of a fall risk evaluation dated 7/24/2024 completed by the MCC, indicated Resident #1 was always disoriented to person place and time, no history of falls, normal gait and balance and was a low risk for falls.

Review of Resident #1's medical record did not reveal an elopement risk assessment.

Review of the admission care plan dated 7/24/2024 revealed Resident #1 was care planned for cognition loss and dementia and had impaired decision making related to Alzheimer's disease. He was to remain in locked memory care unit due to poor safety awareness and risk of elopement.

Review of a nursing note dated 7/24/2024 at 9:12 PM, written by Nurse #2 revealed during the evening Resident #1 had walked around the unit and tried to get out. Resident #1 pushed on the doors on the unit, staff found Resident #1 trying to push through the back door, and staff redirected Resident #1. Staff stated Resident #1 was anxious and wanted to leave. Staff were able to get Resident #1 to sit and watch a horse movie with staff.

A nursing note dated 7/24/2024 at 11:37 PM written by Nurse #2 revealed Resident #1 tried to get out and stated he needed to get to his wife and children. Staff attempted to redirect and attempted to contact the resident's family member. Will continue to monitor.

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A telephone interview was conducted on 10/15/2025 at 12:37 PM with Nurse Aide (NA) #1. NA #1 stated she worked from 3:00 PM to 11:00 PM on 7/25/2024 on the memory care unit. NA #1 stated on 7/25/2024, earlier in her shift, Resident #1 had pushed on the back door and caused the door to open and the alarm to sound but he did not leave the unit. NA #1 stated once the door alarm was activated, a code had to be entered into the keypad for the alarm to turn off and be reset. NA #1 explained she redirected Resident #1 to his room where he sat down in a chair and started to look at a book. NA #1 stated around 7:00 PM, she and NA #2 were providing care for other residents on the unit and when NA #1 came out from providing care for another resident, she looked around and noticed Resident #1 was no longer in his room. NA #1 stated no door alarm had sounded while she provided care for the other resident. NA #1 stated she quickly scanned the unit, which included the back door, and when she did not see Resident #1, she called the nurses' station at assisted living and reported to the MCC that Resident #1 was not in his room and could not be found on the unit. NA #1 stated after she reported Resident #1 could not be found a Code Silver (missing resident code) was called and a search for Resident #1 was started. NA #1 stated she heard from other staff that Resident #1 had managed to get the back door of the secured memory care unit open and went outside without the alarm sounding. NA #1 stated when a resident was admitted to the memory care unit, the staff make sure to frequently check on them since they are new to the unit. NA #1 stated that is why she went to check on Resident #1 after care was provided to another resident.

A telephone interview was conducted on

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10/15/2025 at 9:27 AM with NA #2. NA #2 stated he worked from 3:00PM to 11:00 PM on 7/25/2024 in the memory care unit and was familiar with Resident #1. NA #2 stated he was providing care for another resident when NA #1 came in and stated she could not find Resident #1. NA #2 stated he finished providing care for the other resident and went out to help search but Resident #1 had already been found in the lower parking lot. NA #2 stated while he was providing care for the other resident, he did not hear an alarm sound.

Review of a nursing note dated 7/25/2024 at 10:38 PM written by the MCC revealed the MCC was alerted by staff Resident #1 was no longer in his room. The MCC had last observed Resident #1 when he tried to get out the back door and set off the alarm at approximately 6:30 PM. After the back door was reset, staff assisted Resident #1 to his room. The MCC left the unit at the end of the shift and told the Nurse Aides (NAs) she was leaving. Approximately one minute later NA called assisted unit and told the MCC Resident #1 was no longer in his room and could not be located. The MCC along with two other nurses immediately went to the unit to help look. Security was notified immediately on the walkie talkie as well as other units to be on the lookout for Resident #1. Description of what resident was wearing was sent over the walkie talkie. Nurse manager notified and all staff started searching the building and outside. Security located the resident in the parking lot and got him in the truck. The resident was assisted back into the building by staff via wheelchair and was given crackers and lemonade. The resident was in no distress, no injuries were noted, and he moved all extremities per baseline. The Nurse Manager was made aware the resident was located. Every

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15-minute tracking started, and staff was sitting with the resident one on one at the time. The resident's family member was notified via phone. Medical Director was made aware, and the Administrator was in the facility.

An interview was conducted on 10/15/2025 at 9:42 AM with the Memory Care Coordinator, who was a nurse. The MCC stated Resident #1 was a direct admit from home, and she had assessed him at home, prior to his admission. The MCC stated during her home assessments the Responsible party had stated Resident #1 would wander when he became frustrated or upset. The MCC stated when Resident #1 was admitted he had emotional lability (sign or symptom typified by exaggerated changes in mood or affect in quick succession), was combative and aggressive at times and frequently exhibited exit seeking behaviors. The MCC stated she worked on 7/25/2024 in the memory care unit from 7:00 AM to 7:00 PM. The MCC stated Resident #1 had been aggressive by repeatedly pushing on the back door earlier that day and set off the back door alarm. The MCC stated when she heard the alarm, she and NA #2 responded and found Resident #1 inside the unit next to the back door, and the back door alarm was reset, and she heard the door click, indicating it was closed. Resident #1 was redirected back to his room and the MCC saw Resident #1 in his room shortly after 6:30 PM. The MCC stated at the end of her shift she notified NA #1 and NA #2 she was leaving the unit and went to the assisted living unit to give report. While at the assisted living unit she received a call from NA #1 that Resident #1 was not in his room and could not be found on the unit. The MCC stated she immediately called a Code Silver over the walkie talkie and headed to the memory care unit to conduct a search for

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Resident #1. The MCC stated she gave a description of what Resident #1 was wearing over the walkie talkie. The MCC stated after a completed sweep of the memory care unit she headed to assisted living and received notification Resident #1 had been found, this was within 10-15 minutes of Code Silver being called. The MCC stated Resident #1 was brought back to the lobby of the facility by Security Guard #1 and then the resident was returned to the memory care unit. After Resident #1 returned to the memory care unit he had stated he was going home. Resident #1 was assessed, and no injuries were found. The Memory Care Coordinator stated that the Director of Nursing, Administrator, Medical Director, and responsible party were notified.

A telephone interview was conducted on 10/15/2025 11:15 AM with Nurse #1. Nurse #1 stated on 7/25/2024 she was working on the assisted living unit from 7:00AM to 7:00 PM, but she sometimes worked on the memory care unit, and she was familiar with Resident #1. Nurse #1 stated near the end of her shift she was at the assisted living nurses desk giving report when the MCC was called and was informed they could not find Resident #1. Nurse #1 verified she, Nurse #2, and the MCC went to the memory care unit, notified security, and started the process of searching for a missing resident. Nurse #1 stated Resident #1 was found shortly after by security in the lower parking lot.

Review of weather data from Weather Underground for 7/25/2024 at 7:00 PM revealed the recorded temperature was 81 degrees Fahrenheit with no wind or precipitation.

A facility security report dated 7/25/2024 at 7:10 PM revealed Security Guard #1 was working at

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the front desk and heard over the radio Resident #1 was missing from the memory care unit. It was stated there was a man in the lower parking lot with a cowboy hat on. Security Guard #1 locked the front door, drove the security truck, found Resident #1 in the lower parking lot, brought Resident #1 back to the lobby, and turned him over to a nurse.

A telephone interview was conducted on 10/15/2025 at 11:08 AM with Security Guard #1. Security Guard #1 stated he was the security guard who found Resident #1 in the parking lot on 7/25/2024 but did not remember all of the details about when he found the resident. Security Guard #1 stated he heard the call over the radio and used the security truck to search the parking lot. He explained he found Resident #1 walking around in the lower parking lot near the area where cars can drive up to the facility to a covered pull through drop off next to the driveway located at the bottom of the building for the skilled unit. Resident #1 got into the security truck, was brought to the lobby, and he turned Resident #1 over to the nurse. Security Guard #1 stated during each shift the exterior doors were checked to make sure they were locked and secured as part of rounds, and he checked them every shift he worked. The security guard was unable to recall specifically when he had checked the back door for the memory unit on 7/25/24.

An interview was conducted on 10/15/2025 at 9:17 AM with Maintenance Staff #1. Maintenance Staff #1 stated he responded to the memory care unit on 7/25/24 after being called and informed Resident #1 had opened the back door and got outside unsupervised without the alarm sounding. Maintenance Staff #1 stated the back door to the secured memory care unit was an emergency exit

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L 039	Continued From page 8 that required a code to be entered into a keypad for the door to open and not sound an alarm. He explained when the panic bar on the door was pressed continuously for 15 seconds the alarm would sound and the door would open. A second alarm that would sound as soon as the door was opened, was placed on the door on the night of 7/25/2024. Maintenance Staff #1 stated after an alarm was set off, the door had to be closed, and the code entered into the keypad located next to the door in order to stop the alarm from sounding and reactivate the alarm. Maintenance Staff #1 stated when the security video from inside the unit with a view of the back door was reviewed, they could see Resident #1 repeatedly pushing on the door to try to open it. Then they could tell he was trying to push and work the area near the latch of the door. Maintenance Staff #1 stated he attempted to recreate how they believed Resident #1 was able to open the door and exit without the alarm sounding but after multiple attempts by multiple staff, they were not able to open the door without the alarm sounding. Maintenance Staff #1 stated that in addition to the second alarm being placed, a flat metal guard was installed over the area of the door near the latch, which they believed may have been involved in what had caused the door alarm not to sound. He stated there have been no further instances of residents having an unsupervised exit from the memory care unit. Maintenance Staff #1 stated they routinely check the doors throughout the whole facility and specifically the memory care doors to make sure they functioned properly. The Maintenance Staff #1 also stated the video was reviewed from outside of the facility, they were not able to see the exact path Resident #1 took but were able put together how they believed he traveled from outside the memory care unit to the lower parking lot. Maintenance Staff #1 stated	L 039		

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new cameras were installed outside to provide better surveillance coverage. Maintenance Staff #1 also explained he was unable to show the video from 7/25/2024 due to the video only being available for 30 days from the date it was recorded, and then the video was automatically deleted.

An observation of the secured memory care unit was conducted on 10/14/2025 at 3:15 PM. The secured memory care unit was located on the ground floor of the facility in the assisted living section of the building between the assisted living unit and the skilled nursing unit. Entry to the unit required a code to be entered into a keypad located on the wall next to the door, or the doorbell located on the wall next to the door could be pressed to alert staff in the unit to come to the door. Observation of the back door of the memory care unit, the door that Resident #1 exited, revealed a door that was painted to look like a bookshelf. The door had a panic bar that went across the width of the door that could be pushed to open the door. There was a flat metal guard seen at the edge of the panic bar near the latch side. A keypad was noted on the wall next to the door. Near the top of the door two black sensors for a second "screamer" alarm were observed. One part of the alarm was on the door, and one part was on the frame of the door.

An observation was conducted on 10/14/2025 at 4:00 PM of the area immediately outside of the secured memory care unit back door. There was a rectangular concrete patio outside off of the back door which led to a sidewalk that followed along the back of the secured memory care unit. The sidewalk ended at a grassy area located next to the main driveway of the facility. From this point turning to the right leads to the parking lot

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and main front entrance of the facility. Turning to the left leads toward the lower parking lot and around to the back of the facility. The driveway from the parking lot sloped downward and there was no sidewalk along the driveway. The driveway passed approximately 90 feet from a 4-lane road with a speed limit of 35 miles per hour (MPH). The driveway turned to the left past parking spots and to the lower parking lot located at the rear of the facility. Resident #1 was found at the level parking lot near the back of the facility. The facility is of two-story construction at this location and there was a pull through covered drop off that was attached to the building. Approximately 250 feet from where the resident was found was a two-lane road with a speed limit of 45 MPH and there was an intersection of the two mentioned roads that had a stop light.

A telephone interview was conducted on 10/15/2025 at 3:10 PM with the Medical Director. The Medical Director stated he was notified on 7/25/2024 that Resident #1 had exited the building without staff knowing. He explained once staff realized Resident #1 was missing, they conducted a search, and the resident was found outside in the lower parking lot. The Medical Director stated Resident #1 had cognitive impairment, but the Medical Director thought Resident #1 had enough awareness to step out of the way of a moving vehicle. The Medical Director stated there was potential for Resident #1 to become confused and walk into the roadway or to fall. The Medical Director stated he and the facility would not want any memory care residents to be outside alone.

An interview was conducted on 10/15/2025 at 4:27 PM with the Director of Nursing (DON) and the Administrator. The DON stated she was on

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vacation on 7/25/2024 but had been notified of the incident and was familiar with Resident #1. The DON stated from the reports she received regarding the incident she believed staff had acted quickly and appropriately as soon as they knew Resident #1 was missing. The DON stated she would expect the residents of the memory care unit to remain in the unit and not exit the unit alone. The Administrator stated the Memory Care Coordinator had called, reported there had been an elopement, initiated the search for Resident #1, then called again to report Resident #1 had been found by Security Guard #1, and returned to the building. The DON stated any new resident who was admitted to the secured memory care unit was monitored frequently, not a set schedule, but checked on and monitored frequently as they became acclimated to the facility. The Administrator stated on 7/25/2025, a second alarm was added to the door where Resident #1 had exited. The Administrator stated the Medical Director and Resident Representative were also notified on 7/25/2024. The Administrator stated the fire marshal came onsite to assess and provide guidance for measures that could be taken. In addition, new security cameras were approved and installed. The Administrator stated the door Resident #1 used to exit the unit had a new flat metal guard installed near the latch and verified there had been no further elopements from the memory care unit. The Administrator stated she would expect the residents in the memory care unit to remain in the unit and not exit the unit alone.

The Administrator was notified of the A-2 violation (a violation which resulted in substantial risk that death or serious physical harm will occur) on 10/15/25 at 5:15 PM.

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The facility provided the following A-2 past corrected plan.

Address how corrective actions will be accomplished for those residents to have been affected by the deficient practices.
On July 25, 2024, Resident #1 experienced an unsupervised exit from the memory care unit. The resident exited on foot through the back door and proceeded to the back entrance of the facility at approximately 7:05 p.m. At approximately 7:15 p.m., Nurse Aide #1 on the memory care unit identified that Resident #1 was missing and called for the nurse. At 7:24 p.m., the security guard safely located the resident at the back entrance of the building in the parking lot and escorted the resident back to the main entrance. The staff working stated that the alarm did not sound. The staff followed the elopement policy by communicating back and forth on the walkie talkies. The security guard found the resident and communicated via walkie talkie that Resident #1 was found and safe.

On July 26, 2024, the Maintenance Supervisor attempted to reenact how Resident #1 exited the building in order to identify any potential malfunction or bypass of the door alarm system. During multiple attempts to replicate the event, the alarm activated appropriately each time the door was opened. The Maintenance Supervisor was unable to exit the door without triggering the alarm, confirming that the system was operating as intended. A metal latch guard was installed by maintenance on July 26, 2024, to prevent future residents from tampering with the striker plate.

The Power of Attorney (POA), Licensed Nursing Home Administrator (LNHA), and Director of Nursing (DON), and attending physician were

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notified immediately by the Memory Care Coordinator and Nurse Manager of Resident #1's unsupervised exit from the memory care unit. Staff assisted Resident #1 back into the building via wheelchair, provided lemonade and closely monitored the resident's condition. Immediately upon return, nursing staff obtained vital signs and blood glucose levels. A licensed nurse completed a comprehensive head-to-toe assessment, with no injuries noted. These measures were completed on July 25, 2024.

As an immediate safety intervention, 1:1 supervision with documented 15-minute safety checks was implemented for Resident #1. This supervision remained in place through August 10, 2024, with continued 15-minute safety checks through August 14, 2024, when Resident #1 was sent out to the emergency department and did not return to the facility.

On July 25, 2024, when facility was made aware of Resident #1 missing, staff accounted for all other residents on the unit. Staff immediately checked doors and alarms to ensure that they were functioning properly.

The door alarm associated with the incident was inspected and verified to be fully functional. Maintenance confirmed that no mechanical malfunctions were present and that the door was in proper working order on July 25, 2024.
A comprehensive walk-through of the unit was conducted on July 26, 2024, by quality and safety personnel to identify any additional environmental or procedural risks that could contribute to future elopements.

Address how the facility will identify other residents having the potential to be affected by

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the same deficient practice:

On July 25, 2024, the Memory Care Coordinator reviewed the daily census in the unit and determined that all eleven other residents could potentially be at risk for elopement due to their cognitive impairment and nature of the unit. No changes in their behavior were identified or noted.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur-

To further enhance safety, an additional magnetic door alarm was installed on the exit used by Resident #1 by the LNHA the night of the event, July 25, 2024.

Beginning July 26, 2024, the LNHA or designee re-educated all staff on the elopement policy and process: 1. Initiate the elopement response protocol immediately upon identifying that the resident is still missing. 2. An announcement made via walkie-talkie three times, including the resident ' s name, last known location, and clothing description. 3. All staff conduct a coordinated search of their assigned areas in accordance with the facility ' s elopement policy and floor plan. 4. The exact time the resident was identified as missing is documented, and a timeline of events initiated and maintained to support follow-up and review by Incident Commander. 5. Nursing staff verify at the nursing station that the resident has not been signed out. 6. Activate phone tree to contact appropriate personnel. 7. If resident is not located on the premises, the Incident Commander or LNHA will notify the police to report them missing.

The policy also states and was included in the all

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L 039	Continued From page 15 staff education provided by the LNHA on July 26, 2024 that staff are to complete an assessment upon admission to review any potential resident for wandering or risk of elopement. In addition, staff are educated to notify their supervisor to report any increased behaviors or unsafe practices noted by resident immediately. If resident is noted at this time to pose a risk for elopement, the resident will be added to the ongoing elopement list and emailed and posted in appropriate areas for staff awareness. These new concerns will be discussed in stand-up and weekly interdisciplinary meetings to ensure ongoing safety of the resident. All staff received re-education regarding elopement policies/procedures prior to their assigned shift starting on July 26, 2024. All new staff receive education on the elopement policy and procedures during their onboarding process and training, prior to working any shifts. The facility Safety Supervisor consulted via phone on July 26, 2024 with the fire marshal regarding the installation of a gate at the back entrance; however, the request was denied due to code restrictions. As an alternative, an additional lock with a keypad was installed on the garden gate to enhance security and reduce the risk of future elopements in that specific area. An emergency request for the installation of additional outdoor security cameras to improve surveillance coverage was submitted and subsequently approved at their next senior leadership meeting. The camera installation company did a facility walk through with leadership to determine appropriate placement of outdoor camera systems on July 30, 2024. The installation process began subsequently after contract and pricing approval.	L 039		

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A safety meeting held the following Tuesday, July 30, 2024, to debrief and reinforce future preventive strategies with the interdisciplinary team to include the administrator, director of nursing, nurse managers, dining service director, safety supervisor, maintenance supervisor, social worker, recreation therapy director, environmental services director and administrative assistant. No interventions were added as a result of this meeting.

The incident and related corrective measures were reviewed during the stand-up meeting on July 26, 2024, with ten participants present, including the DON, LNHA, Social Worker and Safety Officer.
Elopement drills are completed bi-annually and as needed.
Elopement risk assessments will continue to be completed upon admission by the admitting nurse and updated as needed with any change in resident status.

How will the facility monitor its corrective actions to ensure the deficient practice will not recur?

The LNHA and DON identified the need for immediate reporting and discussion of the elopement during the July 26, 2024, stand-up meeting. All facility leadership, were notified of the event at the time of occurrence by the LNHA. It was decided that the Safety Committee would conduct focused reviews for three consecutive months to reevaluate the elopement process and identify additional preventive measures.

On July 26, 2024, the lead Safety Officer and security guards were assigned by the LNHA verbally to conduct shift audits of the building and

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grounds, including interior and exterior doors, daily on each shift as part of the facility's routine rounding procedures. These audits are still in place as an ongoing standard practice. Additionally, the Social Worker was tasked with updating the elopement list monthly and as needed to ensure staff are aware of residents at risk for elopement by DON during stand-up meeting on July 26, 2024.

To sustain corrective actions, the LNHA and DON will continue to monitor adherence to the facility's elopement policy and response procedures through ongoing staff education, annual competency evaluations, and scheduled bi-annual elopement drills. Ongoing monitoring also conducted during monthly safety meetings to assure compliance with elopement policy and procedures. Elopement prevention and response protocols will be reviewed during monthly Safety Committee meetings and stand-up meetings to confirm ongoing staff understanding and compliance.

The elopement policy and procedures will continue to be reviewed at least annually by the Safety Committee and as needed based on incidents, regulatory updates, or identified trends. All findings from audits, drills, and safety reviews will be documented, tracked, and addressed through the facility's QAPI process to ensure sustained compliance for the following three months. Changes to the Plan of Correction will be implemented as necessary.

Alleged date of the A-2 violation past correction date: 7/31/24

A validation of the facility's A-2 past corrected plan was conducted on 10/15/2025. In-service

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L 039	Continued From page 18 records and interviews with staff across all departments revealed they had been educated on ensuring safety with residents that exhibit wandering or exit seeking behaviors and resident elopement. Staff were also educated on the facility policies and procedures for resident elopement. Staff were made aware to notify their supervisor or administrative staff if they observe any changes with residents' behaviors or resident safety concerns regarding exit seeking. Staff were also educated on the importance of monitoring the location of their residents as they made rounds throughout the unit. Staff also participated in facility elopement drills to demonstrate knowledge received during their elopement training that was conducted twice a year and at random intervals. Staff were also responsible for making sure all memory care exit doors were closed properly and alarmed during each shift. Licensed nursing staff were educated on completing accurate wandering and elopement risk assessments by reviewing previous assessments, care plans, progress notes, and completing accurate observations of residents. Interviews with the administrative staff revealed they had been educated to make sure all residents have updated, and accurate resident risk assessments were completed to include resident risk for wandering and elopement. Any changes in condition or new behaviors pertaining to wandering or exit seeking residents were being documented and supervisors were made aware. Administrative staff were also completing the education, audits, and monitoring of staff to ensure residents' safety. A security camera was also observed on the outside of the building that faced the door leading to the outside. Interviews with the maintenance department revealed they had received education the resident elopement policy and procedures, participated in the	L 039		

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L 039	Continued From page 19 elopement drills, continued to check the locks and doors alarms on the inside and outside of the memory care unit daily during each shift. An interview with the security department revealed they had received education on resident elopement policy and procedures, assisted with the elopement drills, and monitored exterior doors and outside the facility during each shift for any resident behavior regarding exit seeking. The security department stated part of their daily rounds each shift is to check that the secured memory unit's exterior doors are locked and secured. The facility safety committee meeting was held on 7/26/24 to discuss the elopement incident, and to develop and implement their safety plan to ensure no further residents were at risk for elopement. Plan was reviewed with no issues. The facility's past corrected date of 7/31/24 was validated on 10/15/25.	L 039		