STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375190	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastgate Village Care & Rehab Center	3500 Haskell Blvd Muskogee, OK 74403

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. On 07/01/25, a past non-compliance immediate jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure the safety of residents at risk for elopement. On 06/19/25, Resident #1 eloped from the property through the front entrance at approximately 6:30 p.m. by following out a food delivery person. Resident #1 had a history of threatening to elope and wandering. The police found and returned Resident #1 to the facility at approximately 7:30 p.m. and reported Resident #1 was located in a field near the facility. Based on record review and interview, the facility failed to provide supervision to ensure the safety of a resident for 1 (#1) of 2 sampled residents reviewed with exit seeking behaviors. The DON identified one resident wandered. Findings: A care plan for Resident #1, initiated 08/06/24, showed a focus of the potential for elopement risk/wanderer with interventions which included: assess for elopement/wander risk, disguise exits, cover door knobs and handles, tape floor, distract from wandering by offering pleasant diversions, structured activities, food, conversation, television, books, observe for fatigue and weight loss, observe location frequently, document wandering behavior and attempt diversional interventions in behavior log, provide structured activities, toileting, waking inside and outside, reorientation strategies including signs, pictures, and memory boxes, and utilize wanderguard. A care plan for Resident #1, initiated 12/20/24, showed a focus of the risk for wandering/elopement was identified with interventions which included: clearly identify resident's room and bathroom, engage resident in purposeful activity, identify if there was a certain time of the day wandering/elopement attempts occurred, implement a scheduled toileting program, and implement a scheduled hydration. A progress note, dated 04/20/25, showed Resident #1 was verbally aggressive toward staff and had attempted and threatened to elope, and had kicked at windows and doors. A progress note, dated 04/27/25, showed Resident #1 walked up to the nurses station without their walker with a skin tear to their right forearm. The note showed the nurse went to the room of Resident #1 to find their wheelchair and observed the window open, blankets on the window sill, and the wheelchair was thrown out the window with the window screen on the ground next to the wheelchair. (continued on next page)

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	A progress note, dated 04/29/25, showed Resident #1 was at the front door with staff attempting to redirect the resident to turn around. A progress note, dated 05/03/25, showed Resident #1 was verbally aggressive and had stated they were leaving and no one could stop them. A re-admission after hospitalization elopement risk evaluation, dated 05/15/25, showed Resident #1 was at risk for elopement with a score of 4.0. A quarterly assessment, dated 05/21/25, showed Resident #1 had a brief interview for mental status score of 10 with diagnoses which included hypertension, heart failure, and dementia. A care plan for Resident #1, revised 06/20/25, showed a focus risk for wandering/elopement was identified with interventions which included: the resident would be transferred to a memory unit when the veterans administration sent the contract to the memory unit facility. Review of the facility elopement investigation, dated 06/20/25, showed an elopement risk audit for new admissions form, dated the week of 06/23/25 to 06/27/25. The audit form showed new admissions during the week and if an elopement risk audit was completed upon admission. The audit form showed four residents had admitted and an elopement risk evaluation was completed with scores of zero for all. The facility elopement investigation included the faxed ODH (Oklahoma Department of Health) Form 283, Incident Report Final and a word document which included the facility's investigation findings. The findings, read in part, Upon completion of investigation, the facility determined that the resident had eloped from the facility and was transferred to a veterans administration (VA) contract memory unit in [another city] for his safety. The investigation included an educational in-service record dated 06/20/25 and 06/22/25, titled elopement education. The in-service form showed signatures of all current staff. The investigation included a timeline of when and where Resident #1 was last seen. The timeline showed Resident #1 was last seen at 6:30 p.m. in the lobby. The investigation included elopement risk evaluations of all residents in the facility and a facility map indicating location of outside doors checked and the result. The facility investigation included a quality assurance and performance improvement (QAPI) meeting form dated 06/20/25 with signatures of meeting attendees and corrective action/steps taken immediately, process, systematic changes, ongoing monitoring, and date of compliance 06/20/25. On 07/01/25 at 11:20 a.m., the DON stated Resident #1 was gone approximately 35 to 40 minutes. They stated Resident #1 had walked across the dead end road in front of the facility, crossed over the loose fence to the neighbor's yard, and was sitting under their tree. The DON stated when Resident #1 returned they did a head-to-toe assessment and kept Resident #1 on one on one observation until they transferred to a memory care unit. The DON stated Resident #1 had a wanderguard on their wheelchair, but had taken their walker. The DON stated the representative of Resident #1 had recently brought in a walker and it did not have the wanderguard like the wheelchair.