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	07/03/2025

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. Based on observation, record review, and interview, the facility failed to ensure supervision to prevent an elopement for 1 (#6) of 3 sampled residents reviewed for elopement. The DON identified two residents at risk for wandering/elopement. Findings: On 06/30/25 at 2:05 p.m., Res #6 was observed ambulating independently in the hallway outside of their room. No exit-seeking behavior was observed. An undated policy titled Wandering and Elopement Prevention, read in part, It is the policy of facility to identify residents at risk for wandering and/or elopement and to implement appropriate interventions to ensure their safety. The facility will take reasonable steps to prevent unauthorized exits and promote a safe and secure environment for all residents. A medical diagnosis list, dated 05/29/25, showed Res #6 admitted to the facility with diagnoses which included hypertension and hyperlipidemia. A nursing note, dated 05/30/25, showed Res #6 had decreased awareness and required frequent redirection. The note showed Res #6 was wandering around the facility and looking for their truck in the parking lot. An elopement assessment, dated 05/31/25, showed Res #6 was not at risk for elopement. A nursing note, dated 05/31/25, showed Res #6 was allowed outside by another resident and was observed on the east side of the building looking for their truck. An admission assessment, dated 06/05/25, showed Res #6 had a brief interview for mental status score of 6 and was severely cognitively impaired with disorganized thinking. The assessment showed Res #6 was independent with mobility and had wandered one to three days. An incident report, dated 06/05/25, showed Res #6 was disoriented, agitated, and confused while wandering/pacing facility. The note showed Res #6 was observed leaving through the front door and walking through the parking lot towards the highway. The note showed staff assisted Res #6 back into the facility and they continued to wander and pace the inside of the facility. (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

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	07/03/2025

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	A nursing note, dated 06/25/25, showed an off-duty staff member had observed Res #6 walking down the highway in front of the facility. The note showed the staff member brought Res #6 back to the facility. The note showed Res #6 was assessed upon return to the facility and had not sustained injury. An elopement risk assessment, dated 06/26/25, showed Res #6 was at risk for elopement. A care plan, dated 06/26/25, showed Res #6 was an elopement risk with interventions to identify pattern of wandering and provide distractions when wandering is observed. On 06/30/25 at 2:23 p.m., Res #6 stated they did not remember leaving the facility and walking down the highway on 06/25/25. Res #6 stated they were not in prison and had the right to leave the facility grounds whenever they felt like it. On 07/01/25 at 1:36 p.m., the DON stated the facility determined which residents were at risk for elopement based on the results of an elopement risk assessment. The DON stated Res #6 should have been considered an elopement risk upon admission. They stated Res #6 should not have been outside unsupervised due to cognitive impairment. The DON stated interventions to prevent elopement should have been implemented prior to the incident on 06/25/25. On 07/03/25 at 8:03 a.m., LPN #1 stated Res #6 had been confused and required frequent redirection since admission. LPN #1 stated they had observed Res #6 push on the front door until it opened and exited the facility on 06/05/25. They stated Res #6 should have been considered an elopement risk since admission and interventions to prevent future elopements should have been implemented after the incident on 06/05/25. On 07/03/25 at 8:15 a.m., the administrator stated video surveillance had been reviewed and showed Res #6 had followed a staff member and another resident out of the front door of the facility on 06/25/25 around 9:00 p.m. They stated the staff member should have provided supervision that would have prevented Res #6 from being able to make it onto the highway without anyone's knowledge.