STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375279	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hobart Nursing & Rehabilitation	709 North Lowe Hobart, OK 73651

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a comprehensive assessment accurately reflected wandering/exit seeking behavior for 1 (#1) of 3 sampled residents reviewed for comprehensive assessments. The DON identified 37 residents resided in the facility.Findings:On 04/23/26 at 1:26 p.m., Resident #1 was observed in their room in bed. A housekeeper was observed seated outside of the resident's room providing one on one supervision with a clip board to document the resident's one on one supervision.On 04/28/26 at 1:36 a.m., Resident #1 was observed in their room in bed. Driver #1 was observed outside the room in a chair to perform one on one supervision with a log on a clip board to document the resident's location hourly. A nurses note for Resident #1, dated 03/25/26, showed the resident attempted to exit the facility and had to be redirected back to their room. A comprehensive assessment for Resident #1, dated 03/29/26 showed the resident had a BIMS score of 4 which indicated their cognition was severely impaired. The assessment showed Resident #1 had diagnoses which included dementia and anxiety disorder. The assessment showed the resident was independent for ambulation and transfers. The assessment showed the resident did not wander. An Elopement Risk Assessment for Resident #1, dated 03/29/26, showed no history of elopements and was scored at a 10 which indicated a high risk for elopement. On 04/23/26 at 4:10 p.m., the MDS coordinator stated Resident #1 had dementia, had tried to follow others out of the facility, and was an elopement risk.On 04/24/26 at 9:27 a.m., the MDS coordinator was asked to review Resident #1's annual comprehensive assessment, dated 03/29/26. They stated the assessment was not correct because it did not reflect Resident #1's wandering which was documented in the nurses note on 03/25/26. On 04/24/26 at 9:51 a.m., the DON stated the facility did not have a policy on accuracy of MDS assessments and they followed the RAI (resident assessment instrument) manual. The DON reviewed Resident #1's comprehensive assessment dated [DATE]. The DON stated the assessment was not correct due to the assessment did not document the wandering behaviors from Resident #1's nurses note dated 03/25/26.

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 - 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** Based on observation, record review, and interview, the facility failed to ensure:a. a resident with known exit seeking/wandering behaviors had adequate supervision to prevent elopement for 1 (#1) of 5 sampled residents reviewed for adequate supervision to prevent elopement; andb. adequate supervision to prevent access to the kitchen for 2 (#2 and #3) of 5 sampled residents reviewed for adequate supervision to prevent accidents and hazards.The DON identified five residents at risk for elopement and wandering. 1. On 04/24/26, an Immediate Jeopardy (IJ) situation was determined to have existed related to the facility's failure to prevent a resident with known exit seeking behaviors from eloping from the facility. The deficient practice resulted in Resident #1 eloping from the facility and being found by local law enforcement in a residential neighborhood three blocks from the facility. The failure had the potential for serious injury, serious harm or death.On 04/24/26 at 5:18 p.m., the OSDH confirmed the existence of the immediate jeopardy situation.On 04/24/26 at 5:23 p.m., the DON, corporate administrator, social services, and the MDS coordinator were notified of the IJ situation and provided the IJ template.On 05/29/26 at 8:36 a.m., an acceptable plan of removal for elopement was received related to the facility's failure to prevent a resident with known exit seeking behaviors from eloping from the facility. The POR, read in part, 1. Identification of Residents Affected or Likely to be Affected: The facility took the following actions to address and prevent any additional residents from leaving the facility unsupervised. (Completion Date: 4-8-26) Resident directly involved in this incident had their care plan reviewed and updated by the DON or designee and updated to reflect current wandering and elopement risk. 4-8-26 Resident directly involved in this incident was immediately assessed by DON upon return to the facility with no injuries noted 4-8-26 Resident directly involved in this incident is on 1:1 supervision until alternate placement can be identified or is assessed and does not demonstrate active elopement behavior 4-8-26 and ongoing The DON or designee reviewed the elopement risk assessment on all residents 4-8-26 The DON, designee(s) and/or MDS Coordinator re-evaluated the plans of care for all residents at risk for elopement 4-8-26 All nursing staff on all shifts received education on elopement, and resident safety from the DON or designee(s). Any staff on leave will receive education on their next scheduled work day 4-8-26 and ongoing2. Actions to Prevent Occurrence/Recurrence: The facility took the following actions to prevent this incident from reoccurring. (Completion Date: 4-8-26) Elopement residents' policy was reviewed on 4-8-26. The DON or designee will audit new admissions for elopement risk and ensure appropriate interventions are in place - ongoing. The DON or designee did audit completed MDS's to ensure the care plan reflects needs/concerns identified in the CAAs (care areas assessment) on 4-8-26. New hires will receive education on elopement, and resident safety by the DON, Director of Social Services, or designee(s) - ongoing. Residents at risk for elopement are monitored q 2 hours for safety - ongoing. An Elopement Response Drill schedule was implemented, with drills occurring quarterly on all shifts. 4-8-26 and ongoing. All exit doors and alarms were tested for functionality 4-8-26. Additionally, all doors will continue to be monitored daily - ongoing. Windows in rooms occupied by residents at risk for elopement will be monitored q 2 hours for security. 5-27-26 and ongoing. Root cause analysis has been conducted. Risk factors include:Accurate assessment of resident elopement risk.Training and education of staff on resident elopement.Monitoring process of residents at risk for elopement.Exit doors (including those to the smoking area)Residents at risk for elopement have the potential to follow staff and visitors outside.Environmental assessment including monitoring doors (including doors that lead to the smoking area) and windows for security. 5-27-28 Signage has been posted at the entrance to remind staff and visitors not to allow residents to follow him/her outside the facility. 4-8-26 Staff will be educated on risk factors and take extra precautions to ensure residents are secure and prevent elopement. A Quality Assurance Performance Improvement (QAPI) Performance (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Improvement Project was implemented to review and interpret all audit findings. All findings will be discussed at the monthly QAA meeting for a minimum of three months or until the pattern of compliance is maintained - ongoingDate Facility Asserts This Incident Has Been Addressed: 4-8-26Action Plan to Ensure Relevant Recommendations Are Followed:Action/Task Person(s) Assigned Date CompletedReview current policies to ensure appropriate procedures are in place to prevent elopement. [name of administrator]/ [name of DON] 4-8-26Checklists and monitoring tools used to verify compliance in PCC (point click care).[name of DON] 4-8-26 and ongoingEducate necessary staff on facility procedures with return demonstration, where applicable.[name of DON] and designee(s) 4-8-26 and ongoingDocument PIP implementation, PIP progress, and QAA Committee Meeting Minutes where PIP is discussed.[name of administrator] As scheduled IDT / MDS / Care Planning [name of DON] and IDT 4-8-26 and ongoingImplementation of window monitoring for security. [name of DON] 5-27-26 and ongoing.The IJ related to elopement was lifted, effective 05/29/26 at 5:00 p.m., when all components of the plans of removal had been verified as completed. A review of the resident audits was conducted. Resident #1 discharged to another facility on 05/05/26. Observations were made of the facility exits and signage in place. Staff were observed responding to exit alarms timely. In-service training regarding care plan updating by the IDT, elopement prevention strategies and policy which included facility access monitoring, window monitoring, identifying residents at risk for elopement and their care plans were reviewed. Staff from multiple departments and shifts were interviewed to ensure the in-service trainings had been completed. The deficient practice remained at an isolated level with the potential for more than minimal harm that is not immediate jeopardy. 2. On 05/26/26 at 9:35 a.m., an Immediate Jeopardy (IJ) situation was determined to have existed related to the facility's failure to prevent residents having unsupervised access to the kitchen to prevent potential accidents and hazards. This had the potential for serious injury, serious harm, or death due to access to toxic chemicals, hot liquids, sharp objects, and an unlocked exterior door.On 05/29/26 at 4:18 p.m., the OSDH confirmed the existence of the IJ situation.On 05/29/26 at 4:26 p.m., the administrator was notified of the IJ situation and was provided the IJ template. On 06/02/26 at 10:46 a.m., an acceptable plan of removal was received related to the facility's failure to prevent adequate supervision to prevent residents with a history of wandering from having access to the kitchen in order to prevent potential accidents and hazards. The POR, read in part, 1. Immediate action(s) taken for the resident(s) found to have been affected include:Residents Res #2 and Res #3 could have been affected by failure to prevent access to the kitchen. These residents did not enter the kitchen or sustain injury, but nursing conducted an assessment to ensure the residents were not harmed. 5-29-262. Identification of other residents having the potential to be affected was accomplished by:Residents with cognitive impairment have the potential to be affected by this alleged deficient practice.3. Actions taken/systems put into place to reduce the risk of future occurrence include:a. Facility Administrator read and understands the Accident and Supervision Policy. 5-29-26b. Kitchen staff have been educated on the Accident and Supervision Policy. This education included a discussion about the failure of kitchen staff to leave the environment unsecured / unattended as a case study. This education also included a tour of the kitchen to specifically identify risk factors, i.e. hot surfaces, food items cooking, sharp objects, freezer, chemicals, etc. This education specifically outlined securing the half door, kitchen door, back kitchen door and dish room door to prevent resident entrance. Education also included the importance of not leaving the kitchen unattended, which requires schedule and breaks to align with kitchen supervision. 5-29-26c. Facility conducted a Root Cause Analysis based on findings (the facility failed to provide adequate supervision to prevent resident access to the kitchen). Risk factors include: 5-29-26i. Doors entering the kitchen were not closed and not secured.ii. Staff were not present in the kitchen to monitor the environment.iii. Lack of staff understanding that residents entering the kitchen are at risk for serious injury, serious harm, serious impairment, or death.d. Facility posted signs on the kitchen door, dish room door and door leading outside as a visual reminder to close and lock doors (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to prevent residents entering the kitchen. 5-29-26e. Facility leadership conducted an emergency QAPI to discuss these interventions. The Medical Director was notified telephonically. 5-29-26f. Facility expanded the in-service education to all staff. This education includes a discussion about the failure of kitchen staff leaving the environment unsecured / unattended as a case study. This education also included a tour of the facility to specifically identify risk factors, i.e., closets and areas that contain hazardous items to residents and the importance of securing and locking these doors. Departments specifically reviewedincluded nursing, maintenance, housekeeping, laundry, and the kitchen. During the tour, examples of injuries that could occur in each department were discussed to illustrate the importance of accident and hazard prevention. 6-1-264. How the corrective action(s) will be monitored to ensure the practice will not reoccur:Dietary Manager or designee is responsible for monitoring access to the kitchen during regular ?open' hours of operation. Dietary Manager or designee is also responsible for ensuring half door, kitchen door, back kitchen door, dish room door are secured and locked before leaving the kitchen outside of regular ?open' hours of operations. 5-29-26Facility managers or designees are responsible for monitoring access to that department's area. These areas include housekeeping closets, laundry room, maintenance areas, and medication room / carts. These areas should be secured and locked while not actively in use or monitored by staff. 6-1-26Corrective action completion date: 6-1-26.The IJ related to providing adequate supervision to prevent accidents and hazards was lifted on 06/02/26 when all aspects of the POR was reviewed and validated as completed. A review of potential affected residents' health record was reviewed. In-service trainings reviewed showed staff from all departments received training on ensuring all areas with potential accidents and hazards were secured to prevent residents from having access to all potential accidents and hazards in the facility. Observations were made throughout the facility of all closets, maintenance rooms, medications rooms, storage areas, and the kitchen of being secured and not accessible to residents. Signage was observed to make staff and visitors aware of any risk and to keep all areas with accident and hazards concerns locked and not accessible to residents. All chemicals, sharp objects, hot liquids, medications, and environmental hazards were observed to not be accessible to residents. Staff from multiple shifts and departments were interviewed over the in-service trainings they received. All staff interviewed were able to articulate the in-service training they received over preventing residents from having access to potentially hazardous areas, items, and providing adequate supervision. The deficient practice remained at an isolated level with the potential for more than minimal harm that is not immediate jeopardy. Findings:A policy titled Accidents and Supervision, dated 04/16/24, read in part, The resident will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to decrease the risk of accidents. This includes:Identifying hazards and risk. Evaluating and analyzing hazards and risks.Implementing interventions to reduce hazards and risks.Monitoring for effectiveness and modifying interventions when necessary.4. Monitoring and Modification- Monitoring is the process of evaluating the effectiveness of care plan interventions. Modification is the process of adjusting interventions as need to make more effective in addressing hazards and risk. Monitoring and modification process include:a. Ensuring that interventions are implemented correctly and consistentlyb. Evaluating the effectiveness of interventionsc. Modifying or replacing interventions as neededd. Evaluating the effectiveness of new interventions .5. Supervision- Supervision is an intervention and means mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision:a. Defined by type and frequencyb. Based on the individual resident's assessed need and identified hazards in the resident environment.1. An Elopement Risk Assessment for Resident #1, dated 09/11/25, showed the resident had made one attempt to elope and had to be redirected. The assessment was scored at a 10 which indicated a high risk for elopement. An Elopement Risk Assessment for Resident #1, dated 09/12/25, showed no history of elopements and was scored at a 10 which indicated a high risk for elopement. A nurses note for Resident #1, dated 09/22/25, read in part, Resident exited the door after the Hospice nurse, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	staff is notified immediately and resident is redirected back inside.An Elopement Risk Assessment for Resident #1, dated 12/12/25, showed no history of elopements and was scored at a 10 which indicated a high risk for elopement. A nurses note for Resident #1, dated 03/25/26, showed the resident had attempted to exit seek and had to be redirected back to their room. An annual assessment for Resident #1, dated 03/29/26 showed they had a BIMS score of 4 which indicated their cognition was severely impaired. The assessment showed they had diagnoses which included dementia and anxiety disorder. The assessment showed the resident was independent for ambulation and transfers. The assessment showed the resident did not wander during the seven day look back period.An Elopement Risk Assessment for Resident #1, dated 03/29/26, showed no history of elopements and was scored at a 10 which indicated a high risk for elopement. A facility incident report, dated 04/08/26, showed the BOM received a phone call from the police department. The report showed Resident #1 was found wandering and confused by the local police department in a residential neighborhood three blocks from the facility. The report showed the facility started their elopement drill by counting the residents. A Radio Log police report, dated 04/08/26, showed the following:a. on 04/08/26 at 7:48 a.m., the police located Resident #1 in the neighborhood three blocks from the facility,b. on 04/08/26 at 8:10 a.m., law enforcement notified the facility, that was not aware the resident was gone, they had located Resident #1. The log showed the resident was in the ambulance warming up, and the facility was on their way to get the resident, andc. on 04/08/26 at 8:31 a.m., the log showed Resident #1 was released to the facility.A care plan for Resident #1, revised on 04/08/26, showed a focus for being an elopement risk due to safety awareness. The care plan showed the following interventions:a. one on one supervision initiated on 04/08/26,b. medications reviewed by the physician initiated on 04/07/26,c. attempt to engage the resident in pleasant, meaningful, purposeful activities initiated on 12/29/23,e. distract the resident from wandering with pleasant diversions like food, activities, conversations, books, and television initiated on 12/29/23,f. document the resident's behavior and attempt interventions with meaningful activities, validation, and relationship-based redirection initiated on 12/29/23,g. psychiatric services to treat and evaluate as needed initiated on 03/13/25, andh. observe the resident's location in the community initiated on 12/29/23 and provide directional cues like pictures and names on the door to distract the resident initiated on 12/29/23.There was no revision of Resident #1's care shown after the following: a. a nurses note, dated 09/22/25, showed Resident #1 attempted to elope, andb. a nurses note, dated 03/25/26, showed exit seeking behavior.On 04/23/26 at 1:00 p.m., the front door was observed locked with a keypad and an audible alarm when opened. The door was observed posted with signage to alert visitors to be cautious there were residents in the facility who may try and exit.On 04/23/26 at 1:26 p.m., Resident #1 was observed in their room in bed. A housekeeper was seated outside of the resident's room providing one on one supervision with a clip board to document the residents one on one supervision.On 04/28/26 at 1:36 p.m., Resident #1 was observed in their room in bed. Driver #1 was observed outside the room in a chair to perform one on one supervision with a log on a clip board to document the resident's location hourly. On 04/23/26 at 1:26 p.m., Resident #1 stated they crossed the street and was trying to go home. On 04/23/26 at 1:55 p.m., CMA #1 stated on 04/08/26 at 6:30 a.m., Resident #1 stated they wanted to leave the facility to care for some children.On 04/23/26 at 2:00 p.m., the BOM stated Resident #1 talked about children down the street they needed to care for. The BOM stated Resident #1 hung around by the door. The BOM stated on 04/08/26 at 8:07 a.m., they were notified by local law enforcement Resident #1 was found three blocks from the facility in a residential neighborhood. On 04/23/26 at 4:10 p.m., the MDS coordinator stated on 04/08/26 at 7:30 a.m., Resident #1 had asked to leave the facility to care for children. They stated the resident was redirected to their room and they notified the administrator. The MDS coordinator stated local law enforcement notified the facility around 8:00 a.m., that Resident #1 had been found. They stated the facility started a code green (elopement drill) and started a head count of residents. The MDS coordinator stated they left the facility and went to where local law enforcement located the resident (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	in a residential neighborhood. They stated Resident #1 was in an ambulance when they arrived at the location of the resident. The MDS coordinator stated Resident #1 had dementia, had tried to follow others out in the past, and was an elopement risk.On 04/24/26 at 9:27 a.m., the MDS coordinator was asked to review Resident #1's annual MDS assessment, dated 03/29/26. They stated the assessment was not correct because it did not reflect Resident #1's wandering which was documented in the nurses note on 03/25/26. They stated the care plan was not revised at the time of the assessment because it did not capture the wandering documented in Resident #1's nurses note 03/25/26.On 04/24/26 at 9:51 a.m., the DON stated Resident #1 eloped from the facility on 04/08/26. The DON stated the resident had spoken with the MDS coordinator earlier in the morning and expressed they wanted to leave the facility. They stated the facility was not aware the resident had eloped until law enforcement notified them on 04/08/26 at 8:07 a.m. The DON stated the resident was in an ambulance located in a residential neighborhood three blocks from the facility. The DON stated the resident was returned to the facility, assessed, and found to have no harm. The DON reviewed Resident #1's comprehensive assessment dated [DATE]. The DON stated the assessment was not correct due to the assessment did not document the wandering behaviors from the resident's nurses note dated 03/25/26. The DON stated the care plan should have been updated with new interventions which could have prevented the resident from eloping on 04/08/26. They stated residents with an elopement score of ten were considered a high risk.On 05/29/26 at 9:50 a.m., the CDM stated they could not identify any residents at risk for elopementOn 05/29/26 at 9:51 a.m., cook #1 stated residents at risk for elopement could be identified by a star.On 05/29/26 at 9:52 a.m., the administrator stated there was no star identifier for residents at risk for elopement.2. On 05/29/26 at 9:29 a.m., the lower door and split upper door going from the kitchen to the dining room was observed opened. There was no staff observed in the kitchen or dining area. Resident #2 was in a wheelchair 6 feet from the open door and Resident #3 was seated at a table 6 feet from the open door. A tour of the kitchen was conducted. The following observations were made:a. a stock pot was on the front burner of the gas stove, was being heated with no lid, and steam was coming from the pot, b. kitchen knives were on the wall on a magnetic rail holder,c. the storeroom was open and contained hazardous chemicals in one-gallon containers. The chemicals included: aa. one-gallon container of chlorine bleach, bb. one-gallon container of foaming hand sanitizer, cc. one-gallon containers of purple degreaser, dd. one can of aerosol [NAME] stainless steel cleaner, ee. one-gallon containers of Mach Dry Mate rinse additive, ff. one-gallon containers of Mach Endurance concentrated detergent, gg. one-gallon containers of concentrated quat sanitizer, andd. the exterior door in the back of the kitchen was unlocked and there was access to an unsecured area and extensive farm field.On 05/29/26 at 9:35 a.m., cook #1 was observed to exit the back door of the kitchen to outside the facility. The door was not locked or no alarm sounded.A MSDS titled Mach Endurance, dated 01/13/20, showed the product was harmful if swallowed and could cause burns to the skin and eyes. The sheet showed the product should have been stores locked up. A MSDS titled Mach Drymate, dated 01/01/20, showed the product was harmful if swallowed and if it came into contact with the skin and eyes could cause burns. A MSDS titled Solution QA, dated 01/01/20, showed the product was harmful if swallowed and could cause burns to the skin and eyes. The sheet showed the product should have been stores locked up. A MSDS titled D-Grease, dated 01/10/20, showed the product was harmful if swallowed and could cause burns to the skin and eyes. The sheet showed the product should have been stored locked up. A MSDS titled Stainless Steel Polish, dated 01/01/20, showed the product was harmful if swallowed and could cause burns to the skin and eyes. An undated facility document titled Elopement Risk List showed the following residents were elopement risk:a. Resident #2; andb. Resident #3.A nurses note for Resident #2 dated 04/17/26, showed Resident #2 was cursing at staff, went down a hallway they were not allowed on, grabbed the front door, and was attempting to exit the facility.An annual assessment for Resident #2, dated 04/18/26, showed they had a BIMS score of 00 which indicated their cognition was severely impaired. The assessment showed the resident wandered and (continued on next page)

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