STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375253	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clinton Therapy & Living Center	2316 Modelle Clinton, OK 73601

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** 21731 Based on record review and interview, the facility failed to update a care plan after an assessment for high risk of elopement and a documented event of a missing resident for one (#1) of four sampled residents reviewed for care plans. The DON identified the census was 32. Findings: Res #1 was admitted to the facility on [DATE] with diagnoses which included dementia, Alzheimer's disease, delusional disorder, anxiety disorder, and bipolar type schizoaffective disorder. A Care Plan, initiated 06/11/24, documented the resident was an elopement risk/wanderer and had a history to leave the facility unattended. Interventions included: a. assess for fall risk, b. distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or book, c. identify pattern of wandering. Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. d. monitor for fatigue and weight loss, e. provide structured activities, toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes, f. resident is one on one with every 15 minute visual/supervision for resident safety, and g. the resident's triggers for wandering/eloping are when they run out of cigarettes and want to go home to get more cigarettes. Ensure resident has cigarettes in the facility. Wandering Risk Scales, dated 06/14/24, 07/09/24, and 07/26/24, documented the resident was at high risk for wandering and elopement. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Progress Note, dated 07/29/24 at 3:00 p.m., read in part, .doing our normal look out for resident and could not locate [Res #1] in the building search moved to outside, resident's [family member] was notified as was local police .located [Res #1] .brought back to the facility . The care plan was not been updated to include additional interventions to monitor the resident or interventions to ensure the safety of the resident. A Progress Note, dated 09/08/24 at 5:21 p.m., read in part, .requested a cigarette at [4:10 p.m.] .was told it was too early for the smoke break. @ [4:20 p.m.] all pt were getting together for their smoke break .[Res #1] was not located in room staff sent to locate pt .located at [4:43 p.m.] .5 minutes walk from bldg . A Wandering Risk Scale, dated 09/09/24, documented the resident was at high risk for wandering and elopement. A care plan revision, dated 09/09/24, documented the resident had eloped on 09/08/24. One on one supervision was put into place at this time. It was clarified the resident was to be monitored by staff with one on one, but no additional monitoring or interventions were added from the original elopement care plan initiated on 06/11/24. On 09/16/24 at 12:39 p.m., the DON was asked to review the care plan and explain the interventions for Res #1's risk for elopement to include one on one with every 15 minute visual supervision of the resident for safety. They stated they did not understand the interventions. The DON was asked if they were aware of the multiple times Res #1 had eloped and had been assessed as a high risk for continued elopement. The DON stated they were not aware the resident had eloped prior to 09/08/24. They stated the care plan should have been more clear and updated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375253	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2024
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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** 21731 On 09/16/24 at 2:47 p.m., OSDH identified the presence of an immediate jeopardy related to the facility failed to provide supervision for Res #1 to prevent recurring elopements. Res #1 was admitted to the facility on [DATE]. Res #1 was identified by family to be an elopement risk at the time of admit. Res #1 was assessed to be at risk for elopement. A care plan was not initiated until 06/11/24 with referrals to locked units and a gero-psych unit. Res #1 was placed on one on one supervision with every 15 minute visual checks. On 07/09/24, Res #1 eloped from the building and was found several blocks from the facility. The care plan was not updated until 08/16/24. No new information was added to the care plan. On 09/08/24 at 4:10 p.m., Res #1 remained with 15 minute checks, but was last observed by staff at 4:20 p. m. Staff were unable to locate Res #1 at 4:43 p.m. Res #1 was located approximately 0.4 miles east of facility. Res #1 had to cross one set of rail road tracks and a four lane business freeway. Res #1 was and continues on every 15 minutes checks. The care plan documented on 09/08/24 the resident was to be monitored one on one. Following the incident on 09/08/24, staff were not educated to ensure reocurrence. There were multiple areas on the monitoring tool that did not document Res #1 had been monitored as stated in the interventions of the care plan, including and entire day shift on 09/12/24. On 09/16/24 at 2:50 p.m., the corporate consultant and DON were notified of the presence of an immediate jeopardy related to elopement of Res #1, without the supervision and monitoring per care plan, no interventions placed to prevent further occurrence, and not following the facility policy to include the IDT in decision making of interventions to prevent elopement. On 09/17/24 at 9:09 a.m., the following POR for elopement was submitted to OSDH for review: Corrective Action: Plan of Removal On, 9/16/2024, elopement risk assessments were initiated on all residents with care plans updated to identify any at risk residents. 1. A notification sign has been placed on front door and service door to alert visitors and vendors to not let anyone out without notifying/asking facility staff first. 2. All staff In-Serviced on elopement risk policy, ensuring that identified elopement risk residents are redirected away from doors, properly performing 1:1 monitoring, and location of list of wandering/elopement risk residents and to check list at beginning of shift. 3. MDS Coordinator in-serviced on completion of care plans on all new admissions to include but not limited to potential for risk of elopement and updating care plans if an event occurs. 4. HR/BOM in-serviced on all newly hired personnel will be educated on elopement policy, location of list of at risk for elopement residents with an acknowledgement page. (continued on next page)

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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

5. Nursing Administration In-Serviced on reviewing elopement risk resident list/any new admissions and updating list accordingly 5 times weekly during clinical meeting.

6. DON/Designee will report any negative findings quarterly to QAPI.

7. Any employee that can't be reached for In-Service will be inactive and taken off of schedule until education is provided.

8. Resident #1 has been placed on continuous 1:1 monitoring and will remain on 1:1 continuous monitoring until more secure placement is found.

Completed by 10 a.m. 9/17/2024

On 09/17/24 at 10:57 a.m., the facility was notified the POR was approved. On 09/17/24 at 3:49 p.m., the corporate consultant and DON were notified all components of the POR had been met. The deficiency remains at an isolated level with a potential for harm.

Based on observation, record review, and interview, the facility failed to:

a. provide supervision to a resident with a hx of elopement;

b. update and implement care plan to protect resident safety; and

c. failed to follow policy by not including IDT in decision making of interventions to prevent elopement for one (#1) of three sampled residents reviewed for elopement.

The DON identified the census was 32.

The DON indentifed four residents were high risk to wander and two residents were at risk to wander.

Findings:

A Safety and Supervision of Residents policy, last revised on July 2023, read in parts, .The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents .target interventions to reduce individual risks .including adequate supervision .Ensure that interventions are implemented .Documenting interventions .Safety monitoring .1:1 for 8 hours: 15 minute checks for 8 hours, 30 minute checks for 8 hours .If any issue arise in the monitoring window .begin back at the recent level of monitoring again until not new or continuing behaviors are exhibited or physician recommendation is received .Monitoring the effectiveness of interventions shall include .Ensuring that interventions are implemented correctly and consistently . Evaluating the effectiveness of interventions .Modifying or replacing interventions as needed .Resident supervision is a core component of the systems approach to safety .type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards .type and frequency of resident supervision may vary .Resident Risks .Unsafe Wandering .

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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	Res #1 was admitted to the facility on [DATE] with diagnoses to include dementia, Alzheimer's disease, delusional disorder, anxiety disorder, and bipolar type schizoaffective disorder. A Care Plan, initiated 06/11/24, documented Res #1 was an elopement risk/wanderer and had a history to leave the facility unattended. Interventions included: a. assess for fall risk, b. distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or book, c. identify pattern of wandering. Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate, d. monitor for fatigue and weight loss, e. provide structured activities, toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes, f. resident is one on one with every 15 minute visual/supervision for resident safety, and g. the resident's triggers for wandering/eloping are when they run out of cigarettes and want to go home to get more cigarettes. Ensure that resident has cigarettes in the facility. Wandering Risk Scales, dated 06/14/24, 07/09/24, and 07/26/24., documented the resident was at high risk for wandering and elopement. The care plan was not updated or additional interventions placed to monitor or supervise Res #1 to ensure their safety. A Progress Note, dated 07/09/24 at 3:00 p.m., read in part, .doing our normal look out for resident and could not locate [Res #1] in the building search moved to outside, resident's [family member] was notified as was local police .located [Res #1] .brought back to the facility . The care plan was not updated to include additional interventions to monitor Res #1 or interventions to ensure the safety of the resident. On 08/11/24, the elopement care plan was reviewed. There were no updates to include additional goals, monitoring, or interventions for Res #1's risks of elopement, or the events Res #1 had left the facility unattended. A [One on One] Monitoring for Resident Safety form, dated 09/07/24, documented Res #1 had been monitored with initials of a staff member every 15 minutes. A [One on One] Monitoring or Resident Safety form, dated 09/08/24, documented the resident had been monitored with initials of a staff member every 15 minutes and included: a. at 4:10 p.m., it was documented Res #1 was in the lobby and had requested a cigarette, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. at 4:30 p.m., an initial was documented with a line drawn through the time and initial, and c. at 4:45 p.m., there was no initial and the entry had a line drawn through the full line. There was a hand written note which documented, .pt found @ [4:40 p.m.] on 17th street. A Progress Note, dated 09/08/24 at 5:21 p.m., read in part, .requested a cigarette at [4:10 p.m.] .was told it was too early for the smoke break. @ [4:20 p.m.] all pt were getting together for their smoke break .[Res #1] was not located in room staff sent to locate pt .located at [4:43 p.m.] .5 minutes walk from bldg . Incident Report Form submitted to OSDH for the incident dated 09/08/24, did not contain documentation the local law enforcement was notified to assist in the search of a missing resident. The investigative packet did not contain investigative notes to ensure Res #1's risk factors had been fully assessed. A [One on One] Monitoring for Resident Safety form, dated 09/09/24, did not contain documentation at 7:15 a.m., 7:30 a.m., 8:00 a.m., or 8:15 a.m. A Wandering Risk Scale, dated 09/09/24, documented Res #1 was a high risk for wandering and elopement. A care plan revision, dated 09/09/24, documented Res #1 had eloped on 09/08/24. One on One supervision was put into place at this time. The care plan revision, dated 09/09/24, documented Res #1 was to be monitored one on one by staff. It was clarified Res #1 was one on one or to be monitored every 15 minutes as documented in the original care plan dated on 06/11/24. The clinical records did not contain documentation the IDT had been involved in the risk assessment, analysis of risks and interventions, or consulted for interventions to be put into place. A One on One Monitoring for Resident Safety form, dated 09/10/24, contained staff initials every 15 minutes. A hand written entry near the 12:15 p.m. entry, read in part, .15 min checks 09/10/24 starting 12:30. A One on One Monitoring for Resident Safety form, dated 09/12/24, had times entered every 15 minutes from 7:00 a.m. through 6:45 p.m. The entries did not contain documentation of where the resident was or staff initials the monitoring had been completed. On 09/13/24 at 10:50 a.m., CNA #1 was asked if they were aware of any residents that had eloped. CNA #1 identified Res #1 as having a history of elopement and recently was to be monitored one on one due to elopement risk. They stated there were not enough staff to do one on one staffing. They stated the resident got away when staff were in rooms helping each other with other residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/13/24 at 10:55 a.m., LPN #1 was asked if the facility had any residents that had eloped. They identified Res #1 and they stated the resident was on every 15 minute visual checks. They stated they were working the day Res #1 eloped on 09/08/24. They stated Res #1 was believed to have exited the building when another resident's family left the building. LPN #1 was asked where staff located Res #1. They stated five minutes away. They were asked if Res #1 had gone past a nearby railroad track and a divided four lane freeway. They stated, Yes. On 09/13/24 at 12:50 p.m., a tour from the facility to 17th Street was conducted. The path was across a single railroad track and beyond a divided four lane freeway. The distance was 0.4 miles away from the nursing facility. On 09/16/24 at 12:19 p.m., the DON was asked when was Res #1 first placed on one on one monitoring and the reason. They stated the resident had been on every 15 minute monitoring until the elopement incident on 09/08/24. They stated it was then changed to one on one monitoring. They were asked when was the resident placed on the one on one monitoring. They stated immediately upon return to the facility after the elopement. The DON was asked if the resident was currently on one on one monitoring or every 15 minutes. They stated Res #1 was monitored one on one until 09/10/24 at 12:30 p.m. due to no further attempts to leave, but left on every 15 minutes monitoring due to high risk of wandering and elopement. The DON stated the facility policy was followed for the instruction to change from one on one to every 15 minute monitoring. They were asked who was involved with the determination Res #1 could be monitored every 15 minutes rather than one on one. They stated they made the decision per the facility policy. The DON was asked if the IDT had been consulted prior to the resident monitoring being changed to a longer period of time. They stated, No. They were asked how was Res #1 monitored for elopement risk and safety in the early morning of 09/09/24 and the day shift on 09/12/24. They stated there was nothing documented. They stated all documentation entries on the monitoring tool should have included where the resident was, what the resident was doing, and a staff initial. The DON was asked how it was determined by documentation a resident was to be one on one or every 15 minutes if the same tool was used and there was little documentation to indicate how often a resident was to be monitored. No information was provided. They were asked what interventions had been placed to prevent elopement from the known elopement on 07/09/24 to prevent the elopement on 09/08/24. They stated they were not an employee at those times and was not aware Res #1 had a history of elopement from the facility. The DON was asked how staff ensured adequate supervision for a resident with a high risk for elopement and a history of elopement. They stated the forms were to be reviewed by the administrator. They were asked if the interventions of monitoring every 15 minutes had been effective if Res #1 was monitored every 15 minutes at the time of the elopement on 09/08/24. No additional information was provided. On 09/16/24 at 12:39 p.m., the DON was asked to review the care plan and explain the intervention for Res #1's risk for elopement to include one on one with every 15 minute visual supervision of the resident for safety. They stated they did not understand the interventions. The DON was asked if they were aware of the multiple times Res #1 had eloped and had been assessed as a high risk for continued elopement. They stated they were not aware the resident had eloped prior to 09/08/24. They stated the care plan should have been more clear and updated.