STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375470	A. Building B. Wing	08/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chandler Therapy & Living Center LLC	601 West 1st Street Chandler, OK 74834

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 36191 Based on record review and interview, the facility failed to provide supervision to prevent elopement for one (#2) of three sampled residents reviewed for elopement, which resulted in hospitalization for rhabdomyolysis, acute kidney injury, and UTI. The administrator identified seven residents who were high risk for elopement. Findings: The facility's Elopement policy, revised 12/2007, documented staff should promptly report any resident who was suspected of being missing to the charge nurse or director of nursing, if an employee discovered a resident was missing from the facility premises they should determine if the resident was out on authorized leave or a pass, if not on authorized leave, initiate a search of the building and premises, if the resident was not located notify the administrator and the director of nursing, legal representative, and law enforcement. Resident #2 had diagnoses which included unspecified dementia, psychotic disturbance, mood disturbance, anxiety, and bladder cancer. Resident #1's admission assessment, dated 05/10/24, documented the resident had severe cognitive impairment, was inattentive, had no behaviors of wandering, and was independent with ADLs. A document titled, Wandering Risk Scale, dated 05/20/24, documented Resident #2 had a low risk of elopement and to repeat the assessment in one month and quarterly. A document titled, Incident/Offense Report from the police department, dated 08/02/24, documented a missing person incident occurred on 08/02/24 at 12:00 p.m. The report documented On 08/02/24 at 6:48 p.m. , a police officer was dispatched to the nursing center in reference to a missing resident. The report documented each staff member the officer spoke with gave a different time they had last seen Resident #2. The report documented at 8:30 p.m. a Silver Alert and a Be on the lookout was requested from Oklahoma Highway Patrol. The report documented sometime in the afternoon on 08/02/24 Resident #2 had been found by Oklahoma Highway Patrol and was taken to a rescue mission in Oklahoma City. The report also documented Resident #2 was located on 08/03/24 at a family member's house in Oklahoma City and it was not known how the resident had gotten there. (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 - Actual harm Residents Affected - Few	A document titled, Incident Report Form, dated 08/02/24, documented Resident #2 could not be located on 08/02/24 when the CMA went to administer the resident their evening medications. The report documented Resident #1 was located at their families house in Oklahoma City. The DON and administrator transported Resident #1 to the local emergency room for evaluation on 08/03/24. Employee statements related to the incident documented the following: Employee #1 documented they changed Resident #2's urostomy appliance on 08/02/24 at 2:30 p.m. There was no documentation in the clinical record the care had been completed on 08/02/24 at 2:30 p.m. Employee #2 documented they had not seen Resident #2 for the entire evening shift on 08/02/24. Employee #3 documented they had taken Resident #2's tray to their room around 5:40 p.m. and the resident was not in their room, they looked in the resident's bathroom and in the hall and then went back to Resident #2's room around 15 minutes later to give the resident medication and still did not find Resident #2 in their room. Employee #4 documented they were on lunch break and saw Resident #2 go out the back door and sit down. The employee reported they continued to look at their phone and then went back inside and did not recall if Resident #2 was still outside when they went back in the building. Employee #5 documented at 5:45 p.m., a CMA asked them if they had seen Resident #2 and they stated they had not seen the resident, and they started searching for Resident #2 and notified the police. An undated document titled, Corrective Action: Plan of Removal, documented elopement risk assessments were conducted on all residents, signs posted on front door to alert visitors not to let anyone out, and all staff inserviced. The corrective action plan did not address how Resident #2 had been able to get out of the building. The corrective action plan did not have signatures from the QA committee. A document titled, ED Provider Notes, dated 08/03/24. documented the patient had dementia and a urostomy, had been missing from the skilled nursing facility for 24 hours. The note documented Resident #2 had walked an estimated 20 miles without food or water and was oriented to self only. A document titled, Physician Discharge Summary, dated 08/05/24 documented the resident was admitted to the hospital on 08/03/24 with a diagnoses of rhabdomyolysis (A breakdown of skeletal muscle due to direct or indirect muscle injury causes may include extreme muscle strain, heat stroke, and/or bacterial infection.), acute kidney injury, and urinary tract infection. On 08/09/24 at 3:16 p.m., Resident #2 stated they had lived at the facility for about six months. (The resident was admitted in May 2024.) Resident #2 stated they did not know the name of the facility or the name of the town where the facility was located. Resident #2 stated they had not gone to visit their family recently. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 08/09/24 at 5:27 p.m., CNA #1 stated they had been one of the CNAs assigned to Resident #2's hall on 08/02/24 on the evening shift. The CNA #1 stated they thought the resident was out on leave and had not informed anyone. The CNA #1 stated they had not seen Resident #2 at shift change, during supper or the entire shift, and did not recall if they had assisted any residents with smoking that day. CNA #1 stated they started looking for Resident #2 after supper. CNA #1 stated they thought Resident #2 had dementia. On 08/09/24 at 5:39 p.m., CMA #1 stated Resident #2 had dementia and needed cueing for ADLs and was not sure if the resident knew which town the nursing home was located. CMA #1 stated the last time they saw Resident #2 on 08/02/24 was around lunch time sometime between 12:00 p.m. and 12:30 p.m. On 08/09/24 at 5:57 p.m., LPN #1 stated they had discovered Resident #2 had been missing on 08/02/24. They stated it was around 4:30 p.m., on 08/02/24 when they were on that hall and thought the resident may have been out smoking. They stated around 5:00 or 5:30 p.m., they noticed Resident #2's evening meal tray in their room and knew the resident did not eat in their room. The LPN #1 stated they immediately started asking the staff if they had seen him and started looking for the resident. LPN #1 stated they had heard the resident may have been picked up by the highway patrol and taken to their family's house. LPN #1 stated the resident had a history of bladder cancer and after they found the resident they were admitted to the hospital for Rhabdomyolysis and dehydration. On 08/09/24 at 6:43 p.m., the DON stated they discussed QA related to Resident #2's elopement each morning. They stated they were reviewing new residents and any residents with new risks five times a week for five weeks. The DON stated they had started discussing it in the morning meetings but had not done it on 08/09/24 because they were off that morning. The DON was asked for the QAPI meeting and attendees. The QAPI meeting sign in sheet was not provided. On 08/09/24 at 7:00 p.m., the administrator stated they did not know how resident #2 had gotten out of the facility and did not know how the resident had gotten to their family's house. On 08/09/24 at 7:34 p.m., CNA #2 stated they had been told by the administrator and the DON, Resident #2 had left the building around 12:00 p.m. on 08/02/24 through the door to the smoking area by putting in the door code. On 08/09/24 at 8:08 p.m., the DON was asked if they had performed an elopement risk assessment one month after Resident #2 was admitted as stated on the elopement risk assessment. They stated they did not see one dated for one after admission in the computer. On 08/10/24 at 3:37 p.m., CNA #3 stated they had been working on 08/02/24 and had last seen Resident #2 around 12:00 p.m. CNA #3 stated they had heard Resident #3 had gotten out through the back door. CNA #3 was asked how it was determined the resident had left through the back door. They stated they looked at the cameras. On 08/10/24 at 3:53 p.m., RN #1 stated they had not been given specifics about the time Resident #2 had left the building. RN #1 stated if the staff had done on/off going shift rounds they would have discovered the resident was missing sooner. RN #1 stated they thought the resident had gone out to smoke and had left from there on 08/02/24. RN #1 stated some of the residents had the door code prior to this incident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 08/10/24 at 4:01 p.m., CNA #4 stated the administrator had told them on Saturday 08/03/24, Resident #2 had gotten out through the back door to the smoking area around 12:00-12:30 p.m. On 08/10/24 at 4:27 p.m., residents were observed waiting in the back lobby to go to smoke. Two residents stated they used to have the code to go out to smoke, until a resident left. The residents identified the resident as Resident #2. On 08/10/24 at 5:06 p.m., the administrator was asked if they had determined how the resident had gotten out of the building. They stated they viewed the camera and saw Resident #2 go out the smoking door and they did not know if the resident came back in the building. The administrator stated they did not know how the resident got out of the door to the smoking area.