STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375502	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor	3804 North Barr Ave Oklahoma City, OK 73122

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** 35389 On 03/19/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to provide supervision for Resident #1 who wandered and experienced exit seeking behaviors. An undated elopement policy, read in part, It is the policy of this facility to provide a safe and comfortable environment to prevent resident elopements. Resident #1's Wandering Risk Assessment, dated 02/13/25, showed the resident was a high risk for wandering and was a known wanderer/history of wandering. A nurse note, dated 02/15/25 at 1:03 p.m., showed Resident #1 remains confused trying to exit pushing on north hall door. The note showed Resident #1 was wandering on other halls and went in other rooms. An admission resident assessment, dated 02/19/25, showed Resident #1's BIMS score was 00 (severe cognitive impairment) and the resident was independent for the task of sit to stand and walking 10 feet, 50 feet with two turns, and 150 feet. A nurse note, dated 02/19/25 at 8:35 p.m., read in part, At about [8:35 p.m.] this nurse was notified, by nurses aide, resident had wandered off, and was assisted back in by the neighbor. A State reportable incident, dated 02/19/25, showed staff responded to the alarm at the South door and could not find anyone there. The report showed staff began to perform an elopement drill, during the drill, neighbors brought Resident #1 to the front door. The report showed the neighbors witnessed Resident #1 leaving through the side door. The report showed Resident #1 was placed on every 15 minute observation for safety. On 03/19/25 at 10:42 a.m., Resident #1 was observed lying in bed with their eyes open. When the surveyor attempted to speak to the resident, Resident #1 just smiled and began to laugh. On 03/19/25 at 10:50 a.m., CNA #3 stated Resident #1 liked to walk around. They stated they tried to get the resident to walk toward the main part of the building to make sure the resident was not escaping. They stated the resident liked to go to the end of the hall and push on doors. They stated they tried to get them to watch TV. CNA #3 stated they could not answer whether or not Resident #1 had ever eloped. They stated not on their shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375502	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor	3804 North Barr Ave Oklahoma City, OK 73122

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	On 03/19/25 at 10:57 a.m., CNA #2 stated they were not familiar with Resident #1, but they knew the facility completed 15 minute checks on the resident. They stated they did not know the reason for the 15 minute checks. On 03/19/25 11:02 a.m., CNA #1 stated elopement was when a resident ran off. They stated the facility completed 15 minute checks on certain residents and some were supervised at all times. They stated staff would search the premises if a resident had eloped. They stated staff would try redirecting the resident by offering them a drink to change their mood. CNA #1 stated Resident #1 liked to roam the building a lot. They stated staff completed 15 minute checks. CNA #1 stated from their understanding Resident #1 had not eloped. On 03/19/25 at 11:14 a.m., ACMA #2 stated the facility had codes on the doors so residents could not leave without the codes and they did not share codes with the residents. They stated if residents pushed on the door, after 15 seconds it would open and alarm. ACMA #2 stated elopement was when a resident ran away. They stated they would complete a head count, shut everything down, look around the building, look behind closet doors, and even have staff drive around a two mile radius looking if a resident eloped. They stated they did not know Resident #1. On 03/19/25 at 11:17 a.m., ACMA #1 stated staff checked on Resident #1 every 15 minutes. They stated everyone knew Resident #1 was at a high risk to leave. ACMA #1 stated Resident #1 liked to walk the halls and went to the door. They stated if they observed the resident walking the halls, they would sit them on the sofa because the resident would sit and watch TV. ACMA #1 stated they thought Resident #1 had eloped on a weekend because when they left, everything was fine, but when they came back to work, the nurse told them to keep an eye on the resident. ACMA #1 stated the nurse did not say why and so they did not know if Resident #1 had eloped or had tried to elope. On 03/19/25 at 11:28 a.m., LPN #2 stated the doors of the facility were coded and had alarms. They stated if they knew a resident was a wanderer, they would have someone always keeping an eye on them. They stated the policy for elopement was for everyone to come to the nurses' station, they would delegate where everyone was going to look for the resident inside and outside the building, and would complete a head count. They stated staff would place the residents on 15 minute checks and the nurses were responsible for completing them. LPN #2 stated they had redirected Resident #1 in the past by dancing with them down the hall. LPN #2 stated they knew Resident #1 was a wanderer, but they were not sure if the resident actually did elope. On 03/19/25 at 11:38 a.m., LPN #1 stated anyone who staff knew was an elopement risk, staff would keep an extra eye on. They stated the doors had to be pushed for 15 seconds before you could get out and the buzzer would sound. They stated there were codes for all of the doors. LPN #1 stated if staff noticed a resident was missing they would call everyone to the desk, staff would go to their specific hall, and complete a head count. They stated the nurse would assign who was responsible for searching inside the building, outside the building, and who would be responsible for driving the 2 mile radius from the building looking for the missing resident. They stated staff would continue searching until they were located. They stated the administrator would be called immediately. LPN #1 stated they were not aware of Resident #1 eloping from the facility. They stated the resident had not eloped on their shift and was on every 15 minute checks because the resident exit seeks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375502	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor	3804 North Barr Ave Oklahoma City, OK 73122

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	On 03/19/25 at 11:47 a.m., the DON stated Resident #1 got out. They stated they were not 100 percent, but the door was alarming and as they were doing the drill looking for the resident, the neighbor had seen Resident #1 go out the door and brought them back in the front door. The DON stated the administrator at the time came to the facility that night (02/19/25) and completed an elopement drill. On 03/19/25 at 1:02 p.m., the administrator stated they were new to the facility and was not aware of any resident in the facility that had eloped. They stated they knew Resident #1 was an elopement risk because they discussed it in their morning meetings, but they could not say whether or not it actually occurred because the administrator was not working at the facility at the time of the incident on 02/19/25. There was no documentation to show an elopement drill was conducted on 02/19/25. On 03/19/25 at 4:40 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On 03/19/25 at 4:45 p.m., the administrator, DON, corporate nurse consultant #1, and corporate business office were notified of the IJ situation. On 03/20/25 at 4:46 p.m., the administrator, DON, corporate nurse consultant #1, corporate nurse consultant #2, and corporate business office were notified of the amended IJ template which contained the following additional information: On 02/19/25 between 7:52 p.m. and 8:52 p.m., the Oklahoma City outside temperature was 9 to 10 degrees Fahrenheit. There is a two lane residential road North [NAME] Avenue that sits west of the facility. Approximately half a block north of the facility is U.S. Route 66 which is a busy four lane road. On 03/21/25 at 12:57 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part, Heritage Manor Plan of Removal Immediate Jeopardy 3/19/25 The facility's response to the IJ called for the facility to implement a plan of removal to ensure there is a system in place to protect residents from elopement. The facility will be in compliance on 3/19/25 by 10pm. 1. All staff are educated on the Elopement Policy on hire and annually, as well as periodically as a reminder. An in-service had been completed with nursing staff following the attempted elopement by resident [Resident]. 2. In-service will be completed with all staff by 10 pm on 3/19/25 over the following: A. Elopement Policy to include the following interventions to prevent elopement: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375502	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor	3804 North Barr Ave Oklahoma City, OK 73122

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	a. Any resident who is determined to be a wanderer on admission will be placed on Elopement Risk on their profile and frequent Q 15 minute visual checks to monitor for exit seeking behaviors for 4 weeks and then re-evaluated. If no exit seeking behaviors have been noted, they will no longer be considered an elopement risk. b. Institute 1:1 [one on one] monitoring or Frequent Visual Checks charting Q 15minutes or as indicated if a resident with Dementia is having any exit-seeking behaviors or attempts to go out without supervision, until no longer deemed at risk. c. Re-evaluate at least quarterly for wandering and exit seeking and revise plan for monitoring according to resident's risk. d. Institute other interventions as needed for residents with exit seeking behaviors to re-direct or distract resident from exit seeking behaviors such as: Camouflaging doors with wallpaper or curtains so they are not recognized as doors, Stop signs on exit doors, Encouraging family members to visit, Diversional activities during times of restlessness. B. Location of the Elopement Risk book that has a list and information for all residents on Elopement Risk. C. A list of Resident's at risk for elopement will continue to be posted in each charge nurses report book. 3. Agency will be provided with in-service materials as well. 4. Any staff on vacation or unable to reach will be in-serviced before working their next shift. 5. All residents considered high risk for elopement have an identifier on the residents profile to alert staff, Elopement Risk. The IJ was lifted, effective 03/19/25 at 10:00 p.m., when all components of the plan of removal had been verified as completed. This was verified by staff interviews, review of inservice information, and a review of resident records to ensure interventions were in place for residents who exhibited exit seeking behaviors and residents at risk for elopement. 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 for a resident who wandered and experienced exit seeking behaviors for 1 (#1) of 3 sampled residents reviewed for elopement. The administrator identified 11 residents at risk for elopement resided in the facility. Findings: On 03/17/25 at 1:55 p.m., no residents were observed exit seeking on the East Hall. On 03/17/25 at 2:17 p.m., no residents were observed exit seeking on the North Hall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375502	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor	3804 North Barr Ave Oklahoma City, OK 73122

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	On 03/17/25 at 2:57 p.m., Resident #1 was observed sitting on the couch in the tv area by the front door with their eyes closed. On 03/18/25 8:41 a.m., Resident #1 was observed lying in bed, eyes closed, with audible snoring heard. On 03/18/25 at 11:32 a.m. no residents were observed demonstrating exit seeking behaviors on the East, North, or South hall that were all observed from the nurses' station. On 03/18/25 at 12:26 p.m., Resident #1 was observed in the dining room being fed by ACMA #1 who was seated next to them. Resident #1 was observed using their left hand to take a drink from their cup while ACMA #1 gave the resident a bite of food in between drinks. Resident #1 did not speak during the observation. On 03/18/25 at 1:39 p.m., Resident #1 was observed seated on couch in the dining area, eyes closed, with staff present and the television on. An undated elopement policy, read in part, It is the policy of this facility to provide a safe and comfortable environment to prevent resident elopements .When the resident has been assessed to be a high elopement risk beyond he capability of the facility safeguards, the Administrator and Director of Nursing will ascertaine [sic] possible discharge of the resident to protect the safety of that resident .At any time during the course of the resident's stay, if the resident is assessed to be an elopement risk, the Administrator and Director of Nursing will confer with the resident's physician and family regarding the resident's admission status. If the determination is that the resident is appropriately placed in the facility, then the resident's care plan will address elopement risk and appropriate interventions tailored to the particular resident will be put into place to prevent any elopements .Also, residents who are determined to be at 'high risk for elopements' will have an identifier on the medical record. Resident #1 had diagnoses which included unspecified dementia unspecified severity, with other behavioral disturbance. Resident #1's Wandering Risk Assessment, dated 02/13/25, showed the resident was a high risk for wandering and was a known wanderer/history of wandering. A nurse note, dated 02/15/25 at 1:03 p.m., showed Resident #1 remains confused trying to exit pushing on north hall door. The note showed Resident #1 was wandering on other halls and went in other roomsand occasionally hard to re-direct attempts tohit [sic] staff but not successful. A nurse note, dated 02/16/25 at 3:42 p.m., read in part, Resident after lunch continues on observation r/t [related to] elopementbehavior[sic]/wandering with no incident of existing [sic] or trying to leave/push on doors. A nurse note, dated 02/17/25 at 9:41 p.m., read in part, Resident currently wandering through out facility, exit seekingthroughout [sic] shift, easily redirected. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375502	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor	3804 North Barr Ave Oklahoma City, OK 73122

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	An admission resident assessment, dated 02/19/25, showed Resident #1's BIMS score was 00 (severe cognitive impairment) and the resident was independent for the task of sit to stand and walking 10 feet, 50 feet with two turns, and 150 feet. A nurse note, dated 02/19/25 at 8:35 p.m., read in part, At about [8:35 p.m.] this nurse was notified, by nurses aide, resident had wandered off, and was assisted back in by the neighbor. A State reportable incident, dated 02/19/25, showed staff responded to the alarm at the South door and could not find anyone there. The report showed staff began to perform an elopement drill, during the drill, neighbors brought Resident #1 to the front door. The report showed the neighbors witnessed Resident #1 leaving through the side door. The [NAME] showed Resident #1 was placed on every 15 minute observation for safety. On 02/19/25 between 7:52 p.m. and 8:52 p.m., the Oklahoma City outside temperature was 9 to 10 degrees Fahrenheit. There was a two lane residential road North [NAME] Avenue that sat [NAME] of the facility. Approximately half a block North of the facility was U.S. Route 66 which was a busy four lane road. There was no documentation to show an elopement drill was conducted on 02/19/25. A nurse note, dated 02/22/25 at 8:27 p.m., read in part, Resident wandering in hallway easily directed. A nurse note, dated 02/23/25 at 7:57 p.m., read in part, Resident wandering in hallway easily directed. A nurse note, dated 03/07/25 at 7:48 p.m., read in part, Resident assisted to bed at this time. Elopementmonitoring [sic] continues Given that, [they] tried to open front door threetime [sic]. A nurse note, dated 03/12/25 at 7:52 p.m., read in part, Resident continues on elopement risk precautions. This nurse had to redirect resident a few times. On 03/18/25 at 8:14 a.m., the host was observed seated at a table by the front door. They stated they were responsible for checking visitors in and answering phones. They stated their sign in was primarily for vendors. They stated when family members came in they would sign in and out at the nurses' station. The host stated just the staff members had the number to get out of the building. On 03/19/25 at 10:50 a.m., CNA #3 stated Resident #1 liked to walk around. They stated they tried to get the resident to walk toward the main part of the building to make sure the resident was not escaping. They stated the resident liked to go to the end of the hall and push on doors. They stated they tried to get them to watch TV. CNA #3 stated they could not answer whether or not Resident #1 had ever eloped. They stated not on their shift. On 03/19/25 at 10:57 a.m., CNA #2 stated they were not familiar with Resident #1, but they knew the facility completed 15 minute checks on the resident. They stated they did not know the reason for the 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
	375502	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor	3804 North Barr Ave Oklahoma City, OK 73122

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	On 03/19/25 11:02 a.m., CNA #1 stated elopement was when a resident ran off. They stated the facility completed 15 minute checks on certain residents and some were supervised at all times. They stated staff would search the premises if a resident had eloped. They stated staff would try redirecting resident by offering them a drink to change their mood. CNA #1 stated Resident #1 liked to roam the building a lot. They stated staff completed 15 minute checks. CNA #1 stated from their understanding Resident #1 had not eloped. On 03/19/25 at 11:14 a.m., ACMA #2 stated the facility had codes on the doors so residents could not leave without the codes and they did not share codes with the residents. They stated if residents pushed on the door, after 15 seconds it would open and alarm. ACMA #2 stated elopement was when a resident ran away. They stated they would complete a head count, shut everything down, look around the building, look behind closet doors, and even have staff drive around a two mile radius looking if a resident eloped. They stated they did not know Resident #1. On 03/19/25 at 11:17 a.m., ACMA #1 stated staff checked on Resident #1 every 15 minutes. They stated everyone knew Resident #1 was at a high risk to leave. ACMA #1 stated Resident #1 liked to walk the halls and went to the door. They stated if they observed the resident walking the halls, they would sit them on the sofa because the resident would sit and watch TV. ACMA #1 stated they thought Resident #1 had eloped on a weekend because when they left, everything was fine, but when they came back to work, the nurse told them to keep an eye on the resident. ACMA #1 stated the nurse did not say why and so they did not know if Resident #1 had eloped or had tried to elope. On 03/19/25 at 11:28 a.m., LPN #2 stated they knew Resident #1 was a wanderer, but they were not sure if the resident actually did elope. On 03/19/25 at 11:38 a.m., LPN #1 stated they were not aware of Resident #1 eloping from the facility. They stated the resident had not eloped on their shift and was on every 15 minute checks because the resident exit seeks. On 03/19/25 at 11:47 a.m., the DON stated the facility had doors that required a code to open and had alarms. They stated several residents were on frequent monitoring. They stated staff would redirect them if they were exhibiting exit seeking behaviors. They stated elopement was if a resident was outside the building without staff being aware. The DON stated the policy for elopement was if staff noticed someone was missing, they go to the nurses' station, the nurse calls the elopement drill, everyone checks halls and visually counts each resident. The DON stated if a resident was not found in the building, staff searched the perimeter and notified the administrator, police and family. The DON stated Resident #1 got out. They stated they were not 100 percent, but the door was alarming and as they were doing the drill looking for the resident, the neighbor had seen Resident #1 go out the door and brought them back in the front door. The DON stated the administrator at the time came to the facility that night (02/19/25) and completed an elopement drill. The DON stated the facility put every 15 minute monitoring in place, redirected the resident, used activities, and the mental health provider saw Resident #1 for interventions to prevent it from happening again. On 03/19/25 at 12:53 p.m., the DON was shown only 17 of their 49 staff signed the elopement drill on 03/13/25 and was asked to explain how the remaining staff were educated. The DON stated there had not been any additional elopement drills after Resident #1's elopement other than the one on 03/13/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375502	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor	3804 North Barr Ave Oklahoma City, OK 73122

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	On 03/19/25 at 1:02 p.m., the administrator stated residents were to sign out in the book before they left the facility. They stated they had never been involved in an elopement. They stated the doors were always locked. They stated an alarm would sound if a resident pushed on the door and it opened. They stated they were new to the facility and was not aware of any resident in the facility that had eloped. They stated they knew Resident #1 was an elopement risk because they discussed it in their morning meetings, but they could not say whether or not it actually occurred because the administrator was not working at the facility at the time of the incident on 02/19/25. On 03/19/25 at 1:12 p.m., the DON stated the next quality assurance performance improvement meeting was scheduled on 03/28/25 and elopement would be discussed as well as any other concerns. On 03/19/25 at 3:12 p.m., the DON stated from what they understood everyone was looking for Resident #1 at the time of the elopement. The DON stated as they started looking for the resident, the neighbor saw Resident #1 go out. The DON stated from what they understood, it was minutes and the neighbor brought Resident #1 right back into the front door as they were still searching the building. On 03/19/25 at 3:52 p.m., LPN #1 stated they guess staff should not chart easily redirected. They stated they should say how they were redirecting. LPN #1 stated for instance when they came down the hall dancing with Resident #1, instead of putting easily redirected, they should have put dancing down the hall. They stated easily redirect could mean a lot.