STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375165	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broken Bow Health and Rehab	700 West Jones Broken Bow, OK 74728

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a comprehensive care plan was updated after a wandering risk scale increased to high risk for 1 (#3) of 3 sampled residents reviewed for wandering and elopement risk. The ADON identified 62 residents resided in the facility. Findings: A care plan for Resident #3, dated 03/22/26, showed the resident had impaired cognition, but showed no interventions for wandering risks. A Wandering Risk Scale for Resident #3, dated 03/23/26, showed the resident was at low risk for wandering. The document showed the resident had no history of wandering but did have cognitive impairment. An admission assessment for Resident #3, dated 03/27/26, showed the resident was admitted on [DATE] with diagnoses which included dementia, delirium, and head injury. The assessment showed the resident had a BIMS score of 11 which indicated moderate cognitive impairment. A Wandering Risk Scale for Resident #3, dated 04/22/26, showed the resident was a high risk for wandering. The document showed the resident had a history of wandering and continued to have cognitive impairment. A nurse's progress note for Resident #3, dated 04/26/26 at 8:01 p.m., showed the resident was ambulating, pacing the halls, confused, but easily redirected. A nurse's progress note for Resident #3, dated 05/10/26 at 4:25 p.m., showed a family member was notified the resident exited the facility and was safely brought inside by a CNA #1. On 05/19/26 at 11:54 a.m., CMA #1 described Resident #3 as pleasant, confused, and wandered often. CMA#1 stated the resident did not exhibit exit seeking behaviors prior to 05/10/26. On 05/19/26 at 12:12 p.m., the MDS coordinator stated their process for creating and updating comprehensive care plans included the information gathered from assessments, nurse progress notes, and observations. They stated the nurse should inform the MDS coordinator of changes seen when assessments were completed. The MDS coordinator agreed the care plan for Resident #3 should have included interventions for wandering and risk for elopement when a diagnosis of dementia, and documented confusion and disorientation.

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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(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 record review and interview, the facility failed to ensure adequate supervision was provided to prevent elopement for 1 (#3) of 3 sampled residents reviewed for accidents/hazards. Resident #3 exited the facility and ended up at a fast food restaurant after crossing a busy, four-lane highway. The ADON identified 62 residents resided in the facility and one resident was identified as high risk for wandering. On 05/19/26 at 12:40 p.m., an IJ situation was determined to exist related to the facility's failure to provide adequate supervision for Resident #3, who was determined to have a high risk for wandering, and had prior history of elopement. On 05/19/26 at 5:09 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On 05/19/26 at 5:23 p.m., the administrator, DON, and ADON was notified of the IJ situation and was provided the IJ template. On 05/20/26 at 2:01 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part, Actions Taken to Remove the Immediate Jeopardy: -Resident #3 no longer resides at the facility. -A staff will be placed to monitor the front door starting immediately until alarms and locks are put in place. No one will be able to let themselves in or out. Door will be locked to all people entering or exiting facility unless staff buzzes them in or out. -DON/designee will perform elopement assessments for those residents who have triggered 'high risk to wander' on the wander assessment initiated on 05/19/26. Currently there are no residents that trigger 'high risk to wander.' -All residents currently residing in facility had wander assessment audit and was completed by VP of clinical on 05/19/26 to identify any residents that are considered 'high risk to wander.' -The DON will in-service all staff on the following: elopement policy any resident leaving facility attended or unattended with unsafe exit, 'ex. confusion, physical diagnosis, behaviors, etc. are to notify charge nurse, management/and or administrator. In-services and training will be initiated 05/19/26 and staff will not be allowed to return to work until they have been in-serviced. The VP of clinical will in-service the DON and ADON on assessing residents for risk of elopement until completed by end of day on 05/20/26. On 05/21/26 at 10:38 a.m., the IJ was lifted when all components of the plan of removal had been verified as completed. A staff member was observed to be seated at the nurse's station to buzz people in and out of facility. In-service training regarding elopement and assessments were reviewed. Various members of the staff were interviewed, such as housekeeping, dietary, CNAs, CMAs, LPNs, and registered nurses to ensure in-service training had been completed. Staff were knowledgeable regarding steps to take if a resident exits the facility unattended. Staff stated they were to inform a member of management if a resident began to show a change in behaviors or cognition. The deficient practice remained at an isolated pattern with no actual harm with the potential for more than minimal harm that is not immediate jeopardy. Findings: A care plan for Resident #3, dated 03/22/26, showed the resident had impaired cognition, but showed no interventions for wandering risks. A Wandering Risk Scale for Resident #3, dated 03/23/26, showed the resident was low risk for wandering. The document showed the resident had no history of wandering but did have cognitive impairment. An admission assessment for Resident #3, dated 03/27/26, showed the resident was admitted on [DATE] with diagnoses which included dementia, delirium, and head injury. The assessment showed the resident had a BIMS score of 11 which indicated moderate cognitive impairment. A Wandering Risk Scale for Resident #3, dated 04/22/26, showed the resident was a high risk for wandering. The document showed Resident #3 had a history of wandering and continued to have cognitive impairment. A nurse's progress note for Resident #3, dated 04/26/26 at 8:01 p.m., showed the resident was ambulating, pacing the halls, confused, but easily redirected. A nurse's progress note for Resident #3, dated 05/10/26 at 4:25 p.m., showed a family member was notified the resident had exited the facility and was safely brought inside by CNA #1. A nurse's progress note for Resident #3, dated 05/10/26 at 4:40 p.m., showed the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident had exited the facility and was at a fast food restaurant located four blocks away across a busy four-lane highway. The note showed CMA #2 brought Resident #3 back to the facility. The resident was assessed and determined to have no injuries and was placed on 1:1 care. On 05/13/26, the Oklahoma State Department of Health received an incident report, dated 05/10/26, showed a witness stated Resident #3 had gotten out of the facility earlier, then saw the same resident later in the day at a fast food restaurant. The report showed the witness called the facility to inform a staff member. On 05/19/26 at 11:54 a.m., CMA #1 stated Resident #3 was pleasant, confused, and wandered often. The CMA stated the resident did not exhibit exit seeking behaviors prior to 05/10/26.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on record review and interview, the facility failed to obtain hemoglobin A1c lab as ordered for 1 (#5) of 3 sampled residents reviewed for assess, monitor, and intervene.The ADON identified 62 residents resided in the facility. Findings:A facility policy titled Lab and Diagnostic Test Results-Clinical Protocol, revised 11/2018, read in part, The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs.The staff will process test requisitions and arrange for tests.A physician's order Resident #5's , dated 01/02/17, showed hemoglobin A1c (a blood sugar test) due in January, April, July, and October.Laboratory results Resident #5 were reviewed for January and April 2026. There was no documentation the tests were obtained.A physician's progress note for Resident #5, dated 05/18/26, read in part, We need an A1C with this patients labs every 90 days. Has been missed twice in a row now.On 05/21/26 at 8:37 a.m., LPN #1 stated if a resident had an order for lab, they would fill out a requisition form and lab would be collected on Tuesdays and Thursdays.On 05/21/26 at 8:43 a.m., LPN #1 stated the hemoglobin A1c test was not collected in January and April of 2026.On 05/21/26 at 8:44 a.m., LPN #1 stated the physician's order was not followed.On 05/21/26 at 8:46 a.m., LPN #1 stated the hemoglobin A1c test was collected at 8:00 a.m. today.On 05/21/26 at 9:08 a.m., the DON stated the hemoglobin A1c test should have been collected as soon as possible when the physician noticed the tests were missing.