STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375206	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindsay Nursing & Rehab	1103 West Cherokee Lindsay, OK 73052

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 - Minimal harm or potential for actual harm 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** 34333 Based on observation, record review, and interview, the facility failed to prevent elopement for one (#1) of two sampled residents reviewed for adequate supervision to prevent elopement. The administrator stated one resident elopement in the previous 60 days. Findings: An Elopements policy, dated December 2007, read in part, .Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing .If an employee discovers that a resident is missing from the facility .Determine if the resident is out on an authorized leave or pass .initiate a search of the building(s) and premises .initiate an extensive search of the surrounding area .When the resident returns to the facility, the Director of Nursing Services or Charge Nurse shall .Examine the resident for injuries .Complete and file an incident report .Document relevant information in the resident's medical record . Resident #1 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, depression, anxiety, chronic pain, dysphagia, and insomnia. A care plan for Resident #1, dated 01/16/24, documented the resident was at risk for wandering. Interventions included to implement facility protocol for locating an eloped resident if resident should exit the building. The care plan documented the resident left the faciity on [DATE] without staff and was returned to the facility and placed on 1:1 observation. There were no additional interventions added to prevent elopement following the 1:1 observation. A MDS assessment, dated 10/01/24, documented Resident #1 was severly cognitively impaired. The assessment documented the resident ambulated independently without assist. An Elopement Risk Evaluation, dated 10/03/24, documented the resident was at risk for elopement. The evaluation documented the resident had a history of attempting to leave the facility without informing staff. The evaluation documented the resident's wandering behavior was likely to affect the safety or well-being of self/others. (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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(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 - Minimal harm or potential for actual harm Residents Affected - Few	An Incident Report Form, dated 10/04/24, documented the facility was notified by the local fire department Resident #1 had been found by the church neighboring the facility property. The report documented staff had seen the resident in bed 20 minutes prior to the phone call from the fire department. The report documented staff retrieved the resident and upon return to the facility the resident was assessed for injuries, neuro checks were initiated, and the resident was placed on 1:1 supervision. A follow-up to the report documented an alert and oriented resident had left the building after Resident #1 was seen in bed, but prior to the call from the fire department. The facility suspected Resident #1 followed the other resident out of the building. The report documented upon investigation there was not a witness to corroborate this. One-on-one safety check forms, dated 10/04/24 and 10/05/24, documented the resident would remain on 1:1 observation for eight hours, then every 15 minute checks for eight hours, every 30 minutes for eight hours, every hour for eight hours, then would return to normal care if no incident occurred. The forms documented if another incident occurred the resident would return to 1:1 supervision. An updated Elopement Risk Evaluation, dated 10/04/24, documented the resident was at risk for elopement. The evaluation documented the resident had a history of elopement. The evaluation did not include interventions to prevent elopement. On 10/10/24 at 11:30 a.m., Resident #1 was observed wandering the halls of the facility. The resident was observed to walk independently without assist. Resident #1 was observed to walk to the exit doors at the end of halls, but did not push on the doors or open them. On 10/10/24 at 12:30 p.m., LPN #1 stated they were working the night Resident #1 left the building. The LPN stated the resident was known to go to the exit doors and occasionally push on them, but the LPN was not aware of the resident ever leaving the premises. The LPN stated they had seen the resident in bed at approximately 9:25 p.m., about 20 minutes prior to the fire department calling the facility. The LPN stated they went to retrieve the resident, EMS was on the scene assessing the resident, and the LPN returned the resident to the facility where the resident was assessed and placed on 1:1 supervision. The LPN stated the resident had no injuries, but was placed on neuro checks and 1:1 supervision per facility protocol. On 10/10/24 at 12:40 p.m., the ADON stated there was a previous incident when Resident #1 got outside the doors, but did not leave the property and staff assisted the resident back inside. The ADON stated although Resident #1 wandered the halls and would go to the exit doors, the resident had never gone past the sidewalk in front of the building. The ADON was asked if additional interventions had been implemented to prevent a future elopement. The ADON stated they did not know of other interventions, other than to keep a closer eye on the resident and ensure doors were locked. On 10/10/24 at 12:57 p.m., the administrator stated there had been recent abuse staff in-services, but not one specifically related to resident elopements. They stated the facility had several alert and oriented residents who were free to check out and leave the facility as they wished. They stated staff were very familiar with Resident #1 and knew to supervise them closely due to wandering behaviors, but no additional interventions had been added after the elopement.