

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375424	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Wilkins Health & Rehabilitation Community		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20960</p> <p>On 03/25/25 at 5:45 p.m., the Oklahoma State Department of Health was notified and verified the existence of an immediate jeopardy situation related to the facility's failure to provide safety and interventions to prevent elopement from the facility. Resident #1 was a high risk for elopement and wandering and was let into the court yard unattended. Resident #1 exited through a gate located on the Southeast corner of the facility and staff did not identify and know the resident was missing.</p> <p>On 03/25/25 at 6:05 p.m., the administrator and director of nursing were notified of the immediate jeopardy and provided the immediate jeopardy template.</p> <p>On 03/26/25 at 11:45 a.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part,</p> <p>[NAME] HEALTH & REHABILITATION COMMUNITY</p> <p>IMMEDIATE JEOPARDY- PLAN OF REMOVAL</p> <p>March 26, 2025</p> <ol style="list-style-type: none"> 1. Facility Administrator was informed on 3/25/2025 at 6:05pm of Immediate Jeopardy related to Elopement. 2. The Need for Immediate Action stated: 'The facility failure to ensure residents with a risk for wandering elopement are provided interventions and safety could lead to serious injury, harm, impairment or death.' 3. THE FACILITY PLAN OF REMOVAL IS AS FOLLOWS: <ol style="list-style-type: none"> A. The gate in question has been secured in a different way to ensure residents do not exit through it. (3/25/25) B. Review and revision of Policy and Procedure regarding elopements was conducted (3/25/2025) C. Review of Wandering Risk scales was conducted on all residents. 3/25/25 <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>D. Accuracy of these assessments was ensured.</p> <p>E. Identified all residents scoring 11 or higher on the Risk Scale in order to review the interventions already placed and to evaluate whether additional interventions are necessary. Began 3/25/25 and completed 3/26/2025 by 1200.</p> <p>F. 30 Minute physical checks instituted on all wander-guarded residents until new magnetic locks and Wanderguard system updated to include exits leading to the facility courtyard. Began 3/25/25 completed 3/26/2025 by 1200.</p> <p>G. New procedure inserviced and instituted to supervise all Wander-guarded residents when outside the facility including in the facility courtyard. Began 3/25/25 completed 3/26/2025 by 1200.</p> <p>*Any staff not yet to be inserviced, will not be allowed to work until properly inserviced and response received.</p> <p>H. Immediate Inservice training completed to all staff concerning Elopement. Began 3/25/25 completed 3/26/2025 by 1200.</p> <p>I. Administrator placed call to Wanderguard companies to request immediate order and setup of system on 4 additional doors. 3/26/25</p> <p>J. Gate which is newly secured will be checked twice daily to ensure that it is locked.</p> <p>Completed 0800 3/26/25</p> <p>Plan of Removal submitted by [name withheld] Administrator</p> <p>On 03/26/25 at 5:41 p.m., the facility submitted an amended plan of removal. The plan of removal, read in part, Any staff not yet to be inserviced, will not be allowed to work until properly inserviced and response received.</p> <p>On 03/26/25 after interviews with facility staff, review of resident elopement wander risk assessments, and in-services, the immediacy was lifted, effective 03/26/25 at 5:41 p.m. The deficient practice remained at and isolated level with the potential for more than minimal harm.</p> <p>Based on observation, record review, and interview, the facility failed to provide supervision and interventions to prevent elopement for 1 (#1) of 3 sampled residents reviewed for elopement. Resident #1 was a high risk for elopement and wandering and eloped from the facility with a wander guard in place. Resident #1 was a known exit seeker through exits not equipped with wander guard (a device to secure exit doors if some is that is at risk for elopement is attempting to exit the building) and staff were not aware of Resident #1 being gone until the facility transportation driver returned to the facility. The driver did not know Resident #1 resided in the facility.</p> <p>The DON identified five residents at high risk for wandering, elopement, and had a wanderguard in place.</p> <p>Findings:</p> <p>(continued on next page)</p>		

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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>On 03/25/25 at 12:04 p.m., all exit doors to the center court yard were observed to be unlocked and not equipped with a wander guard system. The gate on the Southeast side of the building was observed. There was a chain with a clip release on the gate. The clip could easily be removed and the gate opened. The only exits equipped with wander guards were the two main entrances in the front of the building.</p> <p>A policy titled Identifying and Protecting Residents at Risk for Wandering and Elopement, revised 03/01/22, read in part, 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. The resident's care plan will indicate the residents is at risk for elopement or other safety issues. Interventions try to maintain safety, such as a detailed monitoring plan will be included.</p> <p>Resident #1 admitted to the facility on [DATE] with diagnoses which included dementia, agitation, acute kidney failure, and heart failure.</p> <p>The admission Minimum Data Set assessment, with an assessment reference date of 10/10/24, showed Resident #1 had a brief interview for mental status score of 12, which showed they had moderate cognitive impairment in decision making. The assessment showed Resident #1 had no wandering and was independent with walking and ambulating.</p> <p>An incident report form, Oklahoma Department of Health form 283, dated 10/13/24, showed Resident #1 was presented to the facility from the police where they were approximately two blocks away from the facility. The report showed an innocent bystander notified the police due to a potential fall. The report showed the care plan was updated for risk of wandering and wander guard placement. The report showed staff conducted visual monitoring every thirty minutes. The incident report showed the resident was a recent admission, was anxious due to noise in the current room, and had a history of dementia with agitation.</p> <p>Resident #1's Wandering Risk Scale, dated 10/13/24, showed they were a high risk for wandering and elopement with a score of 11. A score of 11 or greater showed they were a high risk for wandering and elopement.</p> <p>There was no documented care plan after Resident #1 had eloped from the facility on 10/13/24.</p> <p>Resident #1's progress note, dated 12/25/24 at 6:27 p.m., read in part, This nurse heard the alarm for back door go off and went to investigate, resident noted exiting the back door, when asked what [they] was doing resident stated [they] was ready to go home. This nurse was able to talk resident into coming back inside building. Resident proceeded to go to front door when that alarm went off and resident realized door was locked, resident sat in chair next to door, state[sic] [they] will just sit there until [their] [family] comes to get [them].</p> <p>Resident #1's progress note, dated 12/26/24 at 3:35 p.m., read in part, Resident exited out the back door causing it to alarm to sound. Aide and office nurse walked with resident around the side of the building and assisted resident back into the building. Residents became irritated when staff attempted to redirect the first of the encounter.</p> <p>There were no documented interventions to address Resident #1 exit seeking through doors in the facility that were not secured with the wander guard system.</p> <p>(continued on next page)</p>		

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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>Resident #1's care plan, initiated 01/20/25, read in part, Focus I HAVE A WANDERGUARD AT THIS TIME R/T MY PREVIOUS ELOPEMENT FROM FACILITY ON 10/13/24. I WAS LOCATED BY POLICE SEVERAL BLOCKS FROM FACILITY. I STATE THAT I WAS CLOCKING OUT AND GOING HOME. I HAVE HAD AN INCREASE IN WANDERING AND WILL OCCASIONALLY WANDER TO EMERGENCY EXIT DOOR, IN WHICH WANDERGUARD DOES NOT WORK ON. I WAS MOVED INTO THE MEMORY CARE UNIT FOR SAFETY REASONS ON 12/6/24. ON 12/11/24 I PUNCHED ANOTHER RESIDENT IN FACE D/T [them]. WANDERING INTO MY ROOM. I WAS SENT TO [name withheld] ER AND admitted TO [name deleted]. UPON RETURN TO FACILITY, I AM RESIDING IN PATHWAY AND HAVE WANDERGUARD IN PLACE. I FREQUENTLY EXIT SEEK AND YELL AT STAFF WHEN ATTEMPTING TO ASSIST ME .Goal .I WILL HAVE A DECLINE IN BEHAVIORS OVER THE NEXT 90 DAYS .Interventions. ACTIVITY STAFF TO POST AN ACTIVITY CALENDAR IN MY ROOM MONTHLY .STAFF TO REMIND AND ENCOURAGE ME TO ATTEND ACTIVITIES .PROVIDE IN ROOM ACTIVITIES PER MY CHOICE.family] TO VISIT AS ABLE. STAFF TO ENSURE WANDERGUARD IS IN PLACE AT ALL TIMES.STAFF TO INITIATE ELOPEMENT PROCEDURES IF I AM UNABLE TO BE LOCATED, .STAFF TO OBSERVE ME AND INTERVENE IF PROBLEM BEHAVIORS ARE NOTED TO AIDE IN PREVENTION OF INJURY TO MYSELF AND OTHERS.</p> <p>A care plan, initiated 01/20/25, was the first care plan that addressed wandering and elopement. There continued to be no interventions in place to address the resident exit seeking through doors not equipped with the wander guard system.</p> <p>Resident #1's progress note, dated 03/06/25 at 4:30 a.m., read in part, Awaken at this time and ambulating without walker. Yelled at the nurse's aide when [they] took walker to res [Resident]. Exit seeking at this time trying to open front door and yelling at staff to put code in. Wander guard in place to L [left] ankle.</p> <p>A facility incident report, dated 03/06/25, read in part, Transportation driver [initials withheld] called this nurse [at] 1205 stated that the resident was outside the building on the north side, walking east with walker. [initials withheld] was able to get resident to come back into the building [at]1207. Resident wander guard still in place. Resident was noted at the back door of pathway [at]1150 when staff asked [them] where [they] was going. [They] stated [they] just wanted to go outside. CNA [initials withheld] showed resident that [they] could go through the dining area to the back courtyard. Which is an enclosed area. Resident was last seen at 1155 sitting in a chair outside pathway dining area. Resident states [they] just wanted to go outside.</p> <p>There were no documented intervention changes to address Resident #1 exit seeking through doors in the facility that was not secured with the wanderguard system.</p> <p>On 03/25/25 at 12:10 p.m., LPN #1 stated they were present on 03/06/25 when Resident #1 eloped from the facility. LPN #1 stated Resident #1 was sitting in the courtyard by the dining room and they did not know the resident was gone. LPN #1 stated it was determined Resident #1 left through the gate on the Southeast side. LPN #1 stated the Southeast gate chain could easily be removed and the gate would open. LPN #1 was asked how a resident with a wander guard was able to leave the building. LPN #1 stated only the front doors were equipped with the wander guard system and not the doors to the courtyard. LPN #1 stated Resident #1 had a history of exit seeking and it was documented in the progress notes. LPN #1 was asked about Resident #1 attempting to exit through doors not equipped with the wander guard system. LPN #1 stated they were not aware of any attempts to exit seek through doors not equipped with the system.</p> <p>(continued on next page)</p>		

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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>On 03/25/25 at 12:26 p.m., CNA #1/facility transporter stated they were returning to the facility from the North side of the building and turned the corner to head South. CNA #1 stated they saw a person with a walker at the end of the building getting ready to cross the street to the East, heading toward second street. CNA #1 stated they notified the first nurse they saw when entering the facility and they went out to talk with the person. CNA #1 stated the nurse notified them at that time it was a resident. CNA #1 stated they were not familiar with Resident #1 and did not even know they were a resident because they did not work with them.</p> <p>On 03/25/25 at 1:02 p.m., LPN #2, stated Resident #1 would walk around the facility to the dining room and sun room. LPN #2 stated Resident #1 was at risk for wandering and elopement because they wandered out of the facility and would attempt to exit seek. LPN #2 stated Resident #1 had a wander guard and would do visual checks every 30 minutes to an hour, but it was never documented. LPN #2 stated Resident #1 would attempt to exit through the back door, but while on the memory care unit they never attempted to get out. LPN #2 stated Resident #1 was sent out to the hospital and when they returned was moved off the memory care unit with a wander guard.</p> <p>On 03/25/25 at 1:26 p.m., CNA #2 stated Resident #1 had behaviors of pacing back and forth and would get angry. CNA #2 stated Resident #1 walked with a walker, would wander to the front and back, and sit by themselves. CNA #2 stated Resident #1 would attempt to go through the front door and it would alert them because of the wander guard. CNA #2 stated they asked Resident #1 on 03/06/25 what was wrong and showed them the door opened into the courtyard and let them out. CNA #2 stated they thought the courtyard was secure and Resident #1 got out and they did not have any idea where Resident #1 went. CNA #2 stated they asked the other staff where Resident #1 was and no one knew. CNA #2 stated the wander guard only activated the front doors and not the other exits to the facility. CNA #2 then stated the nurse found out through the transporter who came in and informed them someone was outside with a walker. CNA #2 stated they knew of no times Resident #1 attempted to exit through doors other then the main entrance. CNA #2 then stated again they thought the courtyard was secured, but it was not and Resident #1 got out.</p> <p>(continued on next page)</p>		

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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>On 03/25/25 at 1:58 p.m., LPN #3/ADON stated Resident #1 was admitted to the facility the first of October and became a high risk for elopement after they eloped from the facility on 10/13/24. LPN #3 stated Resident #1 had no range of motion deficits and was able to ambulate with a walker. LPN #3 stated the interventions that were put into place were a wander guard, to check placement, redirect, and diversionary activities. LPN #3 stated the care plan addressed to check on Resident #1, but did not specify how often. LPN #3 then stated 30 minute checks should have been implemented and on the care plan. LPN #3 stated the wander guard only was effective on the front doors because it was the most traveled. LPN #3 stated all other doors could not be secured and needed to remain open. LPN #3 was asked about the intervention of Resident #1 being on the memory care unit and moved back to the non-memory care unit. LPN #3 stated it was due to the decline and Resident #1 did not exit seek and elope. LPN #3 stated they were not aware of Resident #1 exit seeking through doors not secured with a wander guard, but it was on the care plan. LPN #3 stated there must have been a history. LPN #3 was asked about the elopement that occurred on 03/06/25. LPN #3 stated Resident #1 was seen by the driver when returning from a run. LPN #3 stated Resident #1 was located at the North end of the facility getting ready to cross the road. LPN #3 stated Resident #1 was at the end of the parking lot heading East towards a busy city street. LPN #3 stated highway seven was located North of the facility approximately three blocks away. LPN #3 stated highway seven was busy with a lot of traffic all the time. LPN #3 then stated it was determined Resident #1 left through the gate located on the Southeast corner of the building. LPN #3 stated the care plan was not developed until 01/20/25 for wandering and elopement.</p> <p>On 03/25/25 at 2:37 p.m., the DON stated Resident #1 became a high risk for elopement and wandering on 10/13/24 when they eloped from the facility. The DON stated Resident #1 had moderate cognitive skills for daily decision making and had a diagnosis of dementia. The DON stated Resident #1 was ambulatory and had no range of motion deficits. The DON stated a wander guard was placed on Resident #1 and visual checks were every thirty minutes. The DON stated the visual checks were not being completed until February 2025. The DON then stated the wander guard was to lock down the doors and was not allowed to be put on the exit doors other than the front door. The DON stated Resident #1 attempted to exit from doors that were not equipped with a wander guard and Resident #1 was redirected away from the doors. The DON was asked when a care plan was developed for elopement and wandering. The DON stated after the first elopement, then after reviewing the care plan, stated 01/20/25. The DON stated Resident #1 was moved to the memory care unit on 12/06/25 and then moved back to the long term care side with a wander guard when returning from the hospital on 12/23/24. The DON was asked if the care plan addressed the exit seeking from doors not equipped with the wander guard system. The DON stated Resident #1 was to be redirected away from the doors. The DON stated on 03/06/25 Resident #1 had a second elopement and the transport driver notified the nurse of a person outside the facility. The DON stated Resident #1 was going towards Second street which was a residential street. The DON stated highway seven was located about three to four blocks away and was a busy highway. The DON stated the gate was easily accessible on the Southeast side of the building and that was the way Resident #1 left the courtyard.</p> <p>On 03/25/25 at 3:15 p.m., the administrator stated only the front two doors were secured with the wander guard system. The administrator stated all other exit doors and the courtyard doors were emergency exits and did not have the system in place. The administrator stated they determined Resident #1 exited through the gate located on the Southeast corner of the facility.</p>		