STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375158	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Timbers Skilled Nursing and Therapy	2520 South Rankin Edmond, OK 73013

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** 34460 A past noncompliance Immediate Jeopardy (IJ) situation was determined to exist effective 10/24/24 related to the facility's failure to supervise and prevent a resident from elopement. The facility failed to prevent Resident #1 from eloping from the facility which had the potential to result in serious injury or harm. On 11/07/24, the Oklahoma State Department of Health verified the existence of the past noncompliance IJ related to the facility's failure to protect and prevent accident hazards related to elopement. The past noncompliance IJ was removed effective 10/25/24 after the facility put measures in place to prevent recurrence. On 10/25/24 compliance rounds were initiated, the quality assurance committee met, a quality tip report was completed, an onshift notification message was sent to all employees, an inservice on elopement risk assessments were completed by all nurses, four delay egress locks with four keypads were installed, staff were assigned to the memory care door each shift, all staff were inserviced on elopement, and an inservice on the elopement drill was completed. Letters were mailed to families and posted at the memory care doors. On 11/05/24 at 3:25 p.m., a staff member was observed between two egress doors to allow visitors in/out after ringing the doorbell. Based on observation, record review, and interview, the facility failed to prevent and monitor a resident for elopement for one (#1) of two sampled residents with wandering behavior. Findings: Resident #1 was admitted to the facility on [DATE] with diagnosis of dementia in other diseases classified elsewhere with progressive neurological conditions. They were a high fall risk. Resident #1's MDS, dated [DATE], documented their cognition was severely impaired and they were independent with ambulation. It documented the resident was at significant risk of getting to a potentially dangerous place outside of the facility. It documented it was very important for the resident to do their favorite activities and to go outside to get fresh air when the weather was good. (continued on next page)

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

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An initial incident report from, dated 10/24/24, documented at 8:49 p.m. the administrator was notified Resident #1 was unable to be found in the building. It documented they were last seen approximately 30 minutes prior to notification. It documented interventions initiated were an elopement drill, sweep of the facility and outside grounds initiated with no success, two vehicles dispatched to search in a one mile radius with no success, and search radius was increased to a two mile radius. It documented the resident's family, physician, and police were notified. It documented all residents in the building were accounted for except Resident #1. It documented the search was ongoing for the resident. A final incident report form, dated 10/25/24, documented the resident was found at approximately at 2:30 a. m. It documented the resident's family, provider, and police were notified the resident was located. It documented the resident was brought back to the facility and a head to toe and pain assessment were completed with no injury or dehydration noted. It documented the resident was placed one on one and will be evaluated after their interventions were in place. It documented a family member (of another resident) was dropping off their loved one and let the resident out and escorted them out of the front building. It documented to protect the residents they had reviewed and updated their elopement assessments. It documented correction measures to implement would be a door bell system inside the unit that families will ring to have staff escort them out of the system to prevent residents blending in with families. It documented there would be a sign that families would have to sign in and sign out with times. A incident note, dated 10/24/24 at 11:27 p.m., documented focused charting related to a missing resident. It documented upon conducting routine rounds the medication aide on the floor noticed the resident was not in their room. It documented the medication aide notified the nurse and the staff on the floor. It documented a code was called and every staff member in the building searched for the resident. It documented they were unable to locate the resident. It documented the nurse notified the administrator and they asked the nurse to call the emergency agency and the family. It documented the emergency agency responded by sending a police officer to the building. It documented the police officer came in and asked the nurse questions about the description of the resident and the last time the resident was seen in the building. It documented the resident's family arrived to the building and gave some information to the police officer and left the building. It documented the DON, ADON, and the corporate nurse for the facility arrived to the building and helped search for the resident. It documneted the resident was unable to be found. A incident note, dated 10/25/24 at 2:10 a.m., documented focused assessment related to the resident's return to the facility. It documented at about 2:10 a.m. the resident returned to the facility accompanied by a police officer and the DON and ADON were present. It documented the nurse initiated a head to toe assessment on the resident and the residnet was able to move all extremities. It documented there was no edema noted in the BUE and the BLE had 2+ edema. It documented the resident stated they walked a very long distance. It documented there was no bruising. It documented LCTA, no SOB or labored breathing noted. It documented HRR, BS-active in all quads. It documented ABD-soft and non-distended. It documented there was no pain upon palpation and no pain or discomfort. It documented there was no redness to the buttock or perineum. It documented the BLE had redness and protective cream was applied. It documented the resident had redness upon initial assessment of the BLE. It documented BLE were elevated for edema. It documented the BP was 140/74, O2 saturation was 99% on RA, pulse was 88, RR was 18, and temperature 97.8. It documented the resident was resting and placed on 1:1. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/05/24 at 11:30 a.m., the laundry/housekeeping supervisor assisted a visitor to the secured unit and off of the secured unit. They stated there were new codes and procedures for the secured doors since the elopement. On 11/07/24 at 8:15 a.m., Resident #1 stated they liked to go on walks. On 11/07/24 at 8:30 a.m., the regional director of operations stated they thought they had enough signage previously, Do NOT let out ANYONE that is not with YOUR party Thank you, but another residents family member thought they were the family of another resident and escorted them through the memory care door and out the front door.