STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375473	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Epworth Villa Health Services	14901 North Penn Avenue Oklahoma City, OK 73134

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 - 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 05/08/25, a past non-compliance Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to provide supervision to protect residents with exit seeking behaviors. Resident #1 had exit seeking behaviors and exited the facility on 04/28/25. Resident #1 was located by security to be lying on the ground on the sidewalk outside of one of the exit doors from household #3. Resident #1's care plan did not address elopement. 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 wandering and elopement. The administrator identified 70 residents resided in the facility and Resident #1 was the only resident able to walk independently. Findings: On 05/08/25 at 1:15 p.m., the exit door from household #3's sunroom was observed to be unlocked. The sunroom door led to the courtyard which had a gate that kept residents from being able to exit the grounds of the courtyard. All other exit doors were secured with a 15 second egress release and a secondary alarm that sounded when the door handle was pushed. The sound was loud enough to be heard at the nurse's station. An undated policy titled Wandering and Elopement, read in part, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. An undated Profile Face Sheet for Resident #1 showed they were admitted to the facility on [DATE] and had diagnoses of included dementia. Resident #1's elopement risk evaluation, dated 02/17/25, show the resident had an elopement risk evaluation of 14 indicating they were an elopement risk. A score of 10 or more indicated they were an elopement risk. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1's care plan, created on 02/27/25, did not address the risk of elopement. Resident #1's admission Minimum Data Set assessment, with an assessment reference date of 02/24/25, showed they had a brief interview for mental status score of 8 indicating moderate cognitive impairment. The assessment showed Resident #1 was able to ambulate with a walker. A Final Incident Report Form, dated 04/28/25, showed Resident #1 was not in their room at 4:20 a.m., when staff made rounds. Resident #1 was found lying on the sidewalk outside of household #3's back door. The incident report showed Resident #1 had fallen and sustained a fracture of the right wrist. The incident report showed a power surge from recent storms had made the door alarm go offline, causing it to not alarm when opened. A review of in-service documentation showed the facility provided in-service on 04/28/25 related to the doors not locking or alarming. A review of a work order showed on 04/28/25 the electronic company replaced the battery for the maglocks on the doors of household #3 and #4. Doors were then tested to be good. A review of the text message sent to all employees on 04/29/25 at 1:32 p.m. showed all staff were made aware the power outage prevented the doors exiting outside to not lock or alarm. The message showed all staff were to check the doors throughout their shift, especially during power flickers. A review of a Safety Officer Shift Report, dated 04/29/25, showed patrol checked all doors, door alarmed pushed to verify at 2:00 a.m. A review of an undated Shift Checks form showed checking the doors to the outside to ensure they were secured was the first item listed. A review of a document titled Residents at Risk Meeting, dated 05/01/25, showed management had addressed Resident #1's elopement, insomnia, and mobility. On 05/08/25 at 12:44 p.m., RN #1 stated most of the residents had dementia. RN #1 stated Resident #1 was the only resident that was ambulatory on household #3. RN #1 stated staff were in-serviced about checking the alarms on the doors throughout their shift. On 05/08/25 at 1:00 p.m., CMA #1 stated they were in-serviced on checking to ensure the alarms were working on the exit doors. CMA #1 stated the night shift usually had three staff members working, and they stayed in the common area to supervise the residents. CMA #1 stated they usually kept the residents in the common area when they were awake. On 05/08/25 at 2:34 p.m., CNA #1 stated Resident #1 had been refusing care, saying no to everything, and stating they wanted to go to their own home throughout the evening of 04/28/25. CNA #1 stated they were checking on Resident #1 more often due to restlessness and behavioral issues. CNA #1 stated when they went to check on Resident #1 around 30-45 minutes after walking them back to their room from the common area, Resident #1 was not in their room or bathroom. CNA #1 stated they notified the nurse and started to look for Resident #1. Security was then notified. CNA #1 stated security found Resident #1 outside. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/08/25 at 3:54 p.m., the administrator stated the alarm company came the same morning as the incident to check the doors. The administrator stated security was usually the ones responsible for checking the exit doors. The administrator stated checking the doors was now added to the checklist for every shift. On 05/08/25 at 4:18 p.m., the DON stated the interventions put into place for wanderers was to keep them in a public area when they were awake and increased checks. The DON stated if they thought the resident would elope, then they were not admitted because it was not a locked facility. The DON stated Resident #1's family did not want Resident #1 placed in memory care because the family did not want to have to move Resident #1 again when they started to need more physical care than memory care could provide. The DON stated Resident #1 had never tried to elope before and did not have a history of elopement. The DON stated melatonin (sleep hormone) was added to Resident #1's medication profile to help them sleep, occupational therapy was going to evaluate Resident #1 again, and staff would monitor the doors to ensure alarms were working each shift.