STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375325	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burford Manor	505 South 7th Street Davis, OK 73030

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based observation, record review, and interview, the facility failed to protect a resident from physical and verbal abuse by a staff member for 1 (#3) of 3 residents sampled for abuse. The director of nursing reported 46 residents resided in the facility. Findings: A Preventing Resident Abuse policy, dated February 2014, read in part, Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse.The facility's goal is to achieve and maintain an abuse-free environment.Our abuse prevention/intervention program includes, but is not necessarily limited to, the following: .b. Allowing staff to express frustration with their job, or in working with difficult residents.f. Helping staff to deal appropriately with stress and emotions. An Oklahoma State Department of Health incident form 283, dated 03/04/25, showed the DON was notified by staff LPN #1 was becoming increasingly aggravated with Resident #3 due to the resident constantly trying to get up from their wheelchair. The report showed LPN #1 was becoming louder toward the resident and demanding the Resident #3 to sit down. The report showed LPN #1 was observed by staff to push the Resident #3 back into the wheelchair after the resident attempted to get up. The report showed staff removed the Resident #3 away from the LPN and notified the DON. The report showed an investigation was initiated and LPN #1 was ultimately terminated. A quarterly MDS assessment for Resident #3, dated 04/07/25, showed the resident had a brief interview for mental status score of 0, which indicated severe cognitive impairment. A care plan for Resident #3, dated 06/23/25, showed the resident had altered cognition related to Alzheimer's. The care plan showed the resident was dependent on staff for assistance with all activities of daily living and had repeated falls. On 07/03/25 at 10:00 a.m., Resident #3's POA/family member reported when the incident happened with the LPN #1, the facility notified them immediately and updated them on how the matter was handled. The POA reported they had never been concerned about abuse toward the resident and had not witnessed anyone be rude or disrespectful. The POA reported they did not feel the resident was bothered by the incident, probably would not remember it, and did not feel there was any harm done to the resident. On 07/03/25 at 1:55 p.m., the DM reported they witnessed the incident with LPN #1 and Resident #3. The DM reported the resident was trying to get up from their wheelchair and the LPN pushed the resident back down to the wheelchair. The DM reported the incident happened during the evening meal service. The DM reported they removed Resident #3 to another area and suggested LPN #1 take a break. The DM reported they immediately informed the DON. The DM stated the DON initiated an investigation and staff were in-serviced on abuse. On 07/03/25 at 2:04 p.m., RN #1 reported they did not witness the incident between LPN #1 and Resident #3, but could hear the LPN repeatedly saying, Sit down, sit down. The RN reported the incident was loud and caught their attention, but they were not in the same area to visually witness the incident. RN #1 reported the DON immediately addressed the situation and staff were in-serviced on abuse and de-escalation following the incident.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375325	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burford Manor	505 South 7th Street Davis, OK 73030

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 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375325	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burford Manor	505 South 7th Street Davis, OK 73030

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 07/02/25 at 2:10 p.m., the OSDH was notified and verified the existence of an IJ situation related to the facility's failure to provide supervision and interventions to prevent elopement from the facility. Resident #1 had a history of eloping and left the facility unattended. Resident #1 crossed a busy, four-lane street and was located on the side of a highway approximately one mile from the facility. On 07/02/25 at 5:10 p.m., the DON was notified of the IJ and provided the IJ template. On 07/03/25 at 11:55 a.m., an acceptable plan of removal was approved by the OSDH. The plan of removal, read in part, [NAME] Manor, 7-2-25, Plan of RemovalResident [Resident #1] not currently in the building. Currently 46 residents in the facility. Nurses have completed wandering assessments on all 46 residents in house and have identified no additional wander risks. Administrator/Owner [name deleted] in-serviced [name deleted] RN of facility elopement policy and procedures, reviewed all safety measures in place relating to elopement monitoring/prevention. Signage posted on all unarmed doors to remain closed and locked when not in use. Signage posted on coded doors alerting visitors of wander risk environment, not to allow other individuals to leave facility when exiting. Obtained owners manual to key pads. Deleted all previously existing codes and changed to new code. Codes will now be changed on a monthly basis, at minimum, and as needed. New elopement alarm ordered for facility placed 7/2/25. System has transmitter for resident to wear with sensor on door that will alarm when transmitter detected exiting past monitor. This will be initiated upon its arrival. *facility in-service held @ [NAME] Manor 7/2/25 @ 1930/All staff will be in-serviced for the following prior to working next scheduled shift:1. All unarmed/uncoded doors are to remain closed and locked when not in use. Failure to do so will result in immediate reprimand. 2. Review of facility Elopement policy & procedures3. Keypad doors - all keypad door codes to be kept confidential, not verbally given to others. Do not allow residents to know door codes. Staff to immediately notify Charge Nurse and DON if any resident has learned the door code. Door codes will be updated monthly at minimum and on an as needed basis. Code will be located in a secured location not visible to residents. *facility in-service held @ [at] [NAME] Manor 7/2/25 @ 1930When resident returns to the facility they will continue on Q [every] 15 minute elopement monitoring. As ordered on 06/27/25. Resident has been moved to room [ROOM NUMBER]B which is closer to the nursing desk on 07/03/25. Resident will be required to eat all meals in main dining room. On 07/03/25, after interviews with facility staff, review of elopement/wandering risk assessments, review of in-services, and door/alarm safety checks, the immediacy was lifted. The deficient practice remained at an isolated level with the potential for more than minimal harm. Based on observation, record review, and interview, the facility failed to provide supervision and interventions to prevent elopement for 1 (#1) of 1 sampled resident reviewed for elopement. Resident #1 had eloped from the facility two times previously with a tracking device in place in the resident's shoe. The resident eloped a third time after changing shoes and leaving the facility. The director of nursing reported one resident currently at risk for wandering/elopement. Findings: On 07/02/25 at 9:30 a.m., during an initial tour of the facility, the code to the alarm keypad of the front door was observed to be posted on a small piece of paper near the keypad. Other exit doors were observed to have keypads in place and found to be locked. An Elopements policy, dated December 2007, read in part, Staff shall investigate and report all cases of missing residents .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. A care plan, updated 02/2025, showed Resident #1 was admitted on [DATE] with diagnoses which included Schizoaffective disorder, impulse disorder, osteoarthritis, diabetes, hypertension, depression, and insomnia. A physician order summary, dated 02/05/25, showed Resident #1 was to have elopement monitoring every 30 minutes. A care plan for Resident #1, dated 02/05/25, showed the resident had an air tag in the sole of their shoe, placed by the resident's family, and showed the resident was not aware of the tracking device. The care plan showed the resident ambulated independently. The care plan was updated on 05/05/25 and showed the resident was not to leave the facility with anyone except the resident's son/guardian. An OSDH incident report form 283, dated 05/07/25, showed Resident #1 was unable to be located at 12:20 p.m. The resident's tracking device, located in the resident's shoe, was activated and the resident was shown to be approximately 5 blocks from the facility. The resident was located and found to be walking back to the facility at 12:44 p.m. The resident reported they were upset because they were almost out of bananas. The resident was counseled and asked to speak with the charge nurse or DON when upset instead of leaving the facility. An OSDH incident report