STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375530	A. Building B. Wing	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corn Heritage Village and Rehab of Weatherford	801 North Washington Weatherford, OK 73096

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** 35749 On [DATE] at 4:27 p.m., the Oklahoma State Department of Health verified the existence of an Immediate Jeopardy Situation. The facility failed to provide supervision to prevent elopement. Resident #1 resided on the memory unit. A quarterly resident assessment, dated [DATE], showed Resident #1 had moderate cognition impairment, had no wandering behavior seven days prior to the assessment, could walk 150 feet, and had a diagnosis of dementia. Resident #1's care plan, dated [DATE], showed they were at risk for elopement. Behavior notes showed Resident #1 had been experiencing increased behaviors. On [DATE], Resident #1 was getting dressed and stated they had to get out because their daughter died . There were no interventions implemented after the increased behaviors. An incident report, dated [DATE], showed the facility received a phone call at 3:35 p.m., telling them Resident #1 was approximately two blocks away from the facility. Shift assignment sheets for [DATE] on the 3:00 p.m. to 11:00 p.m. shift, showed two CNAs had been assigned to the memory unit. Time records, dated [DATE], showed one of the two CNAs did not come into work until 4:35 p.m. On [DATE] at 4:33 p.m., the administrator and DON were notified of the existence of an immediate jeopardy (IJ) situation related to elopement for Resident #1. The IJ template was provided to the administrator. On [DATE] at 10:43 a.m., an acceptable plan of removal was approved by Oklahoma State Department of Health. The plan of removal, read in part, Corn Heritage Village & Rehab of [NAME] Plan of Removal for IJ Total number of residents potentially at risk are 13 Action to Remove Immediacy (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE]th all sunroom windows had new window alarms installed, windows have been adjusted to open only a few inches where no residents can get through it (in guidance with fire chief). Resident #1 was immediately placed on one-on-one care till [Res #1] was transported to Geri-psych due to voicing self-harm on same day and is not currently in facility. All staff shall receive in-service education on all aspects of the elopement policy and resident behaviors that may indicate elopement. by 12:00 pm [DATE], this training will be done by the Director of Nursing and Assistant Director of Nursing or designee. An elopement assessment will be completed on all residents in the memory care unit and current behaviors reviewed for changes. Nursing director is monitoring and ensuring there is adequate and appropriate staffing in memory care unit every shift Action to Prevent Recurrence Res #1 is not currently in facility When Res# l returns to facility, new elopement assessment shall be completed Nursing team shall check windows every shift to ensure they are secure. Nursing team shall ensure there are always appropriate numbers of nursing staff in memory care unit. Facility shall consult with Fire Marshall for any more possible solutions to securing windows in the memory care unit The Hall Monitor assigned to that hall shall ensure all possible exit points are secure during his/her rounds. Maintenance Director shall check all exit points weekly to ensure safety of residents. All new staff Hired after [DATE] shall receive the same education on all aspects of Elopement. All staff shall receive education on elopement with an emphasis on resident behaviors that may indicate possible elopement and appropriate interventions. Monitoring implementation of Plan of Removal All education, implementation and monitoring of this plan of removal will be completed by the Director of Nursing and administrator and/or their designee. Emergency QAPI meeting will be conducted on [DATE] @ 10:00am to review protocols put into place. This plan will continue to be reviewed in the regulatory quarterly QAPI meetings. On [DATE] at 10:32 a.m., after interviews with facility staff, review of in-services, elopement assessments, and staffing, the immediacy was lifted, effective [DATE] at 12:00 p.m. The deficient practice remained at an isolated level with the potential for more than minimal harm. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on observation, record review, and interview, the facility failed to provide supervision to prevent elopement for 1 (#1) of 3 sampled residents reviewed for elopement. The DON identified 62 residents reside in the facility and 13 residents were at risk for wandering. Findings: On [DATE] at 11:58 a.m., the memory care unit sunroom was observed to have 11 windows approximately one and one-half feet off the ground. An undated Wandering/Elopement policy, read in part, To ensure the residents' safety utilizing the least restrictive means available. To provide a safe and secure environment. An Elopement Risk Evaluation, dated [DATE], showed Resident #1 was at risk of elopement. A quarterly resident assessment, dated [DATE], showed Resident #1 had moderate cognition impairment, had no wandering behavior seven days prior to the assessment, could walk 150 feet, and had a diagnosis of dementia. A Care Plan Report, dated [DATE], showed Resident #1 was at risk for elopement and would have supervision to prevent exiting the building unattended. A Time & Attendance record, dated [DATE], showed CNA #7 (one of the two scheduled CNAs) did not clock in for the 3:00 p.m. to 11:00 p.m. shift until 4:35 p.m. A hand written document, dated [DATE], read in part, [CNA #6 and CMA #3] did rounds in the unit with 2nd shift [CNA #8] [at] 3:10 - 3:15 [Resident #1] was in the unit sun room pacing back [and] forth. Before we left the unit after doing rounds [CNA #6] told the 2nd shift CNA [CNA #8] to keep an eye on the doors in the unit sunroom where [Resident #1] was seen by the 3 of us. After I clocked out and got to my car I left the facility parking lot making a right going to the next block over where I seen [Resident #1] walking kinda [kind of] fast on the sidewalk on E Huber Ave right on N [NAME]. I immediatley [sic] pulled over onto E Huber Ave to stop [Resident #1] from going further away from the facility and contacted the charge nurse [at] 3:35 after stopping [Resident #1]. The document was signed by CMA #3. Resident #1 was located two blocks from the facility on a busy four lane road. An Incident Report Form, dated [DATE], read in part, At 15:35 [3:35 p.m.] received phone call that resident [Resident #1] was observed by staff member [staff initials] 2 blocks from facility on the sidewalk. The nurse immediately went that direction. Resident is observed without physical distress. [Resident #1] is however, observed with agitation and anxiety.On initial investigation, it was identified that resident had climbed out of a window in the sun room of the memory care unit. On [DATE] at 11:52 a.m., CNA #1 was asked how they were made aware of residents in the memory unit at risk of elopement. They stated anyone who could walk was at risk for elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:59 a.m., CMA #2 was asked how they were made aware of residents in the memory unit at risk for elopement. They stated the charge nurse and administrative staff would let them know. CMA #2 was asked how they staffed in the memory unit. They stated they assigned two CNAs, a CMA that worked the unit and two other halls, and a charge nurse who worked the unit and other halls. The CMA stated staff were to make rounds every fifteen minutes in the unit. On [DATE] at 12:58 p.m., the administrator was asked how staff ensured wanderers were kept safe. They stated with wander guards, locked doors, and every two hour rounds. The administrator stated immediately after Resident #1 eloped, they went to the memory care unit and found one of the windows was opened with the screen out of it. On [DATE] at 1:23 p.m., CMA #3 stated they had done rounds with oncoming CNA #8 for the 3:00 p.m. to 11:00 p.m., CNA #7 was not going to be in until 5:00 p.m. CMA #3 stated they had seen Resident #1 while making rounds with CNA #8 during shift change. They stated CNA #8 had been informed to watch Resident #1 closely because they had been pacing. On [DATE] at 2:10 p.m., the DON was asked if one CNA was enough to keep residents safe in the memory care unit. They stated, Most of the time, yes.