STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375424	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilkins Health & Rehabilitation Community	1205 South 4th Street Duncan, OK 73533

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 - Minimal harm or potential for actual harm 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** 41873 Based on record review and interview, the facility failed to: a. provide adequate supervision and interventions to prevent falls which resulted in injury for one (#1) of three sampled residents reviewed for falls; and b. provide adequate supervision and interventions to prevent elopement for one (#4) of three sampled residents reviewed for elopement. The DON reported 109 residents resided in the facility. The DON reported two residents had eloped in the previous six months and four residents were at risk for elopement/wandering behaviors. Findings: A policy titled Identifying and Protecting Residents at Risk for Wandering and Elopement, dated 03/01/22, read in parts,The facility will strive to prevent unsafe wandering by identifying those at risk for elopement and follow-up with interventions to ensure safety for all .Complete and send state an incident report. A policy titled Falls Prevention & Management, dated 10/03/23, read in parts, As part of the initial review of preadmission medical records, the clinician reviewing as well as admission nurse will identify individuals with a history of falls and risk factors for subsequent falling .The staff will address risk factors for falling and work with care plan coordinator in developing a fall care plan individualized to resident. 1. Resident #1 was admitted to the facility on [DATE] with diagnoses which included schizophrenia, Parkinson's disease, and chronic obstructive pulmonary disease. A fall assessment, dated 10/12/24, documented Resident #1 was a high risk for falls. An incident report, dated 10/12/24, read in parts, Resident laying next to bed in the floor on right side . Resident was wet with urine .Resident reported trying to go to the bathroom .No injuries noted at the time of the incident. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan addendum, dated 10/12/24, read in parts, Ask every one to two hours if I need to use the bathroom .Remind to ask for assistance .Reorient to call light if necessary .Answer call light promptly. A incident report, dated 10/14/24, read in parts, Resident found in the floor .Family member [name withheld] reported the resident was found crumpled up on the footboard .Resident attempted to tell the nurse what happened but speech was unintelligible. The incident report documented the resident was transported to the hospital by EMS for evaluation. An ODH Form 283 incident report, dated 10/14/24, read in parts, History of multiple falls .Corrective Measures: Floor mat placed on resident floor next to bed .Staff to make more frequent checks on resident . Assess resident for any needs or wants resident may have. An after visit hospital summary, dated 10/15/24, documented the reason for the visit was a fall. The summary documented diagnoses of head injury and subarachnoid hemorrhage. The summary also documented a new medication of Keppra (a medication to treat seizures), 500 mg 1 tablet by mouth in the morning and at bedtime for 13 doses, and to follow-up with primary care physician in two to three days. A comprehensive assessment, dated 10/23/24, documented Resident #1 was severly impaired with cognition and dependent on staff for most activities of daily living. Incident notes for Resident #1, dated 10/12/24 throught 12/28/24, documented the resident had 15 falls. On 01/03/25 at 9:25 a.m., the administrator reported the facility had tried multiple things to prevent the resident's falls. The administrator reported the facility had put a staff member outside the resident's room Monday through Friday from 8:00 a.m. to 5:00 p.m. and one on one supervision when staffing allowed. On 01/03/25 at 12:50 p.m., family member #1 reported walking into Resident #1's room and finding the resident had fell with their head against the footboard of the bed. The family member reported the resident told them the fall occurred while trying to get to the bathroom. The family member reported the resident was wet with urine due to staff not assisting the resident to the bathroom which they believed resulted in the fall. 2. Resident #4 had diagnoses which included cerebral infarction and chronic atrial fibrillation. A Wandering Risk Scale, dated 12/04/24, documented the resident was at low risk for wandering. The form documented the resident could not follow instructions, was ambulatory, and had no history of wandering. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An incident report, dated 12/07/24, documented the charge nurse received a phone call from a CMA who was driving the facility van returning a resident to the facility. The CMA reported Resident #4 was observed walking down the street. The CMA reported they stopped and attempted to get the resident in the van, but the resident refused. The report documented the nurse drove their private vehicle to retrieve the resident. The report documented the resident told the nurse, I'll go back with you but I will plan my next escape better. The report documented a WanderGuard was applied to the resident's ankle and staff were instructed to watch the resident for any attempts to leave and to check on the resident every 30 minutes. A care plan addendum - Elopement/WanderGuard form, dated 12/07/24, documented the resident would wear a WanderGuard device to prevent elopement. An admission assessment, dated 12/09/24, documented the resident was severely impaired with cognition. The assessment documented the resident was independent with activities of daily living. A progress note, dated 12/10/24 at 9:51 a.m., documented at 9:20 a.m. the facility received a call reporting Resident #4 was observed walking down the street. The note documented the charge nurse and a CNA took the nurse's personal vehicle to the area the resident was last seen, located the resident, and was able to convince the resident to return with them. The note documented the resident was returned to the facility and immediately taken to the secured memory care unit. The note documented the WanderGuard could not be located. The note documented the resident had last been seen, prior to the elopement, at 9:10 a.m. at the nurses station talking to the nurse about needing a cell phone, then was observed to walk back toward their room. A care plan addendum - Elopement/WanderGuard form, dated 12/10/24, documented the resident would be admitted to the secured unit for the resident's safety. On 01/13/25 at 4:15 p.m., the DON reported there was no documentation of 30 minute checks related to Resident #4's elopement incident on 12/07/24. The DON reported an incident report could not be located for Resident #4's elopement on 12/10/24. The DON reported the resident had sustained no injuries during either of the elopement incidents and required no treatment.