STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375472	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Wolfe Living Center at Summit Ridge	18501 Northeast 63rd Street Harrah, OK 73045

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 45583 Based on record review and interview, the facility failed to ensure a resident's assessment was accurately coded for 1 (#1) of 3 sampled residents reviewed for accuracy of resident assessments. The administrator identified 41 residents resided in the facility. Findings: A policy titled MDS 3.0 Completion, dated 10/01/24, read in part, Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. A Quarterly MDS, ARD of 04/18/25, showed Resident #1 had diagnoses of Alzheimer's, dementia, and severely impaired cognition. The assessment showed section E0900 (Section of the MDS for wandering) was coded as 0 for wandering in the seven day look-back period. A Progress note, dated 04/18/25 at 6:00 a.m., showed Resident #1 had wandered/paced three times that shift. An Elopement Risk Assessment, dated 04/18/25 at 2:49 p.m., showed Resident #1 was at risk for elopement. The assessment showed the resident wandered aimlessly or was non-goal-directed. On 04/20/25 at 3:03 p.m., ADON #1 reviewed Resident #1's MDS and progress note for the ARD of 4/18/25. They stated section E0900 was not accurately coded because the resident Went out the door.

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	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 45583 Based on record review and interview, the facilty failed to review and revise the care plan for 1 (#1) of 3 sampled residents whose care plans were reviewed for elopement. The administrator identified 41 residents resided in the facility. Findings: A policy titled Comprehensive Care Plans, dated 03/24/25, read in part, Resident specific interventions that reflect the residents' needs.The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. An incident report for elopement for Resident #1, dated 04/15/25, read in part, Call received from maintenance staff the resident was in the back of the building ambulating across the parking lot. Maintenance staff stayed with resident until nursing staff reached [them] and assisted [them] back into the facility without incident. A head to toe assessment was performed with no noted injuries or distress. Video was reviewed, resident was shown leaving through the ambulance door on East Wing without door alarm sounding.INTERVENTIONS: 15 minute visual checks on resident and hourly checks on door alarms initiated immediately. A Care Plan, initiated 12/01/24, with a target date of 02/19/25, showed a risk for elopement problem listed. The care plan did not show the incident or any interventions added or changed for the incident on 04/15/25. On 04/30/25 at 1:49 p.m., ADON #1 stated care plans were to be updated with any changes needed and with anything new or changed. ADON #1 looked through Resident #1's care plan and progress notes and stated there was not a new update on the care plan for the elopement attempt and did not locate the same incident from 04/15/25 on the care plan. ADON #1 stated they did not add the every fifteen minute resident checks or the hourly door checks.