

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375263	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2025
NAME OF PROVIDER OR SUPPLIER Ballard Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 West 5th Street 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 - Immediate jeopardy to resident health or safety</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 05/20/25, a past non-compliance Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to provide supervision to prevent elopement.</p> <p>Based on record review and interview, the facility failed to provide supervision for 1 (#1) of 3 sampled residents reviewed for wandering.</p> <p>The administrator identified 71 residents resided in the facility.</p> <p>Findings:</p> <p>An undated facility policy Elopement, read in part, 1. 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 .2. If an employee observes a resident leaving the premises, he/she should: 1. Attempt to prevent the departure in a courteous manner; b. Get help from other staff members in the immediate vicinity, if necessary, and c. Instruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident has left the premises .4. If an employee discovers that a resident is missing from the facility, he/she shall: c. If the the resident is not located, notify the Administrator and the Director of Nursing Services, the resident's legal representative (sponsor), the Attending Physician, law enforcement officials, and (as necessary) volunteer agencies (i.e., Emergency Management, Rescue Squads, etc.).</p> <p>An undated facility Profile Face Sheet for Resident #1 showed they were admitted on [DATE] with diagnoses which included Alzheimer's, dementia, difficulty walking, muscle weakness, heart failure, anxiety, acute kidney failure and a history of repeated falls.</p> <p>Resident #1 Care Plan, revised 05/05/25, read in part, The resident is an elopement risk/wander .The resident will not leave facility unattended through the review date initiated: 08/09/24 target date: 05/04/25 .</p> <p>Resident # Care Plan, revised 05/05/25, read in part, Resident #1 wandering in and out of room since 0100. 11/11/24 wandering into other residents room, .Date Initiated ; 08/09/24.</p> <p>Resident #1's Minimum Data Set assessment, with an assessment date of 02/14/25, showed they had a BIMS score of 02 indicating a severe cognitive impairment.</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
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An in-service document titled Wandering and Elopement dated, 05/08/25 was conducted.</p> <p>An untitled document, dated 05/08/25, read in part, 6:15 p.m. seen exiting back door by laundry via cctv . elopement Admin notified at 6:30 p.m.6:33 p.m. Resident located by facility staff.6:33 p.m. Resident #1 located by facility staff.6:35 p.m. assisted back into facility & assessed by liscensed nurse with no injuries found. Head to toe assessment completed. Facility initiated investigation 30-minute checks on Resident #1 started. Family Physician and Hospice notified.6:45 p.m. LPN Charge Nurse completed a head count on all residents to ensure everyone was accounted for with no issues identified.7:00 p.m. Charge nurse completed a 100% audit of all doors & windows in the facility. All windows were locked with security devices in place. All doors were functioning properly. All locked doors were unlocked and reset to assure they were working properly.7:15 p.m. Charge nurse completed review of wandering elopement book, MDS RN notified to update Care Plan; PIP plan iniated .8:00 p.m. Administrator initiated in-services via all group text to all departments on Wander policy & elopement.8:25 p.m. OSDH notified via fax and investigation completed.7:00 a.m. Door Code Changed by maintenance. Roofers will be instructed to use the main entrance when entering or leaving the facility.9:00 a.m. QAPI meeting held with facility Supervisors.</p> <p>A nursing note, dated 05/08/25, read in part, a patient followed the construction worker out of a back door.</p> <p>A Elopement and Wandering document, dated 05/08/25, showed an in service for staff with signatures.</p> <p>A 15 Minute Check document, showed a start date of 05/08/25.</p> <p>A QAPI Meeting document, dated 05/09/25, showed an in service was conducted for Resident #1's elopement.</p> <p>An in-service document titled Wandering and Elopement Risks, dated 05/09/25, showed all staff notified via text group reviewed 05/09/25.</p> <p>A 15 Minute Check document, showed a end date of 05/11/25.</p> <p>On 05/29/25 at 6:10 p.m., CNA #1 stated we had a fire drill that day and they didn't tell anyone. The doors became unlocked and thats when I think Resident #1 eloped out the building.</p> <p>On 05/19/25 at 6:11 p.m., CNA #1 stated I went to the dining hall around 5:30 p.m. to serve dinner to Resident # 1 and they was not in the dining hall. and then I went to check bathrooms and notified nursing staff around 5:45 p.m. because I could not Resident #1.</p> <p>On 05/19/25 at 6:12 p.m., CNA #1 stated Resident #1 got about 3 blocks away.</p> <p>On 05/19/25 at 6:19 p.m., CNA #1 stated Resident #1 is a wander because they always acting like they are leaving and going to work</p> <p>On 05/19/25 at 6:55 p.m., the director of nursing stated during the elopement I believe Resident #1 was at risk for harm and no one knew until the construction workers reported Resident #1 was missing.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 05/20/25 at 9:11 a.m., the Regional Maintenance Director stated Resident #1 acts they are leaving and going to work.</p> <p>On 05/20/25 at 9:12 a.m., the Regional Maintenance Director stated when doors are being tested all the doors will unlock.</p> <p>On 05/20/25 at 9:53 a.m., the DON and LPN #1 stated they didn't know why CNA #1 did not report Resident #1 was missing at 5:30 p.m.</p> <p>On 05/20/25 at 10:20 a.m., the DON stated staff are told when they start working to follow policy and procedures and to notify the Administrator. The Administrator #1 notified me on 05/08/25 at 6:55 p.m</p> <p>On 05/20/25 at 10:27 a.m., Resident #1 stated I left out the building the other day.</p> <p>On 05/20/25 at 5:17 p.m., CMA #1 stated Resident #1's elopement was preventable and was at risk for harm.</p>		