STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375431	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Park Health Care Center	7019 Northwest Cache Road Lawton, OK 73505

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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34333 Based on record review and interview, the facility failed to complete a discharge summary, to include a recapitulation of the resident's stay, for two (#4 and #5) of two residents reviewed for discharge. The administrator reported a census of 78 residents. Findings: A Discharging the Resident policy, dated December 2016, documented in part, .The resident should be consulted about the discharge .ensure that resident and/or responsible party receive teaching and discharge instructions .ensure that a transfer summary is completed .assess and document resident's condition at discharge . 1. Resident #4 was admitted to the facility on [DATE] and discharged on [DATE]. A physician order for resident #4, dated 05/03/24, documented to discharge the resident home on 05/04/24 with medications and discharge instructions. An MDS discharge assessment for resident #4, dated 05/04/24, documented the resident was cognitively intact. The assessment documented the discharge was planned. A discharge summary was not completed for resident #4. 2. Resident #5 was admitted to the facility on [DATE] and discharged on [DATE]. An MDS assessment, dated 07/03/24, documented resident #5 was cognitively impaired with memory problems. Progress notes for resident #5, dated 09/08/24, documented the resident was discharged to another long term care facility. The progress notes documented the resident was being monitored for wandering behaviors. A discharge summary was not completed for resident #5. (continued on next page)

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
	375431	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Park Health Care Center	7019 Northwest Cache Road Lawton, OK 73505

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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/11/24 at 2:35 p.m., the DON reported discharge summaries could not be located but should have been completed for resident #4 and #5.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375431	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Park Health Care Center	7019 Northwest Cache Road Lawton, OK 73505

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** 34333 Based on record review and interview, the facility failed to provide supervision to prevent elopement for one (#5) of one resident reviewed for elopement. The DON reported three residents who exhibited exit-seeking behaviors and no incidents of elopement. Findings: An Elopements policy, dated December 2017, documented 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 .Examine the resident for injuries . Document the event in the resident's medical record . Resident #5 was admitted with diagnoses which included hemiplegia/hemiparesis, hypertension, aphasia, dysphagia, muscle weakness, and a history of transient ischemic attack. An MDS assessment for resident #5, dated 07/03/24, documented the resident was cognitively impaired and had memory problems. The assessment documented the resident ambulated independently. A care plan for resident #5, dated 07/15/24, documented the resident was an elopement risk due to wandering behaviors. Interventions included assessment, distraction, and identification of patterns related to wandering. On 09/06/24 at 5:10 p.m., the ADON reported they were not aware of any residents who had eloped. The ADON reported the facility had a couple of residents who were allowed to check themselves out of the facility and go into the community on their own. On 09/10/24 at 10:50 a.m., CMA #1 and #2, and CNA #1, reported they were not aware of any resident elopements. The staff reported there were certain residents who were allowed to check themselves out of the facility and go into the community. On 09/10/24 at 3:45 p.m., a resident who requested to remain anonymous reported they had heard about a resident getting out of the facility and going near the street. The resident gave a first name of the resident in question but did not know a last name. The resident stated they did not witness the incident and did not know the outcome. On 09/10/24 at 4:10 p.m., the surveyor reviewed the resident roster and there was not a resident listed with the first name provided by the anonymous resident. On 09/11/24 at 10:05 a.m., LPN #1 was interviewed regarding any incidents of resident elopement. The LPN reported there was a previous resident, resident #5, who had wandering behaviors but had never eloped on day shift. The LPN reported the resident had been discharged to another long term care facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375431	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Park Health Care Center	7019 Northwest Cache Road Lawton, OK 73505

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	On 09/11/24 at 10:15 a.m., the closed medical record for resident #5 was reviewed and documented the resident was discharged on [DATE] to another long term care facility. The nurse notes contained no documentation related to an elopement incident. Nurse notes documented the resident was being monitored for wandering behaviors. On 09/11/24 at 10:26 a.m., the corporate RN reported there was not an incident report for resident #5 related to an elopement incident. On 09/11/24 at 12:15 p.m., CNA #1 reported they had heard about resident #5 getting out of the facility but stated they did not witness it and they were not working at the time of the incident. On 09/11/24 at 1:35 p.m., LPN #2 reported they worked at the facility the evening of 09/02/24 when they received a phone call at the nurse's station by an anonymous caller. The caller reported they thought one of the facility's residents was out of the building near the street. The LPN #2 stated by the time they got to the door, an unidentified staff member was walking in with resident #5 and the resident was unharmed. The LPN stated she thought the nurse she was training under was going to report the incident to the DON. On 09/11/24 at 2:20 p.m., CNA #2 reported they were working the evening of 09/02/24 but had gone on break and wasn't aware of the incident with resident #5 until they got back from break. The CNA stated resident #5 was known to wander around the facility independently but they were not aware of the resident ever trying to leave the facility. The CNA #2 stated they talked with the resident that evening, the resident was unharmed, and staff continued to monitor the resident for wandering behaviors. On 09/11/24 at 2:35 p.m., the DON reported they had been notified of resident #5 going out of the door toward the laundry room but stated the resident was never out of sight. The DON stated since the resident was never out of sight, they did not complete an incident report. The DON stated the door leading to the laundry room would not give the resident access to the street, and they were never informed of an incident when the resident got near the street. The DON reported the facility had been looking for more appropriate placement for resident #5 due to the resident's wandering behaviors, and the resident had been discharged on [DATE].