

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375124	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2025
NAME OF PROVIDER OR SUPPLIER Sequoyah Pointe Skilled Nursing and Therapy		STREET ADDRESS, CITY, STATE, ZIP CODE 614 E Cherrie Street Tahlequah, OK 74465	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 05/13/25, a past noncompliance situation was determined to exist related to the facility's failure to provide supervision to protect residents.</p> <p>An incident report, dated 05/02/25, showed Resident #1 had left the facility without staff knowledge and was found by local police in a commercial establishment's parking lot approximately 400 feet from the facility. Resident #1 was returned to the facility within 30 minutes of their departure and was transferred to a secured facility two days later.</p> <p>Based on observation, record review, and interview the facility failed to ensure a resident with a history of elopement did not elope from the facility for 1 (#1) of 3 sampled residents reviewed for accident hazards.</p> <p>Corp. Nurse Consult. #1 reported five residents wandered at the facility.</p> <p>Findings:</p> <p>On 05/13/25 at 10:30 a.m., the lock on the kitchen door was observed during the initial tour.</p> <p>A facility document titled Elopement Risk Guideline, dated 04/2025, read in part, 1. The Elopement risk assessment is completed on all admissions, readmissions, elopements, and significant changes. Elopements and significant changes are reported to a member of the IDT [interdisciplinary team] . 2. If a resident is identified to be at risk for elopement, initiate interdisciplinary care plan accordingly and follow plan of care.</p> <p>A care plan focus, dated 09/27/22 and revised 05/25/23, showed Resident #1 was deemed to have a risk for elopement related to impaired safety awareness and a previous elopement at the facility.</p> <p>A Elopement Risk Scale form, dated 02/28/25, showed Resident #1 had a score of 8 on the assessment which indicated a low elopement risk.</p> <p>An annual minimum data set assessment, dated 04/16/25, showed Resident #1 had a brief interview for mental status score of 14 which indicated the resident's cognitive abilities were intact.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note titled Incident Note, dated 05/02/25 at 10:48 p.m. showed Resident #1 had eloped through a back door of the facility kitchen and was found about one block away at a local store parking lot. The note further showed the resident had stated they were waiting for their family member to pick them up. The note showed the resident was assessed upon return to the facility and no injuries had been identified.</p> <p>A progress note titled Nurses Progress Notes, dated 05/05/25 at 5:15 p.m., showed Resident #1 had been transferred to a geriatric psychiatric unit for evaluation.</p> <p>A progress note titled Nurses Progress Notes, dated 05/12/25 at 1:01 p.m., showed Resident #1 remained at the geriatric psychiatric unit and would be transferred to a more secure nursing facility after discharge from the hospital.</p> <p>On 05/13/25 at 10:30 a.m., the kitchen door where Resident #1 had eloped was observed. The door had a keypad electronic lock on the door.</p> <p>On 05/14/25 at 9:27 a.m., corp. nurse consult. #1 stated Resident #1 had left the facility through a back door in the kitchen. They stated the resident had crossed a dead end street behind the facility to the parking lot of a local market. Corp. Nurse Consult. #1 stated they had gone to a house next to the facility and the occupant felt the resident was confused and called the police. They stated the police found the resident at the store and called the facility.</p> <p>On 05/15/25 at 11:04 a.m., the DON stated a neighbor of the facility called the police department on 05/02/25 at 4:10 p.m. and the resident was back in the facility when they started the incident report at 4:35 p.m. the same afternoon. The DON stated the resident was placed on one on one checks until they were transferred to a hospital on [DATE]. They stated the kitchen door Resident #1 had used to depart the facility had a keypad placed on it on 05/05/25. The DON stated Resident #1 made no further attempts to leave the facility prior to being transferred to the hospital. The DON stated all staff were in-serviced on elopement, and monitoring of both Resident #1 movements as well as the kitchen door. They stated this began the day the resident eloped on 05/02/25.</p> <p>On 05/15/25 at 1:00 p.m., the administrator supplied documentation of corrections made following the elopement including a quality assurance and performance improvement teams document, dated 05/02/25 at 4:30 p.m., that identified the problem and corrections made, staff elopement in-service attendance documents dated 05/02/25 at 5:30 p.m., and monitoring sheets of Resident #1 and the kitchen door dated 05/02/25, 05/03/25, 05/04/25, 05/05/25, 05/06/25, and 05/07/25.</p>		