

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2025
NAME OF PROVIDER OR SUPPLIER Purcell Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 801 North 6th Street Purcell, OK 73080	

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>(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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review and interview, the facility failed to ensure supervision to prevent an elopement for 1 (#1) of 3 sampled residents reviewed for elopement. The ADON identified eight residents at risk for elopement. Findings: On 09/22/25 Residents #2 and #3, identified by the facility as elopement risks, were observed throughout the day. Neither resident showed any elopement behaviors. New elopement assessments were completed for both residents on 09/12/25. An undated facility policy titled Wandering and Elopements read in part, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Res #1 with known exit seeking behaviors eloped from the facility on 09/12/25 and was located down the road from the facility in a residential neighborhood. An undated medical diagnosis list showed Res #1 admitted to the facility with diagnoses which included Alzheimer's and age-related decline. A quarterly assessment, dated 06/13/25, showed the resident's brief interview for mental status score was a 6, which indicated severe cognitive impairment. A progress note, dated 09/10/25 at 10:48 a.m., showed Res #1 showed elopement behaviors and tried to follow a hospice volunteer out the door. Res #1 was placed on every 15 minutes checks. A progress note, dated 09/12/25 at 1:43 p.m., showed Res #1 was observed to be missing from the facility at 11:57 a.m. The note showed certified nurse aide #1, assigned to the hall, reported seeing the resident sitting in the common area at 10:30 a.m. Staff immediately began searching the interior and the perimeter of the facility. At approximately 12:18 p.m. the facility received a call from the local police department indicating they found the resident down the road. Two staff members went to pick them up in the facility van and returned them to the facility. Upon arrival at the facility the resident was immediately placed on 1:1 and a head-to-toe assessment was completed by the charge nurse with no injuries identified. Res #1 stated I waited until someone was going out the door and I followed them out, it's that easy. An in-service, dated 09/12/25, showed all staff were in-serviced on the missing resident's policy and procedures and residents at risk for elopement. A care plan, dated 09/12/25, showed it had been reviewed/ revised on: 07/30/25 because Res #1 had attempted to elope several times. Interventions put in place were distract by offering pleasant diversions, structured activities, food, conversation, television and book. Identify pattern of wandering- purposeful, aimless, or escapist and intervene as appropriate. Provide structured activities- walking inside and outside reorientation strategies including signs, pictures and memory boxes. 09/10/25 Res #1 was let out the door by a volunteer and stayed in sight of the volunteer until staff intervened, and Res #1 was ready to go back inside. Res #1 was placed on every 15-minute checks until further notice. 09/12/25 Res #1 left the facility unassisted. Res #1 was placed on 1:1 until further notice and referrals were sent to inpatient psych and memory care. A final incident report form, dated 09/16/25, showed all staff were in-serviced related to missing resident policy, referrals had been sent to behavioral health facilities and memory care facilities for possible admission were reviewed, facility census checks initiated every two hours facility wide until further notice. New assessments were completed for all residents at risk for elopement on 09/12/25 with eight residents identified to be at risk for elopement. A progress note, dated 09/19/25, showed Res #1 was discharged to an inpatient psychiatric facility for evaluation and treatment. On 09/23/25 at 12:09 p.m., the activities director stated they had received in-service related to elopement policies and procedures and what residents were at risk for elopement. On 09/23/25 at 12:11 p.m., LPN #1 stated they had received in-service related to elopement policies and procedures and what residents were at risk for elopement. On 09/23/25, CMA #1 stated they received an in-service over policy and procedures of elopement and what residents were at risk for elopement. Quality assurance weekly audits of wandering and elopement risk for 09/16/25 and 09/22/25 were reviewed. On 09/22/25 at 3:00 p.m., the ADON stated Res #1 was taken off every 15-minute checks at 8:00 a.m. on 09/12/25 because they had shown no exit seeking behaviors for the last two days. The ADON reported Res #1 began to get verbally and physically aggressive with staff that was performing 1:1 with them.</p>		