STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375540	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montevista Rehabilitation and Skilled Care	7604 Quanah Parker Trailway Lawton, OK 73505

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** 41873 A past noncompliance Immediate Jeopardy (IJ) situation was determined to exist effective 04/04/24 related to the facility's failure to provide adequate supervision to ensure a resident remained safe and free from elopement. The facility failed to provide adequate supervision and interventions to prevent the resident from exiting the facility and leaving the premises unsupervised. On 05/01/24 at 9:57 a.m., the Oklahoma State Department of Health verified the existence of the past noncompliance IJ related to the facility's failure to provide adequate supervision to protect the resident and prevent elopement. Based on record review and interview, the facility failed to ensure a resident received adequate supervision to prevent elopement for one (#3) of four sampled residents reviewed for elopement. The Administrator reported a resident census of 80. Findings: The facility's Elopement Risk Assessment policy, dated 01/12/20, read in part, The licensed nurse completes the Elopement Risk Assessment in the electronic health record and presents the information to the interdisciplinary team for further interventions .The care plan is updated with the initiation of the interventions and changes in interventions, as needed .The licensed nurse documents in the nurse's notes and behavior monitoring in the electronic health record; any exit seeking behavior on an on-going basis and interventions are adjusted as needed . Resident #3 had diagnoses which included dementia, diabetes mellitus, Parkinsonism, and anxiety. A nurse's Admission Data report, dated 03/22/24, documented Resident #3 was a moderate risk for elopement. A nurse's note, dated 03/22/24 at 6:14 p.m., documented Resident #3 was being combative and refusing. The nurse's note documented the resident was cursing and yelling, stating staff were holding him against his will, and he was leaving the building now. (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	A care plan, dated 03/22/24, read in part Care area: behavioral changes related to elopement risk score 11-20, moderate risk .Goal: Resident #3 will remain safe within the facility .Interventions: analyze key times, places, circumstances, triggers, and what de-escalates behavior . The admission assessment, dated 03/28/24, documented the resident's cognition was severely impaired and the Resident #3 required partial to moderate assistance with transfers and supervision with ambulation in a wheelchair. A nurse's note, dated 04/04/24, documented at approximately 4:20 p.m. during routine rounds, Resident #3 was not found to be in his room. The note documented staff began looking throughout the facility and the Resident #3 was located right outside the front entrance on the porch. The note documented the resident was redirected inside the facility and the Resident #3 stated, I cannot stay another night here. The note documented the Resident #3 was provided emotional support and agreed to go back inside the facility. The note documented staff would continue with frequent rounds, redirection, and education. An Elopement Risk assessment, dated 04/04/24 at 4:51 p.m., documented Resident #3 to be above high risk for elopement. The assessment documented in part, .the resident self-propels wheelchair, verbalizes anger and frustration regarding placement, mental status was highly confused or demented, and previous attempts to leave the facility one or more times in the last week . An OSDH Form 283 incident report, dated 04/04/24, documented at 10:30 p.m. the facility was unable to locate Resident #3 and elopement procedures were initiated. The incident report documented the Resident #3 was located at 12:30 a.m. on 04/05/24, was taken to the emergency room for evaluation, and returned to the facility. The incident report documented the facility investigation identified that the front door of the facility was unlocked. The incident report documented the facility implemented a QAPI plan, Resident #3 was placed on one-on-one supervision, and education was provided related to elopement. A police case report, dated 04/04/24, documented, on 04/04/24 at approximately 11:05 p.m., Officer [name removed] and Officer [name removed] were dispatched to the facility [name removed] for a missing and at-risk person. The report documented the facility Administrator informed the officer that Resident #3 went missing at approximately 9:30 p.m. - 10:30 p.m. The report documented the Administrator reported the Resident #3 had dementia and wanted to return to their residence, and it was all they talked about. The report documented Officer [name removed] went to the facility next door and asked if they had video footage of the facility. The report documented the lead administrator of the facility next door reported they had seen Resident #3 outside [name removed] doors unattended at approximately 7:30 p.m. when leaving work. The report documented Officer [name removed] found Resident #3 at the [name removed] dealership parking lot at 12:30 a.m. on 04/05/24. The report documented the Resident #3 required medical care due to his blood pressure and mental capacity and was transported to [name removed] medical center. A nurse's note, dated 04/05/24, documented Resident #3 returned from the ER at 2:35 p.m. with no new orders or injuries documented. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A care plan, updated 04/08/24, read in part, .Care Area: Resident #3 is at risk for elopement .The resident has diagnoses of dementia, Parkinson's, and cognitive ability varies throughout the day .Interventions: : Analyze key times, places, circumstances, triggers, and what de-escalates behavior .Notify physician and family/responsible party .Offer activities of interest .Offer foods or snacks .Remove resident from immediate situation to assure safety .Staff to monitor his whereabouts at all times . On 04/29/24 at 11:35 a.m., CNA #1 reported when Resident #3 had admitted to the facility he had been aggressive and verbalizing that he wanted to leave the facility and go home. The CNA #1 reported resident #3 had started verbalizing about going home and stating, I'm ready to get out of here about a week before his elopement. The CNA #1 reported on 04/04/24 during the afternoon, the Resident #3 was found outside the front door by the CNA #1 and ADON. The CNA #1 reported Resident #3 was asking someone from transportation to take him home. On 04/29/24 at 3:12 p.m., the Regional Nurse Consultant reported the incident when Resident #3 was found outside the front door on 04/04/24 had not been considered an elopement by the facility due to the resident still being on the facility's premises. The Regional Nurse Consultant reported after that incident, the ADON and Administrator made the decision to lock the front door and require a passcode to open to prevent the resident from leaving the facility. On 04/29/24 at 2:18 p.m., family member #1 reported two days before Resident #3 eloped from the facility, the ADON had called to inform family member #1 that Resident #3 had been found outside the facility and they were going to put interventions in place to prevent him from getting outside the facility. The family member reported that on the afternoon of 04/04/24, the ADON called to inform family member #1 the Resident #3 was found outside the facility, they were going to lock the door front door, and require a passcode to exit. The family member #1 reported they had been informed after Resident #3's elopement on 04/04/24 that the front door was found unlocked. On 04/30/24 at 12:56 p.m., LPN #1 reported Resident #3 was usually in their wheelchair near the nurse's station if they were not in their room. The LPN #1 reported the resident would talk about leaving the facility and was confused on and off. On 04/30/24 at 1:05 p.m., CNA #2 reported Resident #3 would wheel up to the nurse's station from their room and stated they was going to leave and needed to get out the door. On 05/01/24 at 9:21 a.m., the Administrator reported that Resident #3 had made comments that they was going to leave the facility, but the facility had no indication that they would leave the facility's property. The Administrator was unaware of any reports that the Resident #3 had gotten out the front door of the facility two days prior to elopement. The Administrator reported the front door was supposed to be locked after the Resident #3 exited the facility the afternoon of 04/04/24 but for unknown reasons, was found unlocked when Resident #3 was found missing on 04/04/24. The Administrator reported if the front door had been locked it may have prevented the Resident #3 from eloping. The Administrator reported the elopement incident had the potential for serious injury or harm to the resident. On 05/01/24 at 9:57 a.m., the Administrator was presented with the IJ template and notified of the past non-compliance IJ situation for the elopement incident on 04/04/24 for resident #3. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/01/24 at 10:18 a.m., the regional nurse consultant reported that they were not aware of Resident #3 going outside the facility on 04/02/24 as documented on the IJ template. The regional nurse consultant reported they agreed with the rest of the documentation on the IJ template. On 05/01/24 at 10:23 a.m., per phone call, the ADON reported the resident had not been found outside the facility prior to 04/04/24. The facility's investigation of the elopement incident, dated 04/05/24, and provided by the Administrator, documented the need for immediate action had been resolved on 04/05/24. The investigation documented the following: Resident #3 was placed on one-on-one supervision when Resident #3 returned from theER on [DATE] until Resident #3 was discharged on [DATE]. On 04/05/24, the facility reassessed Resident #3's elopement risk and updated the care plan. The facility completed a headcount of all residents, reviewed all resident's elopement risk assessments and updated care plans as needed. The elopement risk book kept at the nurse's station was reviewed and updated. The facility locked all the coded doors, changed the door codes to make them harder to figure out, and placed signage on all doors to not let residents out. Daily checks of doors were implemented for 4 weeks. Staff members were in-serviced on elopement and keeping the doors locked 24/7. The facility conducted a root cause analysis exercise to determine the reason the elopement occurred. Throughout the survey, staff members were interviewed regarding the education and in-services provided on 04/05/24 and 04/08/24. All staff were knowledgeable on the topics covered during the in-service.