

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER Jan Frances Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 815 North Country Club Road Ada, OK 74820	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>41873</p> <p>Based on record review and interview, the facility failed to provide adequate supervision to prevent elopement for 1 (#1) of 3 sampled residents reviewed for elopement.</p> <p>The assistant administrator reported 50 residents resided in the facility.</p> <p>The facility elopement book identified four residents at risk for elopement.</p> <p>Findings:</p> <p>A policy titled Wandering, Unsafe Resident, dated 12/01/08, read in part, The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement.</p> <p>Resident #1 had diagnoses which included dementia.</p> <p>An elopement risk evaluation, dated 08/19/24, showed Resident #1 was at risk for elopement.</p> <p>A care plan, dated 08/19/24, showed Resident #1 was an elopement risk due to ambulation status, history of elopement, dementia, and wandering.</p> <p>A progress note, dated 01/11/25 at 5:09 a.m., showed the resident got up through the night wandering halls, trying to go into other resident rooms, and was easily redirected.</p> <p>A quarterly assessment, dated 01/13/25, showed Resident #1's cognition was severely impaired and the brief interview for mental status was unable to be scored.</p> <p>A incident report, dated 03/12/25, showed the facility was notified by a realtor at 11:20 a.m. of a possible missing resident. The report showed staff returned Resident #1 to the facility. The report showed the resident's window screen had been removed and the window was open. The report showed the resident had been last seen in the front lobby at 10:30 a.m.</p> <p>(continued on next page)</p>

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: 375243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER Jan Frances Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 815 North Country Club Road Ada, OK 74820	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note, dated 03/12/25 at 12:16 p.m., showed a real estate office reported a resident was sitting in their office. The progress note showed Resident #1 was picked up by a nurse and the resident reported to the nurse it was a nice day for a walk. The progress note showed it appeared the resident had removed their window screen and climbed out the window.</p> <p>On 03/17/25 at 4:00 p.m., the assistant administrator reported Resident #1 had been moved to a room on the front hall due to plumbing issues from the resident stuffing items down their toilet. The assistant administrator reported after the elopement, another resident reported Resident #1 had been messing with their window before the incident. The assistant administrator reported the resident had been moved back to their old room which improved their wandering behavior.</p>		