STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375313	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Antlers Manor	511 East Main Antlers, OK 74523

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, the facility failed to ensure elopement prevention interventions were implemented on the care plan for 1 (#1) of 3 sampled residents reviewed for elopement.A wandering and elopement risk assessment for Resident #1, dated 05/28/25, showed the resident was at risk for wandering and elopement.An incident report form, dated 11/06/25, showed Resident #1's family member informed the facility the resident had walked to their home. The report showed the resident had a small abrasion to their forehead.Resident #1's care plan did not show wandering and elopement incidents/interventions prior to 11/06/25.The administrator identified 21 residents in the facility at risk for elopement.On 05/13/26, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure a resident at risk for wandering and elopement had care plan interventions to address and prevent elopement. This resulted in the elopement of Resident #1 from the facility.On 05/13/26 at 5:11 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation.On 05/13/26 at 5:16 p.m., the administrator was notified of the IJ situation and the IJ template was provided.On 05/14/26 at 4:23 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal read in part,Amended Plan of Removal F656 Elopement Care PlansCompletion Date 5-14-26 3:00 p.m.Clinical Staff EducationClinical managers will be educated on how to care plan accurate interventions for residents at risk for wandering/elopement. This education will be provided by [name withheld], Regional Nurse.A sign in sheet will be utilized for staff that are currently in the facility. Any remaining staff will be called to the facility for education; or educated over the telephone. Employee names and the time of the telephone call will be documented. This education will be completed by 9:00 p.m. on 5-13-26.Currently in progress:All care plans will be audited and updated accordingly for residents that are at risk for wandering/elopement.Resident #1's elopement risk assessment and care plan will be updated.The resident elopement book will be updated to include any residents at risk for elopement.On 05/18/26, the IJ was lifted, effective 05/14/26, when all components of the plan of removal had been verified as completed. Clinical staff were interviewed regarding care plan interventions for elopement and wandering. All staff interviewed were knowledgeable on the education and training provided. The plan of removal records including staff education, care plan audits, elopement risk assessments, and elopement book were reviewed.The deficiency remained at a pattern level with the potential for more than minimal harm that is not immediate jeopardy. A facility policy titled Care Plans-Comprehensive, revised 10/2010, read in part, Each Resident's comprehensive care plan is design to .Incorporate identified problem areas .Incorporate risk factors associated with identified problems.A wandering and elopement risk assessment for Resident #1, dated 05/28/25, showed the resident was at risk for wandering and elopement.A nursing note, dated 06/01/25 at 4:18 a.m., showed Resident #1 wandered frequently in the facility.A nursing note, dated 08/29/25 at 12:27 a.m., showed Resident #1 frequently ambulated aimlessly in the facility.A quarterly assessment for Resident #1, dated 09/01/25, showed the resident had a diagnosis of dementia and their cognition was severely impaired with a BIMS score of 5. The assessment did not show the resident wandered.An incident report form, dated 11/06/25, showed Resident #1's family member (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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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	informed the facility the resident had walked to their home. The report showed the resident had a small abrasion to their forehead.Resident #1's care plan did not show wandering and elopement incidents/interventions prior to 11/06/25.On 05/12/26 at 2:27 p.m., a family member of Resident #1 stated the resident arrived at their home in the middle of the night. They stated the resident was wearing dark clothes and had to cross the main road to get to the house. The family member stated they were grateful it was in the middle of the night because the resident could have been hit by a truck. They stated Resident #1 had a skin tear on their forehead and the resident told them they had fell. The family member for Resident #1 stated it was a chilly night and the resident was cold.On 05/13/26 at 11:26 a.m., CMA #1 stated the resident occasionally wandered and liked to walk around hall three.On 05/13/26 at 11:47 a.m., the MDS coordinator stated Resident #1 had wandering behaviors since admission to the facility. They stated the resident wandered around the dining room and hall three.On 05/13/26 at 12:08 p.m., the MDS coordinator stated Resident #1's care plan did not address wandering and elopement prior to 11/06/25. They stated the care plan should have included interventions for wandering and elopement.On 05/13/26 at 12:10 p.m., the MDS coordinator stated they reviewed nurse's notes, nursing assessments, talked with residents, and talked with staff for care plan development and revision.On 05/13/26 at 12:49 p.m., the administrator stated the facility investigation showed Resident #1 left the facility because the laundry room was left unlocked and the back gate by the laundry room was unlocked and slightly opened. The administrator stated it would take about 13 minutes to walk from the facility to Resident #1's home. They stated the resident was missing for about two hours and 30 minutes based on the facility's investigation.

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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. Based on observation, record review, and interview, the facility failed to provide adequate supervision and maintain a secure environment to prevent elopement of a resident with a known history of wandering and elopement risk for 1 (#1) of 3 sampled residents reviewed for elopement.A wandering and elopement risk assessment for Resident #1, dated 05/28/25, showed the resident was at risk for wandering and elopement. A quarterly assessment for Resident #1, dated 09/01/25, showed the resident had a diagnosis of dementia and their cognition was severely impaired with a BIMS of 5.An incident report form, dated 11/06/25, showed Resident #1's family member informed the facility the resident showed up at their home. The report showed the resident had a small abrasion to their forehead.On 05/12/26 at 2:27 p.m., Resident #1's family member stated the resident showed up at their home in the middle of the night. They stated the resident was wearing dark clothes and had to cross the main road to get to the house. Resident #1's family member stated they were grateful it was in the middle of the night because the resident could have been hit by a truck. They stated Resident #1 had a skin tear on their forehead and the resident told them they had fell. Resident #1's family member stated it was a chilly night and the resident was cold.On 05/13/26 at 12:49 p.m., the administrator stated the facility investigation showed the resident left the facility because the laundry room was left unlocked and the back gate by the laundry room was unlocked and slightly opened.The administrator identified 21 residents in the facility at risk for elopement.On 05/13/26, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to provide adequate supervision and a secure environment to prevent elopement for a resident with known wandering and elopement risk. This resulted in the elopement of Resident #1.On 05/13/26 at 5:11 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation.On 05/13/26 at 5:16 p.m., the administrator was notified of the IJ situation and the IJ template was provided.On 05/14/26 at 4:23 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal read in part,Amended Plan of Removal F689 Elopement PreventionCompletion Date 5-14-26 3:00 p.m.All Staff EducationElopement Policy and ProceduresAll staff will be educated on the facility elopement policy and procedures to include interventions and prevention of elopement by [name withheld], Administrator.Interventions/prevention can include observing and redirecting wandering /eloping residents by the staff in all departments. Optimizing environmental conditions such as securing exit doors, not propping doors open, and checking the door locks for proper locking. Educating staff members on each resident's habits as well as any physical, mental, or behavioral issues they may have. Social engagement and increasing participation in activities. Clinical Staff EducationAll RNs and LPNs will be educated on the proper completion of the Elopement Risk Assessment upon admission and quarterly by [name withheld], Regional Nurse.A sign in sheet will be utilized for staff that are currently in the facility. Any remaining staff will be called to the facility for education; or educated over the telephone. Employee names and time of the telephone call will be documented. This education will be completed by 9:00 p.m. on 5-13-26.Currently in progress:All residents will be assessed for wandering/elopement with the completion of an Elopement Risk AssessmentResident #1's elopement risk assessment will be updated.The resident elopement book will be updated to include any residents at risk for elopement. Enhanced supervision rounds initiated for identified high risk residents.All exterior exit doors and locking mechanisms are being checked for proper function by maintenance. Any malfunctioning equipment will be repaired immediately or taken out of service until repaired. The door keypad codes have been changed. The facility implemented routine checks of exterior exit doors each shift. The Administrator will conduct environmental rounds to identify additional safety concerns related to wandering/elopement. On 05/18/26, the IJ was lifted, effective 05/14/26, when all components of the plan of removal had been verified as completed. Staff in (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	various departments and shifts were interviewed regarding elopement policy and procedures, securing and checking exit doors, supervision rounds, and completion of wandering and elopement risk assessments. All staff interviewed were knowledgeable on the education and training provided. The plan of removal records including facility's elopement policy and procedure, observation of the elopement book, elopement risk resident audits, exit doors check off sheets, and staff in-services were reviewed. Doors were checked for security. The deficiency remained at an isolated level with the potential for more than minimal harm that is not immediate jeopardy. Findings: On 05/12/26 at 12:17 p.m., Highway 3, the road Resident #1 crossed to walk home, was observed as a busy two-lane road in which vehicles passed through. The highway was the main street adjacent the facility.On 05/14/26 at 3:45 a.m., Highway 3 was observed as dimly lit with some streetlights. There was no continuous dedicated sidewalk which led from the facility to Resident #1's home. Three cars were observed driving on the highway during the drive to Resident #1's neighborhood.An undated facility policy titled Elopement, read in part, To identify residents at risk for unsafe wandering and exit seeking behavior and prevent elopements .Upon admission, quarterly and with significant change in status, the nurse will complete an Elopement Screen.A wandering and elopement risk assessment for Resident #1, dated 05/28/25, showed the resident was at risk for wandering and elopement. There was no additional wandering and elopement assessments.A nursing note, dated 06/01/25 at 4:18 a.m., showed Resident #1 wandered frequently in the facility.A nursing note, dated 08/29/25 at 12:27 a.m., showed Resident #1 frequently ambulated aimlessly in the facility.A quarterly assessment for Resident #1, dated 09/01/25, showed the resident had a diagnosis of dementia and their cognition was severely impaired with a BIMS score of 5. The assessment did not show the resident wandered.An incident report form, dated 11/06/25, showed the Resident #1's family member informed the facility the resident showed up at their home. The report showed the resident had a small abrasion to their forehead.On 05/12/26 at 2:27 p.m., Resident #1's family member stated the resident showed up at their home in the middle of the night. They stated the resident was wearing dark clothes and had to cross the main road to get to the house. Resident #1's family member stated they were grateful it was in the middle of the night because the resident could have been hit by a truck. They stated Resident #1 had a skin tear on their forehead and the resident told them they fell. Resident #1's family member stated it was a chilly night and the resident was cold.On 05/13/26 at 11:26 a.m., CMA #1 stated the resident occasionally wandered and liked to walk around hall three.The facility laundry room was observed on hall three.On 05/13/26 at 11:28 a.m., CMA #1 stated the last time they laid eyes on the resident was around the 2:00 a.m. rounds. They stated they were in the middle of the 4:00 a.m. round when the administrator called to inform them the resident had eloped from the facility.On 05/13/26 at 11:47 a.m., the MDS coordinator stated Resident #1 had wandering behaviors since admission to the facility. They stated the resident wandered around the dining room and hall three.On 05/13/26 at 12:32 p.m., the DON stated Resident #1 had one wandering and elopement assessment completed since admit on 05/28/25. They stated the assessments were to be completed quarterly.On 05/13/26 at 12:39 p.m., the DON stated the facility did not complete an elopement and wandering assessment after the resident eloped on 11/06/25.On 05/13/26 at 12:49 p.m., the administrator stated the facility investigation showed Resident #1 left the facility because the laundry room was left unlocked and the back gate by the laundry room was unlocked and slightly opened. The administrator stated it would take about 13 minutes to walk from the facility to Resident #1's home. They stated the resident was missing for about two hours and 30 minutes based on the facility's investigation.On 05/13/26 at 1:50 p.m., LPN #1 stated they were not sure how Resident #1 eloped. They stated the staff had checked on the resident during the 2:00 a.m. round. LPN #1 stated Resident #1 had some confusion, and their gait was not steady.