STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375396	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lakes	5701 West Britton Road Oklahoma City, OK 73132

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 35389 Based on record review and interview, the facility failed to implement their abuse policy for three (#2, 5, and #6) of three sampled residents reviewed for abuse. The DON identified 70 residents resided in the facility. Findings: An Abuse Investigation and Reporting policy, revised 07/17, read in part, .All reports of resident abuse, neglect .shall be promptly reported to local, state and federal agencies .and thoroughly investigated by facility management .The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation .Role of the Investigator .The individual conducting the investigation will, as a minimum .Interview the person reporting the incident .Interview any witnesses to the incident .Interview the resident (as medically appropriate) .Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident .Interview the resident's roommate, family members, and visitors .Interview other residents .Review all events leading up to the alleged incident . Witness reports will be obtained in writing . 1. Resident #5 had diagnoses which included dysphagia following cerebral infarction and osteoporosis. A Quarterly Resident Assessment, dated 06/10/24, documented Resident #5 had moderate cognitive impairment. A Quarterly Resident Assessment, dated 09/10/24, documented Resident #5's cognition was intact. 2. Resident #6 had diagnoses which included unspecified dementia without behavioral disturbances, Alzheimer's disease, and psychotic disorder with delusions. An Admission Resident Assessment, dated 07/06/24, documented Resident #6 had severe cognitive impairment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Combined Initial and Final State Reportable Incident, dated 08/14/24, documented an allegation of abuse/mistreatment. It documented Resident #5 slapped the hand of Resident #6. It documented the residents were separated. It documented no staff observed the incident, but overheard commotion from other residents in the area. It documented the physician and family were notified. It documented no reports of the action had previously been received. It documented staff were educated to redirect Resident #5 and to increase frequent checks while the resident was in the public area around others. It documented relocation for Resident #6 had occurred since they were previously roommates. There was no documentation of interviews with Resident #5, witnesses, visitors, staff, or family members conducted in conjunction with this abuse allegation per the facility policy. On 10/10/24 at 10:15 a.m., Resident #5 stated the staff were good to them. The only concern the resident shared when asked about abuse/neglect was the price they were charged for a haircut and to have their eyebrows done and a resident who followed them sometimes had bumped into their wheelchair. They stated they would speak with staff if they had any concerns. On 10/10/24 at 10:57 a.m., an attempt was made to interview Resident #6. The resident did not respond. On 10/10/24 at 1:35 p.m., CNA #1 stated the policy for abuse was to report any concerns to the charge nurse or DON. They stated they were not aware of any incidents of abuse involving Resident #5 or Resident #6. On 10/10/24 at 1:45 p.m., CNA #2 stated any signs of abuse were to be reported to the administrator, DON, and ADON. They stated they were not aware of any incidents of abuse involving Resident #5 or Resident #6. On 10/10/24 at 1:48 p.m., CMA #1 stated if they saw abuse they were to immediately report it to the nurse. They stated they were aware of an incident of hitting involving Resident #5 and Resident #6. They stated Resident #5 did not like roommates. They stated the resident could get physically aggressive at times. On 10/10/24 at 2:00 p.m., LPN #1 stated abuse was to be reported to the administrator/abuse coordinator. They stated if they observed a resident to resident altercation they would remove the residents and report to the DON and administrator. They stated if they were injured, depending on the severity, they would be sent to the hospital. They stated the authorities would typically be called, they would complete behavior monitoring, and an investigation would be completed. LPN #1 stated they had heard there was an incident involving Resident #5 and Resident #6. They stated they believed Resident #5 slapped Resident #6. They stated Resident #6's cognition was not intact. They stated Resident #5 rambled and it was difficult to get a detailed report from them. On 10/10/24 at 2:04 p.m., the administrator stated staff worked on abuse concerns together. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/10/24 at 2:10 p.m., the administrator stated an investigation would be completed. The DON stated an incident report and state reportable would be completed. The administrator stated they would provide supporting documentation, notify the family, and would conduct interviews in a private location. They stated they would interview witnesses, the resident, and roommate to get the story of what had occurred. The DON stated when it was a resident to resident incident, staff would separate them to ensure safety was maintained and would need to monitor them. The administrator stated the physician and police would be notified. On 10/10/24 at 2:15 p.m., the administrator stated if abuse was witnessed, reported, or suspected, staff were to report it. The DON stated a CNA or medication aide could separate the residents and notify the charge nurse. On 10/10/24 at 2:17 p.m., the DON stated they would notify the physician, police, family, APS, the State, proper licensing board as needed, the DON, administrator and corporate. On 10/10/24 at 2:19 p.m., the administrator reviewed the state reportable incident involving Resident #5 and Resident #6 dated 08/14/24, and stated they did not have any good answers. They stated it happened in the television area. They stated there was a commotion and they separated the residents. The administrator stated staff did not witness the event. They stated since they were roommates the facility separated them. On 10/10/24 at 2:25 p.m., the administrator stated they did not interview any witnesses because there were not any. The administrator stated Resident #6 was not interviewable and Resident #5 was not interviewed. The administrator stated Resident #5 had a wonderful imagination. The DON stated Resident #5's communication was hard to understand. On 10/10/24 at 2:27 p.m., the administrator stated they did not remember interviewing any staff regarding this incident. On 10/10/24 at 2:28 p.m., the administrator stated they did not interview other residents, family members, or visitors regarding the incident. On 10/10/24 at 2:30 p.m., the administrator stated Resident #5 was kept in an area where they could be closely monitored by staff. They stated they did not have any documentation of staff completing additional monitoring of the resident during this time. The DON stated they had already looked for additional monitoring and did not find it. On 10/10/24 at 2:31 p.m., the administrator stated they did not have any documentation of QAPI having been involved in this allegation of abuse. On 10/10/24 at 2:32 p.m., the administrator stated they did not have any documentation of any education with staff regarding this abuse investigation. 3. Resident #2 had diagnoses which included closed fracture of right distal femur, osteoarthritis, and osteopenia. An Admission Resident Assessment, dated 02/26/24, documented Resident #2's cognition was moderately impaired. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Facility Incident Report, dated 08/24/24, documented the nurse had received report from the CNA Resident #2 had complained of their leg hurting when they were turned. It documented Resident #2's description was I don't know, it just hurts. I haven't done anything. It documented the resident was taken to the hospital. Resident #2's x-ray results, dated 08/24/24, documented acute displaced femur fracture. A Combined Initial and Final State Reportable Incident, dated 08/24/24, documented certain injuries and Resident #2 complained of pain in their right leg upon staff trying to assist them out of bed. It documented the x-rays from the hospital documented acute mildly displaced fracture of the distal femoral diametaphysis. It documented the resident did not complain of falling. A Follow-up State Reportable Incident, faxed 08/26/24, documented the facility was seeking updated notes. It documented Resident #2's hospital paperwork stated the resident felt they were handled roughly by nursing staff during a transfer and an investigation was initiated. Resident #2's hospital records, dated 08/26/24, read in part, .It is reported that patient was aggressively moved causing pain . It documented the resident thought they were handled roughly by nursing staff and had worsening pain since. There was no additional documentation of the facility investigating this allegation of abuse. A Quarterly Resident Assessment, dated 09/02/24, documented Resident #2's cognition was intact. On 10/09/24 at 8:40 a.m., Resident #2 stated they believed staff had dropped them in the shower or going to the shower. They stated they could not remember who was helping them. They stated they had no concerns of abuse or mistreatment. Resident #2 denied going to the hospital and stated they had gone to doctor appointments. They stated they knew they were supposed to call staff for help to get up, but sometimes they tried to get up on their own. On 10/11/24 at 9:07 a.m., CNA #3 stated they knew Resident #2's fracture had happened over the weekend. They stated when they came in on Monday the resident had been to the hospital. CNA #3 stated the facility was taking extra precautions with the resident when utilizing the lift. On 10/11/24 at 9:09 a.m., LPN #2 was observed reviewing the incident report for Resident #2 dated 08/24/24, and stated it lacked a description. They stated they knew the resident had a history of fractures. LPN #2 stated the resident had not fallen at the facility in the last six months. They stated the resident had osteoarthritis and they were not aware of the cause of the fracture. On 10/11/24 at 9:11 a.m., LPN #2 stated they were not aware of any reports of abuse, neglect, or mistreatment involving Resident #2. On 10/11/24 at 9:16 a.m., the administrator stated the incident involving Resident #2 happened on 08/24. They stated the resident was sent to the hospital for evaluation and treatment. They stated the x-ray results showed a fracture. The administrator stated different stories were coming out and they believed the resident told a family member staff had transferred them weird. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/11/24 at 9:18 a.m., the administrator stated on the follow-up state reportable, there were notes in the hospital portal that documented the resident reported they felt they were handled roughly by staff. The administrator stated according to what the facility had been told the resident reported leg pain. On 10/11/24 at 9:20 a.m., the administrator stated they had spoken to staff regarding this information. They stated they did not believe anything was completed on paper. They stated they would speak with the ADON to see if there was any additional documentation. On 10/11/24 at 9:55 a.m., the administrator stated there was a care plan meeting with the resident's family member. The administrator provided a copy of the social service note, dated 10/03/24, that documented the family discussed concerns with the facility related to the fracture and the resident possibly being manually lifted or dropped. The administrator stated they could not locate any additional documentation of the facility investigating the above allegation.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 35389 Based on record review and interview, the facility failed report an allegation of abuse to APS and local law enforcement for two (#5 and #6) of three sampled residents reviewed for abuse. The DON identified 70 residents resided in the facility. Findings: An Abuse Investigation and Reporting policy, revised 07/17, read in part, .All reports of resident abuse, neglect .shall be promptly reported to local, state and federal agencies .All alleged violations involving abuse . will be reported by the facility Administrator .to the following persons or agencies .Adult Protective Services . Law enforcement officials . 1. Resident #5 had diagnoses which included dysphagia following cerebral infarction and osteoporosis. A Quarterly Resident Assessment, dated 06/10/24, documented Resident #5 had moderate cognitive impairment. A Quarterly Resident Assessment, dated 09/10/24, documented Resident #5's cognition was intact. 2. Resident #6 had diagnoses which included unspecified dementia without behavioral disturbances, Alzheimer's disease, and psychotic disorder with delusions. An Admission Resident Assessment, dated 07/06/24, documented Resident #6 had severe cognitive impairment. A Combined Initial and Final State Reportable Incident, dated 08/14/24, documented an allegation of abuse/mistreatment. It documented Resident #5 slapped the hand of Resident #6. It documented the residents were separated. It documented no staff observed the incident, but overheard commotion from other residents in the area. It documented the physician and family were notified. It documented no reports of the action had previously been received. It documented staff were educated to redirect Resident #5 and to increase frequent checks while the resident was in the public area around others. It documented relocation for Resident #6 had occurred since they were previously roommates. There was no documentation this allegation of abuse was reported to APS or local law enforcement. On 10/10/24 at 10:15 a.m., Resident #5 stated the staff were good to them. The only concern the resident shared when asked about abuse/neglect was the price they were charged for a haircut and to have their eyebrows done, and that a resident who followed them sometimes had bumped into their wheelchair. They stated they would speak with staff if they had any concerns. On 10/10/24 at 10:57 a.m., an attempt was made to interview Resident #6. The resident did not respond. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 1:35 p.m., CNA #1 stated the policy for abuse was to report any concerns to the charge nurse or DON. They stated they were not aware of any incidents of abuse involving Resident #5 and Resident #6. On 10/10/24 at 1:45 p.m., CNA #2 stated any signs of abuse were to be reported to the administrator, DON and ADON. They stated they were not aware of any incidents of abuse involving Resident #5 and Resident #6. On 10/10/24 at 1:48 p.m., CMA #1 stated if they saw abuse they were to immediately report it to the nurse. They stated they were aware of an incident of hitting involving Resident #5 and Resident #6. They stated Resident #5 did not like roommates. They stated the resident could get physically aggressive at times. On 10/10/24 at 2:00 p.m., LPN #1 stated abuse was to be reported to the administrator/abuse coordinator. They stated if they observed a resident to resident altercation they would remove the residents and report it to the DON and administrator. They stated if they were injured, depending on the severity, they would be sent to the hospital. They stated the authorities would typically be called, they would complete behavior monitoring, and an investigation would be completed. LPN #1 stated they had heard there was an incident involving Residents #5 and Resident #6. They stated they believed Resident #5 slapped Resident #6. They stated Resident #6's cognition was not intact. They stated Resident #5 rambled and it was difficult to get a detailed report from them. On 10/10/24 at 2:04 p.m., the administrator stated staff worked on abuse concerns together. On 10/10/24 at 2:17 p.m., the DON stated they would notify the physician, police, family, APS, the State, proper licensing board as needed, the DON, administrator, and corporate. On 10/10/24 at 2:19 p.m., the administrator reviewed the state reportable incident involving Resident #5 and Resident #6 dated 08/14/24, and stated they didn't have any good answers. They stated it happened in the television area. They stated there was a commotion and they separated the residents. The administrator stated staff did not witness the event. They stated since they were roommates the facility separated them. On 10/10/24 at 2:29 p.m., the administrator and DON stated APS was not notified of the event. The administrator stated law enforcement was not notified of the incident of abuse.

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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** 35389 On 10/09/24, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to provide adequate supervision to prevent elopement for Resident #1 with severe cognitive impairment, daily wandering behaviors, and a history of elopement. An initial State Reportable Incident, dated 10/06/24, documented the facility charge nurse was called and notified by the local church Resident #1 was at their facility. It documented the resident was assessed and noted to have bruising to left and right lower extremities, and bilateral knees. It documented the resident reported they fell but did not hit their head. It documented the resident was sent to the ER and would be placed on 1:1 with staff to ensure safety. An Incident Note, dated 10/06/24 at 1:29 p.m., documented Resident #1 returned to the facility from the hospital with no new orders. Staffing assignment sheets were reviewed from 10/06/24 through 10/09/24. There was no documentation 1:1 was completed by staff on 10/06/24 for the day and evening shift. On 10/09/24 at 4:58 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On 10/09/24 at 5:05 p.m., the administrator and DON were notified of the IJ situation. On 10/10/24 at 11:25 a.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal documented: .Identification of total number of residents at risk for the same failed practice: 105 Actions to remove the immediacy of the alleged failed practice: . There are (four) residents at risk for this alleged deficient practice including this resident. Resident (initials removed) intentionally hides from the staff thinking it is a joke, Resident (initials removed) and (initials removed) occasionally exit seek and are easily redirected. .The identified resident was placed on 1:1 supervision on 10/06/24 1:29 PM upon return from the hospital check-up post incident and will remain on 1:1 if (the resident) remains as a resident at the facility. .Identified resident's family is seeking placement in a secure dementia unit which is a more appropriate setting for meeting this resident's needs and with the help of facility staff, the (family) found placement in a secure dementia facility and is planning to admit identified resident there on Friday, [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	.Training of all staff in the areas of elopement risk including identification of those at risk for elopement, protection measures to prevent elopement, and dementia care including documentation of 1:1 when provided and lasted for 30 minutes for all current staff by the Nursing Leadership Team staff at 7PM October 9, 2024 and no other staff will be permitted to work until they have been in-serviced before their next scheduled shift by phone contact or in-person. .The facility will monitor resident (current and future) behaviors to observe for exit seeking, verbalization of needing to go home and/or unsafe wandering. New admits will be screened through interview and record review for at risk behavior including potential elopement or unsafe wandering. If a resident is determined to be at risk, then this information will be care planned with individualized interventions for that resident will be determined and implemented. This information will be captured on the initial baseline care plan for new admissions and on regular care plans for current residents. Any behaviors exhibited would be captured in the behavior notes and screened daily by the DON or designee to identify behaviors that might lead to elopement or unsafe wandering. The staff will also notify the DON or Administrator for residents that are wandering or exit seeking at the time of the event so an immediate intervention can be placed. Actions taken to prevent recurrence of alleged failed practice: DON or designee will: .Daily review of all incidents and behavior notes to identify residents at risk for elopement. .Review will include protection of residents from elopement or unsafe wandering and interventions to reduce potential elopement or unsafe wandering in residents with dementia. .Training for staff will continue re: dementia including protective measures from unsafe wandering and elopement as well as dementia care and behaviors prevention/management and including documentation for 1:1 Care when provided, on an on-going basis by the DON, ADON, MDS, Corporate staff or Administrator and will include new hires on 10/09/2024 and on-going. .The facility will monitor resident (current and future) behaviors to observe for exit seeking, verbalization of needing to go home and/or unsafe wandering. New admits will be screened through interview and record review for at risk behavior including potential elopement or unsafe wandering. If a resident is determined to be at risk, then this information will be care planned with individualized interventions for that resident will be determined and implemented. This information will be captured on the initial baseline care plan for new admission and on regular care plans for current residents. Any behaviors exhibited would be captured in the behavior notes and screened daily by the DON or designee to identify behaviors that might lead to elopement or unsafe wandering. The staff will also notify the DON or Administrator for residents that are wandering or exit seeking at the time of the event so an immediate intervention can be placed. Actions will be completed by: 10-10-2024 3:00 PM and no staff will be permitted to work until they have completed training, and this training will be completed before the start of their next worked shift. All current staff will be in-serviced about this as of 7PM on 10-09-2024 . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The IJ was lifted, effective 10/10/24 at 3:00 p.m., when all components of the plan of removal had been verified as completed. The deficient practice remained isolated with the potential for more than minimal harm. Based on observation, record review and interview, the facility failed to provide adequate supervision to prevent elopement for a resident with severe cognitive impairment, daily wandering behaviors, and a history of elopement for one (#1) of three sampled residents reviewed for elopement. The ADON identified four residents at risk for elopement resided in the facility. Findings: An Elopement policy, revised 12/07, read in part, .Staff shall investigate and report all cases of missing residents . A Wandering policy, revised 08/14, read in part, .The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement .The staff will offer corrective interventions that may minimize risk .The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety, such as a detailed monitoring plan will be included . Resident #1 had diagnoses which included mood disorder, vascular dementia, parkinsonism, and repeated falls. A State Reportable Incident, dated 01/07/23, documented Resident #1 had eloped from the facility and was self-propelling in a wheelchair in the street to the shopping center next to the facility. A Quarterly Resident Assessment, dated 10/04/24, documented Resident #1's cognition was severely impaired. It documented the resident exhibited the behavior of wandering daily. Resident #1's Care Plan, revised 07/06/24, read in part, I wander often and at times am exit seeking. It documented the following interventions. a. 10/06/24 staff to provide 1:1 care date initiated 10/09/24, b. change door code as needed to prevent the resident from memorizing it. Date initiated 04/08/24, c. encourage the resident to attend activities for diversion. Date initiated 04/06/24, and d. observe the resident's movements and redirect away from the door as needed. Date initiated 04/08/24. Resident #1's care plan did not document the resident was at risk for elopement or that the resident had eloped in the past. August 2024 behavior monitoring records documented no behaviors were observed for Resident #1 for the month. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	September 2024 behavior monitoring records documented Resident #1 exhibited elopement/exit seeking behaviors on the 7th and the 15th. They documented no behaviors were observed any other days of the month. October 2024 behavior monitoring records documented Resident #1 exhibited elopement/exit seeking behaviors on 10/03/24. An Incident Note, dated 10/06/24 at 8:52 a.m., documented LPN #3 was notified by a member of the local church that Resident #1 was at their facility. It documented the nurse walked to the facility with two other staff members to bring Resident #1 back to the building. It documented upon assessment the resident had bruising to their left and right lower extremity and bilateral knees. It documented the resident reported they fell , but did not hit their head. It documented the DON, ADON, POA, and NP were notified. An Incident Note, dated 10/06/24 at 8:58 a.m., documented Resident #1 was picked up by emergency transport and taken to a local hospital for further evaluation. An initial State Reportable Incident, dated 10/06/24, documented the facility charge nurse was called and notified by the local church Resident #1 was at their facility. It documented the resident was assessed and noted to have bruising to left and right lower extremities, and bilateral knees. It documented the resident reported they fell , but did not hit their head. It documented the resident was sent to the ER and would be placed on 1:1 with staff to ensure safety. An Incident Note, dated 10/06/24 at 1:29 p.m., documented Resident #1 returned to the facility from the hospital with no new orders. Staffing assignment sheets were reviewed from 10/06/24 through 10/09/24. There was no documentation 1:1 was completed by staff on 10/06/24 for the day and evening shift. The hospital after visit summary, dated 10/06/24, documented Resident #1 was diagnosed with a closed head injury and accidental fall. On 10/09/24 at 8:23 a.m., CNA #4 was observed seated in a chair in Resident #1's room. Resident #1 was observed lying in bed. CNA #4 stated they were assigned to Resident #1. They stated wherever the resident went, they went. They stated they believed Resident #1 had gotten out of the building, but that was all they knew. They stated they believed the resident had fallen and experienced scratches. They stated the resident could foot propel themselves in a wheelchair. On 10/09/24 at 10:15 a.m., CNA #4 stated Resident #1 exhibited the behavior of kicking the door. They stated the resident was not able to use the key pad because it was too high. They stated the resident did not wear any monitor for wandering. On 10/09/24 at 12:50 p.m., an interview attempt was made with family member #1. Family Member #1 reported they did not want to be interviewed without council for themselves. On 10/09/24 at 1:15 p.m., CNA #2 stated staff had to redirect Resident #1 and keep an eye on them to ensure they were not by the door. They stated the resident went everywhere in the building. They stated staff would redirect the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER The Lakes		STREET ADDRESS, CITY, STATE, ZIP CODE 5701 West Britton Road Oklahoma City, OK 73132	

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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	On 10/09/24 at 1:18 p.m., CNA #2 stated they believed Resident #1 had left the building within the last year. They stated the resident was found by the trash can looking for a cigarette. They stated they were not at the facility when Resident #1 eloped on 10/06/24. They stated now someone was sitting with the resident for safety. They stated the door to exit the facility was coded and only staff knew the code. On 10/09/24 at 1:45 p.m., LPN #3 stated if a resident was known to wander the doors to the facility were locked. They stated a code had to be used to exit. They stated there was a door to the gated patio that was not locked. On 10/09/24 at 1:47 p.m., LPN #3 stated they did not know the policy for identifying residents at risk for elopement. They stated they believed they completed an elopement assessment and it was care planned. On 10/09/24 at 1:48 p.m., LPN #3 stated Resident #1 liked to move around freely and go up and down halls and tried to get out of the facility often. They stated staff would take the resident out back to get fresh air. On 10/09/24 at 1:50 p.m., LPN #3 stated Resident #1 headed to the front door pretty often. They stated staff would redirect the resident when they experienced this behavior. On 10/09/24 at 1:51 p.m., LPN #3 stated they really did not know what happened on 10/06/24. They stated the church had called them and reported Resident #1 was there. They stated the door would alarm if someone was trying to get out without the key pad. They stated they did not hear an alarm sounding. LPN #3 stated they were down the hall doing blood sugars at the time. They stated no staff observed Resident #1 leave the building. LPN #3 stated they completed a head to toe assessment of the resident and looked for bruising, pain, and obtained vital signs. They stated the DON, NP, emergency transport company, and family were notified. LPN #3 stated they were not sure how Resident #1 got to the church, but they thought the resident might have fallen because of the resident's knees. They stated the resident was sent out and returned to the facility shortly after with no new orders. On 10/09/24 at 1:56 p.m., LPN #3 stated as soon as the resident came back the facility had a sitter with the resident 24 hours a day. LPN #3 stated they had not received any additional education regarding elopement since the incident occurred. On 10/09/24 at 2:30 p.m., the DON and administrator were asked the policy for wandering. The administrator read the policy word for word. The DON stated the facility did not have an assessment tool, but monitored resident behaviors. On 10/09/24 at 2:35 p.m., the administrator stated staff were to promptly report elopement concerns to the charge nurse and DON. The DON stated staff monitored residents for exit seeking behaviors. The DON stated 1:1 was not part of the policy, but the facility felt it was needed for Resident #1. On 10/09/24 at 2:40 p.m., the DON reviewed Resident #1's behavior monitoring forms and Resident #1's quarterly resident assessment that documented the resident experienced the behavior of wandering daily. The DON stated they could not explain the discrepancy. The DON stated Resident #1 did wander around everyday and even went towards the door. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: The Lakes		STREET ADDRESS, CITY, STATE, ZIP CODE: 5701 West Britton Road Oklahoma City, OK 73132	

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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	On 10/09/24 at 2:49 p.m., the DON stated there was not an assessment completed on residents for elopement. They stated there was an option on the behavior monitoring form for elopement. On 10/09/24 at 2:53 p.m., the DON provided the behavior monitoring forms for Resident #1. They stated when everything was marked no for Resident #1's behaviors, You don't have to verify a lot. On 10/09/24 at 2:55 p.m., the administrator stated Resident #1 liked to smoke. The DON stated that was generally when the resident would go to the door. The DON stated in the past month they had noticed the resident going to the front door and they would redirect them. The DON stated they had never seen the resident go to the door at the end of the halls. The DON stated Resident #1 was quick at foot propelling themselves in a wheelchair. On 10/09/24 at 2:59 p.m., the DON stated Resident #1 had a history of exit seeking behaviors. On 10/09/24 at 3:01 p.m., the DON stated Resident #1 had eloped from the facility on 10/06/24. They stated no one saw the resident leave the building because staff were on the halls providing treatments to residents. The DON stated they were still investigating and getting statements. The DON stated no one knew Resident #1 had left until they received a call from the church. The DON stated the resident got out of the building and went across the street to the church. The DON stated the resident had apparently fallen and reported getting themselves back into their wheelchair. On 10/09/24 at 3:04 p.m., the DON stated the resident was sent out to the hospital because the fall was unwitnessed and the resident had experienced scrapes. The DON stated when the resident returned they were placed on 1:1. The DON stated 1:1 was documented in nurse notes and on the schedule with a 1:1 next to the name. On 10/09/24 at 3:06 p.m., the DON stated the resident had eloped on 05/30/22 to the facility parking lot but did not leave facility grounds. The administrator stated Resident #1 also eloped from the facility on 01/07/23. They stated the facility had encouraged family to transfer the resident to a more secure facility in the past and the family refused. They stated this time the family was willing to transfer the resident to a sister facility. On 10/09/24 at 3:08 p.m., the DON stated they did not know how Resident #1 exited the building. They stated there was about a 30 second delay of when the door would relock. They stated they facility did not believe the resident pushed the door the 30 seconds because the alarm was not sounding. The DON stated they do not know if the resident followed behind someone to exit the building. On 10/09/24 at 3:12 p.m., the DON reviewed Resident #1's care plan and stated there was nothing that stated the resident had eloped from the facility. The DON stated the facility had not in-serviced any staff related to Resident #1's elopement on 10/06/24. On 10/09/24 at 3:15 p.m., the DON stated the facility did not conduct any additional assessments of residents at risk for elopement after this elopement occurred because the facility did not use an actual assessment. The administrator stated QA was involved in the incident. The administrator was observed looking through documentation for the facility stand up meetings and stated nothing was written down. They stated it was discussed via phone and in text messages. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lakes	5701 West Britton Road Oklahoma City, OK 73132

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/09/24 at 3:28 p.m., the administrator was observed pushing on the front door for several seconds. The door alarmed and the lock released. On 10/09/24 at 3:29 p.m., the surveyor stood in the common area by the nurses' station. The administrator pushed on the front door sounding the alarm. The alarm was faintly heard in the common area. On 10/09/24 at 3:40 p.m., the DON stated staff did not document 1:1 was completed on 10/06/24 when Resident #1 returned to the facility. On 10/09/24 at 3:52 p.m., the administrator provided three staff interviews related to the 10/06/24 elopement of Resident #1.