STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375185	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Park Skilled Nursing and Therapy Memory	1201 North Vinita Avenue Tahlequah, OK 74464

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 42171 Based on record review and interview, the facility failed to follow the regulatory requirements for transfer and discharge a resident for one (#1) of one sampled resident reviewed for discharge. The charge nurse reported the census was 49. Findings: Resident #1 had diagnoses which included dementia and psychotic disorder. A nurse's note, dated 01/01/25 at 8:30 p.m., documented LPN #1 notified RN #1 that Resident #1 was threatening to leave the facility and stating they could not force them to stay in the facility. The note also documented the on call physician was contacted and they requested a BIMS assessment (an assessment to determine cognitive statue) be completed. The note documented the assessment was completed and the resident was cognitively intact. The note documented if the resident insisted on discharging the discharge would be AMA. A police report #2501T0167, dated 01/01/25, documented a police officer observed Resident #1 standing on the side of the road. The report stated the police officer contacted Resident #1 and they reported they had been kicked out of the motel. The report stated the police officer then transported the resident back to the facility and when the officer went to the door of the facility, they saw a note stating staff had been instructed not to open the door and to contact RN #1 for assistance. The police report documented the police officer contacted RN #1 and a short time later the facility came out and took Resident #1 inside. On 01/24/25 at 11:40 a.m., RN #1 stated the police located Resident #1 and brought them back to the facility. They also stated when Resident #1 arrived at the facility they stated they did not want to go back to the facility, they wanted to go to the hospital or a motel. RN #1 further stated they, along with CMA #1, attempted to take Resident #1 to the hospital. RN #1 stated on the way to the hospital Resident #1 decided they did not want to go to the hospital, but wanted to go to a motel instead. RN #1 stated they explained to the resident the discharge would be against medical advice and they would need to sign an AMA form. They stated the resident refused to sign the AMA form and CMA #1 witnessed the refusal. RN #1 stated they rented Resident #1 a room at the motel and left the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/24/25 at 1:18 p.m., LPN #1 stated on 01/01/25 at approximately 8:30 p.m. they entered Resident #1's room to administer medications and discovered the window was open and Resident #1 was missing. LPN #1 stated they notified other staff on duty and searched the facility and the grounds. LPN #1 stated they were unable to locate Resident #1. LPN# 1 stated they contacted the police and RN #1 who was not on duty at the time. LPN #1 stated RN #1 instructed them that RN #1 would enter the documentation into Resident #1's medical record regarding the incident. LPN #1 reviewed the nurse's note dated 01/01/25 at 8:30 p.m. and stated it was not an accurate account of the incident. On 01/24/25 at 1:28 p.m., CMA #1 stated they did not accompany RN #1 to the motel with Resident #1. They also stated they did not witness RN #1 offer an AMA form for Resident #1 to sign. On 01/27/25 at 12:34 p.m., LPN #1 stated on 01/01/25 after RN #1 left Resident #1 at the motel, the other nurse on duty got a call from RN #1 instructing them not to let the resident back in the facility and to have them call RN #1. LPN#1 stated the other nurse on duty then put the note on the door. LPN #1 stated on 01/01/25 at 11:47 p.m., they received a text message from RN #1 that read don't let [them] in, followed a short time later by a text from RN #1 telling them to admit the resident.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42171 Based on record review and interview, the facility failed to provide supervision to prevent elopement for one (#1) of three sampled residents reviewed for elopement. The charge nurse reported the census was 49. Findings: Resident #1 had diagnoses which included dementia and psychotic disorder. A care plan, initiated 12/12/24, documented Resident #1 was at risk for leaving the facility related to confusion and they needed staff to monitor their location. A Medicare five-day assessment, dated 12/13/24, documented Resident #1 was severely impaired for daily decision making. A nurse's note, dated 12/16/24 at 12:40 a.m., documented Resident #1 was going into other resident rooms and required redirection. A nurse's note, dated 12/16/24 at 1:25 a.m., documented Resident #1 had blocked the entrance to their room and Resident #1 had opened their window more than once during this shift. A nurse's note, dated 12/16/24 at 4:43 a.m., documented Resident #1 had been going into other resident rooms. A nurse's note, dated 12/19/24 at 2:49 p.m., documented Resident #1 had been wandering and exit seeking and was moved to the dementia care unit. An elopement risk scale, completed 12/20/24, documented Resident #1 was at high risk for elopement. On 01/27/25 at 11:00 a.m., LPN #2 stated the windows on the memory care unit that open toward the road have alarms. They also stated nursing staff do not routinely monitor the alarms for functionality, but if they notice a problem they reported it to maintenance. On 01/27/25 at 11:38 a.m., the maintenance supervisor reported that they usually checked on the window alarms in the morning, but there was no documentation of routine monitoring or testing. On 01/27/25 at 12:35 p.m., LPN #1 stated on 01/01/25 at approximately 8:30 p.m. they entered Resident#1's room to administer medications and discovered the window was open and Resident #1 was missing. LPN #1 stated they notified other staff on duty and searched the facility and the grounds. They stated they were unable to locate Resident #1. The window alarm was not sounding. The clinical record was reviewed did not document the elopement. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/27/25 at 2:38 p.m., the corporate administrator stated they could not say for sure if the alarm was disabled by the resident or was not functioning.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 42171 Based on record review and interview, the facility failed to ensure medical records were complete and accurate for one (#1) of three sampled residents reviewed for elopement. The charge nurse reported the facility census was 49. Findings: A facility policy titled Content of Resident Medical Records, revised on 08/19/03, read in part, A medical record is to be completed as a confidential medicolegal document containing sufficient data to identify the resident, justify the diagnosis and treatment, and document the end results accurately. Resident #1 had diagnoses which included dementia and psychotic disorder. A nurse's note, dated 01/01/25 at 8:30 p.m., documented LPN #1 notified RN #1 that Resident #1 was threatening to leave the facility and stating that they could not force them to stay in the facility. The note also documented that the on call physician was contacted and they requested a BIMS assessment (an assessment to determine cognitive statue) be completed. The note documented the assessment was completed and the resident was cognitively intact. The note documented that if the resident insisted on discharging the discharge would be AMA. On 01/27/25 at 12:35 p.m., LPN #1 stated on 01/01/25 at approximately 8:30 p.m. they entered Resident #1's room to administer medications and discovered the window was open and Resident #1 was missing. LPN #1 stated they notified other staff on duty and searched the facility and the grounds. They stated they were unable to locate Resident #1. LPN # 1 stated they contacted the police and RN #1 who was not on duty at the time. LPN #1 stated RN #1 instructed them that RN #1 would enter the documentation into Resident #1's medical record regarding the incident. LPN #1 reviewed the nurse's note dated 01/01/25 at 8:30 p.m. and stated it was not an accurate account of the incident.