STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375466	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Drumright Nursing Home	701 N Bristow Ave Drumright, OK 74030

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to ensure a resident's care plan was updated to reflect each time the resident eloped from the facility for 1 (#1) of 3 sampled residents reviewed for elopement. The infection control nurse identified six residents at risk for elopement resided in the facility. Findings: A resident care plan policy, revised 03/27/17, read in part, The comprehensive care plan will be reviewed and updated by the IDT [interdisciplinary team] after each quarterly and annual assessment thereafter. A quarterly resident assessment, dated 03/15/25, showed Resident #1's BIMS was 06 (severe cognitive impairment). The assessment showed Resident #1 had diagnoses of Alzheimer's disease, non-Alzheimer's dementia, and psychotic disorder. An incident note, dated 05/10/25 at 7:35 p.m., showed Resident #1 escaped the facility at approximately 7:00 p.m. The note showed the resident made it down to Cimarron one block down the road before a worker realized they were gone. The note showed CNA #3 brought the resident back in their car and took the resident back down to their room. The note showed no injuries were found. A care plan for the resident's elopement risk was not created until 05/12/25. Resident #1's care plan, dated 05/12/25, showed the resident had the potential for elopement/exit seeking wandering. The approaches showed staff were to complete the wander risk inventory on admission, quarterly and as needed and staff were to ensure exit doors are activated/alarmed. The care plan showed if wandering/exit seeking was observed, staff were to remain with Resident #1, engage them in a meaningful activity or redirect the resident. The care plan showed staff would instruct family, visitors, and residents to not open the door for others without checking with nursing staff. The care plan did not document the actual elopement on 05/10/25. A combined initial and final facility reported incident, dated 06/01/25, showed Resident #1 escaped the building through the front door of the facility. Resident #1 was seen walking down the highway by the nursing home in the opposite direction. The facility reported incident showed the resident was placed on 15 minute checks to ensure safety. (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
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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan was not updated after the resident's elopement on 06/01/25. An initial facility reported incident, dated 06/23/25, showed LPN #1 was called to the front door. The reported incident showed Resident #1 was walking across the facility lawn. The facility reported incident showed LPN #1 and two CNAs went to the resident and directed them back into the facility and into bed. The form was completed by LPN #1. The care plan was not updated after the resident's elopement on 06/23/25. On 06/25/25 at 1:08 p.m., family member #2 stated they had been called several times over the past month and a half by the facility regarding exit seeking behaviors. They stated on two occasions Resident #1 did get out of the facility. Family Member #2 stated on one occasion Resident #1 went toward the residential neighborhood and someone had brought them back in a car. They stated the other time Resident #1 went right out the front door towards the highway. The person responsible for updating care plans was unavailable for interview on 06/25/25 because they were in a training session. On 06/25/25 at 3:47 p.m., the DON reviewed Resident #1's care plan and stated they did not find any updates to the care plan after the resident eloped form the facility. On 06/25/25 at 4:26 p.m., the administrator stated the ADON was at the State completing classes and was responsible for care plans and assessments. They stated if a resident had a history of elopement, it needed to be care planned. They stated they were assuming Resident #1's elopements were care planned. On 07/02/25 at 1:27 p.m., the ADON stated they would update a resident's care plan when they were on an antibiotic, if they fell, and with any diagnoses, they would update the care plan. They stated the dashboard on the computer told them when a care plan needed to be completed and reviewed.

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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	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** On 06/25/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to provide supervision to prevent a resident with a cognitive deficit and a history of exit seeking behaviors from eloping from the facility. An order note, dated 03/08/25, showed Resident #1 tried to get out the front door. A quarterly resident assessment, dated 03/15/25, showed Resident #1's BIMS was 06 (severe cognitive impairment). A wander risk assessment, dated 04/12/25, showed Resident #1 was a high risk (score 15) for wandering. An incident note, dated 05/10/25 at 7:35 p.m., showed Resident #1 escaped the facility at approximately 7:00 p.m. Resident #1 made it one block down the road to Cimarron before worker realized they were gone. Staff assisted the resident into their car and drove the resident back to the facility. A care plan for the resident's elopement risk was not created until 05/12/25. A heath status note, dated 05/30/25, showed Resident #1 exhibited exit seeking behaviors. A combined initial and final facility reported incident, dated 06/01/25, showed Resident #1 escaped the building through the front door of the facility. Resident #1 was seen walking down the highway by the nursing home in the opposite direction. On 06/01/25 from 3:53 p.m. to 6:53 p.m., the outside temperature in [NAME] Oklahoma was 84 degrees Fahrenheit. Highway OK-33 is located in front of the facility, approximately 25 feet from the entrance door. The facility is surrounded by residential roads on the other three sides. A behavior note, dated 06/23/25 at 10:38 a.m., showed Resident #1 had attempted to exit the front door. An initial facility reported incident, dated 06/23/25, showed LPN #1 was called to the front door. The reported incident showed Resident #1 was walking across the facility lawn. The reported incident showed LPN #1 and two CNAs went to the resident and directed them back into the facility and into bed. On 06/23/25 from 9:53 a.m. to 12:53 p.m., the outside temperature in [NAME] Oklahoma ranged from 85 to 100 degrees Fahrenheit. The care plan was not updated after the resident's elopement on 06/01/25 and 06/23/25. On 06/25/25 at 4:21 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. (continued on next page)

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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 06/25/25 at 4:50 p.m., the administrator and DON were notified of the IJ situation. On 06/27/25 at 10:53 a.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part, Effective immediately, one on one staff assignment has been made for Resident #1. Staff will remain within 10-15 feet of the resident at all times. Other interventions include prevent resident #1 from exiting the building and engage resident in a meaningful activity. Resident #1's care plan will be updated to reflect each episode of exiting the facility and will reflect the intervention described above. All other residents identified as exit seeking have had their care plan updated to reflect interventions when demonstrating exit seeking behaviors. All current staff on duty will receive inservice training that will include the intervention of one on one for resident #1, the identification of any other current resident who demonstrates exit seeking behavior, how to identify exit seeking behavior in any other current resident, to notify the nurse immediately when any resident demonstrates exit seeking behavior or elopes the facility. Staff were instructed to prevent each resident with exit seeking behavior from leaving the building and to attempt to engage the resident in a meaningful activity. All remaining staff will be inserviced either in person or by phone by 10 pm on 06.25.2025 on the above information. For those staff members inserviced by phone or otherwise unable to contact, those staff members will receive additional in person inservice at the start of their next shift. The IJ was lifted, effective 06/25/25 at 10:00 p.m., when all components of the plan of removal had been verified as completed. This was verified by observing the location of residents at risk for exit seeking behaviors, staff interviews, review of in-service information, and a review of resident records to ensure interventions were in place for residents who exhibited exit seeking behaviors. 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 to prevent a resident with a cognitive deficit and a history of exit seeking behaviors from eloping from the facility for 1 (#1) of 3 sampled residents reviewed for elopement. The infection control nurse identified six residents at risk for elopement resided in the facility. Findings: 1. On 06/25/25 at 9:03 a.m., as the surveyor was standing in the parking lot of the facility, they observed two semi trucks pass by on the highway that was located approximately 25 feet from the entrance of the facility. There were also a large set of stairs outside the facility entrance door that led to the parking lot. On 06/25/25 at 10:21 a.m., Resident #1 was observed lying in bed, then sat up independently on the side of their bed. Resident #1 started touching their blanket, giggled, then pointed to their gold colored blanket. The resident began to speak, but the words were nonsensical. (continued on next page)

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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 06/25/25 at 10:25 a.m., Resident #1 moved their bedside table to the side and laid back down in their bed independently. There were no staff present in the resident's room. On 06/25/25 at 12:16 p.m., Resident #1 was observed standing in their room. CNA #2 brought the resident their meal tray and asked if the resident wanted to sit in their chair. Resident #1 walked over to the sink and obtained a napkin. On 06/25/25 at 12:17 p.m., CNA #2 opened the bathroom door and Resident #1 walked into the bathroom. CNA #2 opened the resident's meal tray and cut up the enchilada, opened the dessert, and opened the cups of liquids. On 06/25/25 at 12:19 p.m., Resident #1 exited the bathroom walked toward the surveyor and talked about their head. CNA #2 had to direct the resident on how to get soap on their hands and the resident rubbed their hands together and rinsed them in the sink. On 06/25/25 at 12:21 p.m., Resident #1 walked over to the recliner, sat down, and CNA #3 pulled the bedside table over, and put sour cream on the enchilada. The resident thanked CNA #3. CNA #3 cleaned up the resident's room, handed the resident a call light, and told the resident they would be out in the hallway if they needed anything. On 06/25/25 at 12:25 p.m., CNA #2 exited Resident #1's room. An undated procedure for locating and reporting missing residents, read in part, It shall be the plan of this facility to locate a missing client/resident as quickly as possible and return him/her to the facility to prevent an accident or any type of actual harm that might occur .Upon discovery that there is a missing client/resident, this facility will .Make a thorough search of the building for the missing client/resident and request any information from any of client/resident or visitor who may have observed any actions or have any comments concerning the missing client/resident .Make a thorough search of the grounds and land adjacent to the building .If not found, notify administrator if available. If Administrator cannot be located within 30 minutes then the next person in charge will be located and notified .Send one employee as a minimum to search the vicinity .If not found within two hours the police department is to be notified and supplied with the name and description of the client/resident along with the description of the clothing worn by the client/resident when last seen .The next of kin, responsible part, or individual who visits the client/resident shall be notify of the missing client/resident within two hours .When the client/resident is determined to be missing the Oklahoma State Department of Health will be notified by verbal or written report within 24 hours of the approximate time that the client/resident was discovered missing. An order note, dated 03/08/25, showed Resident #1 tried to get out the front door. A quarterly resident assessment, dated 03/15/25, showed Resident #1's BIMS was 06 (severe cognitive impairment). The assessment showed Resident #1 had diagnoses of Alzheimer's disease, non-Alzheimer's dementia, and psychotic disorder. A wander risk assessment, dated 04/12/25, showed Resident #1 was a high risk (score 15) for wandering. (continued on next page)

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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	An incident note, dated 05/10/25 at 7:35 p.m., showed Resident #1 escaped the facility at approximately 7:00 p.m. The note showed the resident made it down to Cimarron one block down the road before a worker realized they were gone. The note showed CNA #3 brought the resident back in their car and took the resident back down to their room. The note showed no injuries were found. A care plan for the resident's elopement risk was not created until 05/12/25. Resident #1's care plan, dated 05/12/25, showed the resident had the potential for elopement/exit seeking wandering. The approaches showed staff were to complete the wander risk inventory on admission, quarterly, and as needed, and staff were to ensure exit doors were activated/alarmed. The care plan showed if wandering/exit seeking was observed, staff were to remain with Resident #1, engage them in a meaningful activity or redirect the resident. It showed staff would instruct family, visitors, and residents to not open the door for others without checking with nursing staff. The care plan did not document the actual elopement on 05/10/25. A heath status note, dated 05/30/25, showed Resident #1 exhibited exit seeking behaviors. A combined initial and final facility reported incident, dated 06/01/25, showed Resident #1 escaped the building through the front door of the facility. Resident #1 was seen walking down the highway by the nursing home in the opposite direction. The facility reported incident showed the resident was placed on 15 minute checks to ensure safety. On 06/01/25 from 3:53 p.m. to 6:53 p.m., the outside temperature in [NAME] Oklahoma was 84 degrees Fahrenheit. Highway OK-33 is located in front of the facility, approximately 25 feet from the entrance door. The facility is surrounded by residential roads on the other three sides. The care plan was not updated after the resident's elopement 06/01/25. The forms provided to the surveyor for the every 15 minute checks following the incident were: a. one completed status location form dated 06/02/25 from 6:45 a.m. through 11:45 a.m.; b. one completed status location form dated 06/03/25 from 12:00 a.m. to 8:15 a.m.; c. one unlabeled, undated form that started at 5:00 p.m. and went through 11:45 p.m. There were blanks for the 6:30 p.m. and 6:45 p.m. checks; and d. one unlabeled, undated form that started at 12:00 p.m. and went through 11:45 p.m. There were blanks from 3:30 p.m. through 6:45 p.m. for the every 15 minute checks. A behavior note, dated 06/23/25 at 10:38 a.m., showed Resident #1 had attempted to exit the front door. An initial facility reported incident, dated 06/23/25, showed LPN #1 was called to the front door. The facility reported incident showed Resident #1 was walking across the facility lawn. The facility reported incident showed LPN #1 and two CNAs went to the resident and directed them back into the facility and into bed. The form was completed by LPN #1. (continued on next page)

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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 06/23/25 from 9:53 a.m. to 12:53 p.m., the outside temperature in [NAME] Oklahoma ranged from 85 to 100 degrees Fahrenheit. The care plan was not updated after the resident's elopement on 06/23/25. On 06/25/25 at 10:08 a.m., family member #1 stated there were confused residents in the facility who tried to enter their loved one's room. They stated when they visited the facility, residents were in their wheelchairs at the front door, but family member #1 had not experienced them trying to leave the facility when they entered or left the facility. On 06/25/25 at 10:17 a.m., LPN #1 stated Resident #1 was a high elopement risk. They stated the resident had dementia and an altered mental status. They stated Resident #1 walked independently. On 06/25/25 at 1:04 p.m., family member #2 stated Resident #1's mind was not 100 percent. They stated at times, Resident #1 did not know family member #2's name. On 06/25/25 at 1:08 p.m., family member #2 stated they had been called several times over the past month and a half by the facility regarding exit seeking behaviors. They stated on two occasions Resident #1 did get out of the facility. Family Member #2 stated on one occasion Resident #1 went toward the residential neighborhood and someone had brought them back in a car. They stated the other time Resident #1 went right out the front door towards the highway. On 06/25/25 at 1:11 p.m., family member #2 stated the facility told them they were watching for where Resident #1 was at in the building. They stated the facility was doing what they could to care for Resident #1. On 06/25/25 at 1:21 p.m., CNA #1 stated if a resident did go outside the building, they would do their best to try to get them back inside. They stated they would notify the DON and administrator depending on how far they got. On 06/25/25 at 1:26 p.m., CNA #1 stated the facility doors were locked and required a code to open. They stated if you pushed on the door too long, it would open after about 15 seconds. They stated that was probably how the residents were getting out. On 06/25/25 at 1:27 p.m., CNA #1 stated Resident #1's cognition was not the best. They stated the resident was not oriented to person, place or time. They stated the resident would often ask where they were and what was going on. On 06/25/25 at 1:28 p.m., CNA #1 stated they were not working at the time, but had heard Resident #1 had escaped the building a couple of times. They stated staff were to check on the resident every fifteen minutes and document what they were doing. On 06/25/25 at 1:32 p.m., CNA #1 stated Resident #1 walked independently. On 06/25/25 at 1:32 p.m., the administrator stated Resident #1 had severe dementia. They stated in the last month, the resident was smart enough to know if they pushed on the door 15 seconds it would open. The administrator stated they could not afford to have a guard standing at the gate 24 hours a day to guard the door. (continued on next page)

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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 06/25/25 at 1:34 p.m., the administrator took the surveyor down a hall where no residents resided. There was a double door at the end of the hall the administrator explained this was going to be the memory unit at the facility. They stated Resident #1 would be the first resident when it opened and it would be a locked unit. On 06/25/25 at 1:36 p.m., the administrator stated once the facility got the memory unit opened in the next seven to 14 days, Resident #1 would not be able to get out anymore. They stated that was their plan of correction. On 06/25/25 at 1:39 p.m., the administrator stated they were proactively dealing with Resident #1. On 06/25/25 at 2:18 p.m., CNA #2 stated the past couple of times a resident had eloped the facility had completed every fifteen minute checks on Resident #1. They stated they were here when Resident #1 escaped on 06/23/25. CNA #2 stated staff went outside, redirected the resident, sat them outside, and brought them in through the door of the skilled unit. CNA #2 stated Resident #1 had been wandering all morning that day. They stated a coworker redirected the resident to the dining room. CNA #2 stated when they came back from the bathroom, kitchen staff alerted them Resident #1 was outside because they could see them through the windows in the dining room. CNA #2 stated that was when they went and got the resident from outside. On 06/25/25 at 2:22 p.m., CNA #2 stated they took Resident #1 to the bathroom, laid them down, and were completing every fifteen minute checks on the resident to prevent them from eloping again. CNA #2 stated the resident was pretty drained because it was pretty hot outside. CNA #2 stated the resident was near the [NAME] Nursing Home sign by the highway when they got them. On 06/25/25 at 2:25 p.m., CNA #2 stated they had not received training related to elopement. They stated the door was locked and a code was needed to open it. They stated if you held the door long enough, it would open. They stated they believed that was with every door. On 06/25/25 at 2:49 p.m. CNA #3 stated they did not know the policy for elopement. They stated they knew elopement was when a resident was exit seeking. They stated if a resident did exit the building, they would first assess the situation and make sure they were ok. They stated they would speak to them calmly and try to redirect them in the right direction. On 06/25/25 at 2:51 p.m., CNA #3 stated they had not received any training related to elopement. 06/25/25 at 2:52 p.m., CNA #3 stated the facility had doors that locked and required security codes to keep residents from exiting the building. They stated they believed the memory care unit that was opening would help. On 06/25/25 at 2:54 p.m., CNA #3 stated on 05/10/25, they saw Resident #1 walking down the road when they got off work. CNA #3 stated they brought the resident back to the facility in their car. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/25/25 at 2:58 p.m., CNA #3 took the surveyor outside and pointed to [NAME] the road directly behind the skilled unit. CNA #3 stated they believed Resident #1 was on Pine and thought Resident #1 got out through the skilled door but no one knew for sure. CNA #3 stated Resident #1 had been trying to go out the skilled door earlier on their shift and they had to redirect them that night before they left. CNA #3 stated Resident #1 made it another block and a half. They stated they picked Resident #1 up at Pine and Cimarron. CNA #3 stated they were doing 15 minute checks on the resident, but was not sure if they were still in place. They stated they were unsure if the resident had gotten out another time but, We all know [the resident] has attempted it. On 06/25/25 at 2:34 p.m., LPN #1 stated the policy for elopement was to get the resident safe and into the facility if possible, notify the physician, DON, administrator and family. They stated they had been completing 15 minute checks and were working on a policy for how long the facility was going to complete the 15 minute checks. They stated staff tried to keep as many eyes on the resident to keep them safe and prevent elopement if possible in the future. On 06/25/25 at 2:36 p.m., LPN #1 stated they did not think they had received specific training on elopement. They stated if a resident exhibited exit seeking behaviors they would try to redirect them with an activity, snack, or some alone time in their room. They stated they would also increase the amount of times they were checking on them. On 06/25/25 at 2:37 p.m., LPN #1 stated the facility had double doors with a lock system on them and staff were at the desk most of the time to keep an eye on the door. On 06/25/25 at 2:38 p.m., LPN #1 stated Resident #1 was only alert and oriented to self. They stated the resident often times looked for their family. They stated the resident was confused and needed help finding their room. They stated the resident walked on their own. On 06/25/25 at 2:39 p.m., LPN #1 stated they were only present for Resident #1's elopement on 06/23/25. They stated prior to the elopement, the resident was exhibiting exit seeking behaviors. LPN #1 stated staff took the resident to their room, changed their clothes, got them a drink in the dining room and took them to the television room. LPN #1 stated Resident #1 seemed comfortable in the dining room. LPN #1 stated they had to go complete blood sugars and heard a scream and observed Resident #1 walking on the lawn. They stated they along with two other staff members got the resident back inside through the side door. LPN #1 stated they believed Resident #1 pushed the door for the 15 seconds and it opened. On 06/25/25 at 2:41 p.m., LPN #1 stated they resident agreed to go to bed because they were tired and wanted to go home. They stated once the resident was able to see their personal belongings, they recognized their room. LPN #1 stated they obtained the resident's vital signs, looked the resident over, and placed the resident on 15 minute checks. On 06/25/25 at 2:45 p.m., LPN #1 stated they were aware of other elopements and believed Resident #1 had eloped two or three times in the past month or two. On 06/25/25 at 3:03 p.m., the infection control nurse stated RN #1 who completed the facility reported incident on 06/01/25 was the former DON. They stated RN #1 had not been at the facility since 06/15/25. (continued on next page)

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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 06/25/25 at 3:06 p.m., the infection control nurse stated to their understanding, if a resident got out of the facility and did not leave the property, they completed an internal incident report and notified the administrator and DON. They stated if the resident left the property including getting to the highway, a State reportable incident should be completed and the administrator, DON, family, and physician should be notified. They stated staff would go and look for the resident, and once located and brought back, then everyone would be notified. On 06/25/25 at 3:08 p.m., the infection control nurse stated they had not received training related to elopement. They stated Resident #1 was always looking for their family member. They stated when Resident #1 left, they were trying to find their family member. On 06/25/25 at 3:09 p.m., the infection control nurse stated the facility had locked doors. They stated if the doors did not shut all the way, an alarm would sound so staff would know it was open. They stated the facility did have a couple exit seeking residents. On 06/25/25 at 3:10 p.m., the infection control nurse stated Resident #1 had full blown dementia and did not know they were in a nursing home. They stated the resident did know their name and knew who their family member was. They stated the resident walked on their own and went to the bathroom on their own. On 06/25.25 at 3:12 p.m., the infection control nurse stated the elopement they knew about for Resident #1 was on 05/10/25. They stated the only way they knew about the one on 06/23/25 was LPN #1 came in and said there was a commotion in the dining room. They stated another resident was hollering for staff because they were in the dining room and saw Resident #1 was outside. They stated Resident #1 was in the front lawn towards the highway. They stated they did not know about the one on the highway, but was told about it. On 06/25/25 at 3:16 p.m., the infection control nurse stated as of now the facility was going to continue the 15 minute checks on Resident #1 until the memory care unit was opened on 07/01/25. On 06/25/25 at 3:19 p.m., the DON stated they had just looked up the elopement policy. They stated staff were to look around the building grounds and if the resident was missing two hours, they were to notify the police. They stated staff were to notify the family immediately. They stated they were to give a description of the resident, complete a State reportable within 24 hours, and complete an incident report. On 06/25/25 at 3:20 p.m., the DON stated they had not received or provided any training related to elopement, but it was on the list. They stated when residents were exhibiting exit seeking behaviors, staff were to redirect or distract them by taking them to the television room, giving them an activity to do, or give them a snack. They stated staff were to be notified when residents exhibited exit seeking behaviors and the information was to be passed on in report. On 06/25/25 at 3:22 p.m., the DON stated the facility had coded doors and a different code to enter and exit the building. They stated they were break away doors and if you held them long enough they would open. The DON stated if a resident did elope, staff were to notify the DON and the administrator, complete a head to toe assessment to make sure there were no injuries, and complete frequent checks. They stated it was not in the policy, but they usually completed every 15 minute checks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375466	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Drumright Nursing Home	701 N Bristow Ave Drumright, OK 74030

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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 06/25/25 at 3:23 p.m., the DON stated Resident #1 was very confused and oriented to self only. They stated the resident ambulated independently most of the time. On 06/25/25 at 3:25 p.m., the DON stated they were unable to find the every 15 minute checks for the 05/10/25 or the 06/01/25 elopement of Resident #1. They stated the every fifteen minute checks were to be documented on the status location forms. The DON stated the 06/01/25 facility reported incident did document Resident #1 was on every fifteen minute checks to ensure safety. The DON stated Resident #1 was on 15 minute checks now. On 06/25/25 at 3:28 p.m., the DON stated Resident #1 was on every 15 minute checks for 24 hours, then the facility was completing every 30 minute checks. The DON stated they spoke to the facility nursing specialist who instructed them to go ahead and keep the resident on 15 minute checks because they were such a high risk. On 06/25/25 at 3:30 p.m., the infection control nurse brought in the every 15 minute checks and every 30 minute checks for Resident #1 for the elopement on 05/10/25 and 06/01/25. There were forms dated 05/10/25 through 05/12/25 completed. For the 06/01/25 elopement, they provided two forms with no dates, one form dated 06/02/25 and one form dated 06/03/25. The infection control nurse stated there were no dates on the two pages and if it was not dated they did not know when it was done. The infection control nurse identified the blanks in documentation on one of the undated forms from 3:30 p.m. through 6:45 p.m. On 06/25/25 at 3:32 p.m., the infection control nurse identified the blanks in documentation for 6:30 p.m. and 6:45 p.m. on the other undated form. On 06/25/25 at 3:54 p.m., the DON stated Resident #1's most recent wander risk assessment was completed on 04/12/25 and showed the resident was a high risk to wander. On 06/25/25 at 4:16 p.m., the administrator stated the facility did not have a specific elopement policy. They stated they had a missing persons policy. They stated when staff realized a resident was missing, it was all hands on deck and everyone looked for them. They stated if they could not locate them, they would notify the police and fire department to complete an area search. They stated most of the time they would catch them on the property, bring them back inside and complete every 15-30 minute checks on them to watch them more closely. On 06/25/25 at 4:20 p.m., the administrator stated they completed orientation with new employees and they assumed elopement was discussed in the training procedure. They stated you did not need any formal training, it was common sense if someone was wandering staff needed to keep an eye on them. The administrator stated when Resident #1 first exited the building, the nurse was the former DON. The administrator stated they would think they would know to send something into the State. The administrator stated when they returned to the facility the following Monday after 05/10/25, they asked staff if they completed a report to the state and they said no. The administrator stated they instructed them to complete one. They stated they did not think RN #1 even put anything in the nurses' note. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375466	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Drumright Nursing Home	701 N Bristow Ave Drumright, OK 74030

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/25/25 at 4:26 p.m., the administrator stated the nurses and aides were busy. They stated they could see Resident #1 one minute and three minutes later they were out the door. They stated they wished they could lock the door where they could not get out, but due to life safety, they could not. They stated they were shocked Resident #1 was cognitive enough to push on the door until it opened. The administrator stated they facility was keeping a close eye on the resident and documenting every 15 minute checks. They stated prior to 05/10/25 they had no problems, and all of a sudden Resident #1 escapes three times. The administrator stated the DON was new, but the infection control nurse would know what assessment they used to identify residents at risk for elopement. The administrator stated they were unable to remember if QAPI was involved in the elopements and to ask the infection control nurse to verify. On 06/25/25 at 4:36 p.m., the infection control nurse stated the facility completed a wandering risk under the assessment tool to determine a resident's elopement risk. They stated they were completed quarterly. On 06/25/25 at 4:38 p.m., the infection control nurse stated QAPI had not had any involvement with the elopements. 2. A quarterly resident assessment, dated 03/30/25, showed Resident #8's BIMS score was 15 (cognitively intact). On 06/25/25 at 10:34 a.m., Resident #8 stated the door to the facility was supposed to be locked. They stated a couple days ago, a resident got out. Resident #8 stated they did not know what the resident was doing playing on the highway. They stated there were two or three residents who liked to get out of the facility because their minds weren't right. Resident #8 stated they did not know the names of the residents. 3. An annual resident assessment, dated 05/29/25, showed Resident #9's BIMS score was 15 (cognitively intact). On 06/25/25 at 10:41 a.m., Resident #9 stated there were residents who wandered in the facility. They stated they had to keep their door to the bathroom locked so Resident #1 and Resident #2 would not wander into Resident #9's room.