
Delivery via email to: michelle.grigsby@jasmineestatesokc.com;
laura.leehan@jasmineestatesokc.com

December 5, 2025

License Number: AL5598

Laura Leehan, Administrator
Jasmine Estates Of Edmond
1001 S Bryant Ave
Edmond, OK 73034

Survey Event ID: DQDH11

Dear Ms. Leehan:

On **November 19, 2025**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template. Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: <http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Services**, then **click on Long Term Care**. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;
- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action will be completed for each violation; and

(6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies. If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste.1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to OSDH.LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Respectfully,



Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

INVESTIGATIVE REPORT

Facility: Jasmine Estates of Edmond
Address: 1001 South Bryant
City, State, Zip: Edmond, OK 73034
Provider #: AL5598
Complaint #: OK00087624
Investigation Date(s): 11/16/25

ALLEGATION(S)
The center failed to ensure residents did not elope
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 11/16/2025 at 3:30 p.m.

A sample of 3 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation: Observations of resident behaviors, resident activity, staff to resident ratio and interactions were made. Records of incident reports, resident health charts, resident contracts, staff training, and center policies were reviewed. Interviews with residents, families, and staff were conducted. Based on observation, record review, and interview, the center failed to ensure a resident did not elope.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 11/17/2025

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/19/2025
NAME OF PROVIDER OR SUPPLIER JASMINE ESTATES OF EDMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S BRYANT AVE EDMOND, OK 73034		
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C 000	INITIAL COMMENTS A complaint investigation (#OK00087624) was conducted from 11/16/25 through 11/19/25. Deficiencies were cited as a result of the survey. Facility Census: 38 Listed below are abbreviations that will be used throughout this document. CMA - certified medication aide CNA - certified nurse aide DON - director of nursing EOD - end of day IJ - immediate jeopardy mg - milligram OSDH - Oklahoma State Department of Health QA - quality assurance	C 000		
C1512 SS=J	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician,	C1512		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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C1512	Continued From page 1 qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: On 11/16/25, an IJ situation was determined to exist when the center failed to prevent Resident #1 from elopement which resulted in the resident being found on a busy, four lane street by a passerby. Resident #1 had a previous elopement	C1512		

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C1512	Continued From page 2 on 10/31/25. On 11/16/25 at 5:51 p.m., the OSDH was notified and verified the existence of the IJ situation. On 11/16/25 at 6:39 p.m., the administrator and resident care coordinator were notified of the IJ situation related to the elopement of Resident #1 and an IJ template was provided. On 11/18/25 at 8:15 a.m., the general manager submitted an acceptable plan of removal. The plan of removal, read in part, "Plan of removal - Jasmine Estates Memory Care Effective: 11/18/25 7:00 p.m. Resident-Specific Interventions 1. Immediate Face-to-Face Assessment A face-to-face assessment via video/phone was conducted immediately by the facility medical director, to assess resident's current condition and identify immediate clinical needs. 2. In-Person Medical Evaluation Medical director will conduct an in-person evaluation on 11/18/2025 to reassess the resident's medical status, behaviors, and ongoing safety needs. 3. Medication Review and Adjustments Medical director is reviewing all medications and will make adjustments as clinically indicated. Depakote (an anticonvulsant used for mood stabilizing) has been ordered for resident to address behavioral and mood stabilization needs. 4. Enhanced Supervision / One-on-One Monitoring The resident will be placed on one-on-one monitoring by a dedicated staff member from 8:00AM [sic] to 8:00PM [sic], 8:00 p.m. being bedtime for [Resident #1] along x 5 days, to ensure medication is effective. A 1:1 log sheet is	C1512		

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C1512	Continued From page 3 in place from 8:00 a.m. to 8:00 p.m. The four-night shift staff members will rotate rounds and will sit on the benches provided in the hallway ensure the exit door is in view. 30 minute checks will be implemented with a log to verify the checks are being made. The log sheets will be submitted to the DON at the end of each shift to ensure accuracy. All 1:1 log and 30 minute checks will be kept in a binder in the Don office for the QA team review. During this period, the Wellness Director/DON will observe and document medication absorption, side effects, and overall efficacy, and will report findings to the medical director. Building Safety and Security Interventions 1. Door and Keypad System Evaluation 2. [Name withheld] will be on-site to evaluate whether the rear/delivery door keypad and locking mechanism (location of the elopement incident) require replacement or further hardware repair. Current Door Status: Both doors with access outside the community will be operable with a badge. Keypads that are at the front entrance and back delivery door will be removed and replaced with the swipe system. Staff are monitoring door status every shift until the vendor completes a full assessment and replacement. All staff will not use the exit door to travel in and out of the building. Staff Training and Education 1. Elopement Prevention Training Revision New hire training will be updated immediately to include: Door monitoring procedures Alarm response expectations Proper supervision of at-risk residents 2. All-Staff In-Service All facility staff will receive mandatory in-service	C1512		

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C1512	Continued From page 4 training on security door response, monitoring, and elopement prevention by EOD 11/18/2025 any staff unable to attend will received 1:1 training via phone or in person. 1:1 training will be documented on the in-service sheet. Random staff review on training will take place weekly x 90 days to ensure staff are following the door protocol's and will be documented for the QA team to review. 3. Resident Elopement Risk Chart All residents will be assessed for elopement risk with the Elopement Risk form by 11/18/2025. A visual, accessible Elopement Chart will be created for at risk residents and posted in the med room & employee break room The chart will be updated as needed with any resident status changes and reviewed during shift report. QA: Will review all logs and door access and training and will meet weekly x 2 months then monthly x 3 months then quarterly." The IJ was lifted, effective 11/18/25 at 7:00 p.m., when all components of the plan of removal had been verified as completed. Observation of Resident #1 with one on one staff attention was made on 11/19/25. Observations of an elopement risk chart were made in the medication room and employee breakroom. Observations of exit doors showed keypads had been removed and a badge was required for exiting and entering. Records of one on one staff attention from 11/16/25 through 11/19/25 showed Resident #1 had a staff member with them at all times. Records of in-service staff training showed all staff, including administration, had received training in security door response, monitoring, and elopement prevention. Records of resident assessments showed all residents were reassessed for elopement risk. Resident #1's medical record showed they were assessed	C1512		

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C1512	Continued From page 5 by the physician and new medications for anxiety and mood were initiated. Interviews conducted with staff verified they received training in security door response, monitoring, and elopement prevention. Staff were able to identify residents who were at a high risk for elopement. The deficiency remained at an isolated level with the potential for more than minimal harm. Based on record review and interview, the center failed to prevent an elopement for 1 (#1) of 3 residents sampled for elopement. The general manager identified 38 residents resided in the center. Findings: On 11/16/25 at 3:30 p.m., the delivery door was observed to be secured from the outside. On 11/16/25 at 3:39 p.m., Resident #1 was observed in the center's common living room with other residents and CMA #1. On 11/16/25 at 4:00 p.m., Resident #1 was eating a cookie and kept attempting to shove the cookie in the surveyor's mouth, despite repeated attempts to redirect the resident. The surveyor had to take the cookie and pretend to eat it for Resident #1 to stop forcing it onto the surveyor. On 11/19/25 at 8:15 a.m., an observation of a badge swiping mechanism was made to all exit doors. The keypads had been removed. On 11/19/25 at 9:10 a.m., CMA #4 was observed following Resident #1 in the community. CMA #4 took Resident #1 outside.	C1512		

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C1512	Continued From page 6 A "Care Plan," dated 10/15/25, showed Resident #1 was being monitored three times daily for elopement. A "14-day Comprehensive Assessment," dated 10/31/25, showed Resident #1 was admitted to the center on 10/15/25 with a diagnosis of dementia. The comprehensive assessment showed Resident #1 was an elopement risk, their usual mood was agitated and anxious, and they had a history of aggression and combativeness. An untitled document, dated 10/31/25, read in part, "[Resident #1] is now to be on 30 minute checks for safety precautions/elopement risk. Please sign your name when laying eyes on [them] with the time and date." This document showed staff was visually observing Resident #1 every 30 minutes starting 10/31/25 indefinitely. Resident #1 was on 30 minute checks due to their previous elopement on 10/31/25. There was no negative outcome to Resident #1 related to the elopement on 10/31/25. A "Medication Administration Record," dated November 2025, showed Resident #1 was not taking any medications for anxiety, aggression, or combativeness. An "Observation Note," dated 11/09/25 at 4:16 p.m., read in part, "[Resident #1] started to walk back into the main TV area to the exit door and was pushing on it. [CMA #1] told [them] no, to come with me. [CMA#1] lead them down to [their] room, [they] walked ahead of me"... "went to the exit door and was pushing on it." On 11/11/25 at 2:32 p.m., OSDH received an incident report. The incident report, read in part, "[Resident #1] eloped from the community using	C1512		

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C1512	Continued From page 7 the secured employee code on 11/08/25 to exit the delivery door that's located at the rear of the community at 3:28 p.m. Resident brought back in the front door of community by a passer by at 3:38 p.m." The incident report showed Resident #1 was asked how they were getting out and Resident #1 typed in the code to the delivery door, opening the delivery door. The incident report did not state what immediate interventions were put into place to protect the resident from further elopements. No negative outcome was reported. An "Observation Note," dated 11/15/25 at 6:32 p.m., read in part, "Resident was observed exit seeking multiple times today." An untitled document, dated 11/17/25, read in part, "1 on 1 care for [Resident #1]." The document showed staff signatures for direct supervision for Resident #1 from 11/17/25 through 11/19/25. An "Elopement Prevention and Alarm Response" policy, dated 11/18/25, read in part, "The purpose of this policy is to establish strict procedures for preventing resident elopement and ensuring immediate and appropriate staff response to all alarms"..."All staff must respond immediately to all alarms under no exceptions." This policy was put into place in response to Resident #1's elopement. Each staff member signed a copy of the policy acknowledging receipt of the training. An "In-service Sign-in Sheet," dated 11/18/25, showed all staff had signed acknowledging training on elopement, not using the delivery door, protocols on all alarms, one on one staff presence for Resident #1, 30 minute and 15 minute checks for residents, and a two hour	C1512		

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C1512	Continued From page 8 checklist for all residents. A document titled "Transitional Care Management," dated 11/18/25, read in part, "[Resident #1] was evaluated for elopement risk and increased agitation." The document showed the physician started Resident #1 on Depakote 125 mg three times daily and added Ativan (an anxiolytic) 0.25mg three times daily. An "Invoice," dated 11/19/25, read in part, "Labor for emergency card reader installation: removed keypads from front door and back door. Installed new card readers for front and back door." On 11/16/25 at 3:49 p.m., CMA #1 was asked what Resident #1's normal mood and behavior were. They stated, "[Resident #1] gets anxious and then starts walking around a lot, going into other people's rooms." CMA #1 was asked if Resident #1 exit sought or had ever eloped. They stated yes, they did exit seek and Resident #1 eloped on 11/08/25. CMA #1 was asked if Resident #1 was on any medications for anxiety. They stated, "No." CMA #1 was asked to recall Resident #1's elopement from 11/08/25. They stated, "Another staff member was going on break, so when I heard the delivery door alarm, I looked and saw feet under the door. I just thought it was [CMA #2] going for [their] break." CMA #1 stated when they walked to the front of the building to give another resident their medications someone was at the front door with Resident #1, saying they found Resident #1 walking down the street. CMA #1 stated to prevent elopement after Resident #1 was returned to the center they had Resident #1 follow them around while giving medications to other residents and Resident #1 was on hourly checks.	C1512		

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C1512	Continued From page 9 On 11/16/25 at 4:00 p.m., an interview with Resident #1 was attempted. Resident #1 was asked how they were doing and if they had a good day. Resident #1 responded, but it was unintelligible. Resident #1 was asked if they had left the center lately. They nodded their head, "Yes." Resident #1 was asked where they went and their response was unintelligible. On 11/16/25 at 4:40 p.m., CNA #1 was asked if Resident #1 had exit seeking behaviors. They stated Resident #1 did. CNA #1 was asked what interventions were in place to prevent elopement for Resident #1. They stated, "Communicating with each other frequently so we know where each other are. One staff member is on duty for the living room to watch the residents sitting in there at all times. We changed the door codes and had inservice. We monitor Resident #1 and others frequently." CNA #1 was unable to say how frequently, exactly. On 11/16/25 at 4:49 p.m., the general manager was asked if Resident #1 had seen a physician since the elopement on 11/08/25. They stated, "No." On 11/16/25 at 4:53 p.m., CMA #3 was asked to recall Resident #1's elopement on 11/08/25. They stated they were on their break and only knew Resident #1 eloped. They were asked if Resident #1 was exit seeking on 11/08/25 prior to their elopement. They stated, "Constantly." CMA #3 stated keeping Resident #1 distracted was the intervention for preventing another elopement. They stated, "[Resident #1] was exit seeking earlier today, so I had [them] help me fold laundry." CMA #3 stated on 11/08/25 after Resident #1's elopement that CMA #2 sat one on one with the resident. They stated, "I don't know	C1512		

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NAME OF PROVIDER OR SUPPLIER JASMINE ESTATES OF EDMOND			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S BRYANT AVE EDMOND, OK 73034		
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C1512	Continued From page 10 for how long. We check on [Resident #1] every 30 minutes on paper, but we all keep our eyes on him now." On 11/16/25 at 5:30 p.m., CMA #2 was asked if Resident #1 was exit seeking on 11/08/25 prior to their elopement. They states yes, Resident #1 had been exit seeking that day. CMA #2 stated, "I saw [Resident #1] at 3:00 p.m. up front doing an activity. At 3:24 p.m., I saw [them] walking down the music hall. I left for my break and got a call at 3:49 p.m. that a passerby had just brought [Resident #1] back to the building." CMA #2 stated the general manager instructed them to have staff sit with Resident #1 for the rest of the night. CMA #2 stated the center changed the door codes on the keypads because they were able to observe Resident #1 enter the staff's code to open the exit door after they eloped. CMA #2 stated, "Three to five days prior to [Resident #1's] elopement they put a screamer on the delivery door so that any time it opened we'd know it was a resident going out. When [CMA #1] heard the door when I went out for break [they] thought it was me. If [CMA #2] would have gone out right then [they] would have seen it was the resident." CMA #2 was asked how often Resident #1 was exit seeking. They stated on the weekends they would exit seek three to five times per day and staff would try to sit one on one with them. On 11/19/25 at 9:15 a.m., CMA #5 was asked what the center's policy was for when a door alarm sounded. They stated, "Check the door and surrounding areas immediately for an elopement." CMA #5 stated they were last educated on elopement and door response on 11/18/25. On 11/19/25 at 9:19 a.m., CNA #2 was asked	C1512			

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C1512	Continued From page 11 what the center's policy was for when a door alarm sounded. They stated, "Respond immediately to the door alarm and communicate with staff." CNA #2 verified Resident #1 had one on one staff attention and their last elopement and door response in-service was 11/18/25. On 11/19/25 at 9:22 a.m., CMA #4 stated they were last educated on elopement and door response during in-service on 11/18/25. They stated the policy for responding to door alarms was to respond immediately. On 11/19/25 at 9:26 a.m., CNA #3 was asked what the center's policy was for door alarms and elopements. They stated to respond to door alarms immediately, be aware of where the residents are, and check surrounding areas for any elopement. CNA #3 verified their last education regarding door alarm response and elopement was on 11/18/25.	C1512		

Delivery via email to: Laura.leehan@jasmineestatesokc.com

December 18, 2025

License Number: AL5598

Laura Leehan, Administrator
Jasmine Estates Of Edmond
1001 S Bryant Ave
Edmond, OK 73034

Survey Event ID: DQDH11

Dear Ms. Leehan:

On **November 19, 2025**, a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **December 17, 2025**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,



Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/16/2025

Facility Name: Jasmine Estates Edmond

License Number: AL5598

Survey Event ID: DQDH11

Date Survey Completed: 11/19/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1512

Based on: On 11/16/2025, an IJ situation was determined to exist when the center failed to prevent resident #1 from elopement which resulted in the resident being found on a busy, 4 lane street by a passerby. Resident #1 had a previous elopement on 10/31/2025. On 11/16/2025 at 5:51 p.m., the administrator and RCC were notified of the IJ situation related to the elopement of Resident #1 and an IJ template was provided. On 11/18/2025 at 8:15 a.m., the general manager submitted an acceptable plan of removal.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Following the IJ situation the center acknowledged that a rear security door had a faulty key pad, leading to the residents exit. A QAIP meeting (attached) was conducted on 12/16/2025 at 10:30 a.m. to review the plan of correction and any risk or interventions (if applicable) since removal of the IJ.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

All door keypads were immediately replaced with badge readers on 11/19/2025 (invoice attached). Immediate interventions were put in place to ensure the residents safety, including ½ hour monitoring by staff, an elopement prevention/door alarm monitoring in-service was immediately conducted for all staff, and a Care Management visit with the facility medical director was conducted. A medication review was conducted and medication (Depakote) was ordered to address and mitigate extreme exit-seeking behaviors. Family of the affected resident was notified immediately of all applicable interventions.

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

An Elopement Binder has been created and kept in the Med-Room and the Wellness Directors office. All current staff have been oriented on the use and importance of the binder. All new hires will be oriented on the elopement binder. The binder will contain a table chart of residents (including photo) with exit-seeking behaviors, their Face Sheet, The Elopement/Missing Resident Policy & Procedure Addendum, and documentation of the most recent Elopement Drill & In-Service Training. All staff have been advised that they must immediately report exit seeking behaviors. Care staff must document accordingly in Alis. An elopement assessment will be conducted on all new residents to the community. An elopement assessment has been conducted for all existing residents.

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The Maintenance Department will utilize the TELS platform to conduct and document weekly operational testing of all door safety functions. This will include verification of proper functionality of badge readers, egress capabilities, and door alarm activation and response. Any deficiencies identified during testing will be immediately reported, corrected, and documented within the TELS system to ensure continued compliance and resident safety. An addendum will be made to the Operations Manual - Elopement/Missing Resident Policy & Procedure (attached). The addendum will be added to the 'Elopement Binder' and accessible to all staff. In addition to the elopement binders, A list of elopement risk/exit seeking residents (with photo) will be posted in the employee breakroom and all four laundry rooms where clinical staff have access to tablets for charting and all other relevant and applicable resident care information. All new hires will be required to complete the "Elopement Prevention & Door Alarm Response" training (attached) prior to their floor training. Subsequent All Staff, In-Service training will be conducted twice a year in correspondence with an Elopement Drill. The Wellness Director and RCC will continue to conduct daily "shift huddles" with care staff to communicate any resident concerns or changes in behavior and will advise on appropriate interventions. Discovery of concerns or changes will be charted in Alis and addressed immediately.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Enter methods to ensure corrections are sustained: a. The center will evaluate the effectiveness of the corrective actions through weekly audits of door alarm and badge reader functionality, review of staff training completion, and observation of staff response during elopement drills to ensure timely and appropriate intervention. b. The corrective actions will be incorporated into the center's Quality Assurance and Performance Improvement (QAPI) program, with monitoring results reviewed during scheduled QAPI meetings and any trends or deficiencies addressed through additional training or corrective action as needed.

		c. Monitoring records will be maintained to evidence regulatory compliance and will include door alarm and badge reader inspection reports (TELS), staff training documentation, and elopement drill evaluations, all of which will be retained on file and available for review.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		12/17/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Laura J. Leehan, ED OAC 310:663-25-4(F)		Date 12/16/2025	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			

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C 000	INITIAL COMMENTS A complaint investigation (#OK00087624) was conducted from 11/16/25 through 11/19/25. Deficiencies were cited as a result of the survey. Facility Census: 38 Listed below are abbreviations that will be used throughout this document. CMA - certified medication aide CNA - certified nurse aide DON - director of nursing EOD - end of day IJ - immediate jeopardy mg - milligram OSDH - Oklahoma State Department of Health QA - quality assurance	C 000	Refer to POC Template, Survey Event ID: DQDH11. ID Prefix Tag C1512.	
C1512 SS=J	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician,	C1512		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

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C1512	Continued From page 1 qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: On 11/16/25, an IJ situation was determined to exist when the center failed to prevent Resident #1 from elopement which resulted in the resident being found on a busy, four lane street by a passerby. Resident #1 had a previous elopement	C1512		

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C1512	Continued From page 2 on 10/31/25. On 11/16/25 at 5:51 p.m., the OSDH was notified and verified the existence of the IJ situation. On 11/16/25 at 6:39 p.m., the administrator and resident care coordinator were notified of the IJ situation related to the elopement of Resident #1 and an IJ template was provided. On 11/18/25 at 8:15 a.m., the general manager submitted an acceptable plan of removal. The plan of removal, read in part, "Plan of removal - Jasmine Estates Memory Care Effective: 11/18/25 7:00 p.m. Resident-Specific Interventions 1. Immediate Face-to-Face Assessment A face-to-face assessment via video/phone was conducted immediately by the facility medical director, to assess resident's current condition and identify immediate clinical needs. 2. In-Person Medical Evaluation Medical director will conduct an in-person evaluation on 11/18/2025 to reassess the resident's medical status, behaviors, and ongoing safety needs. 3. Medication Review and Adjustments Medical director is reviewing all medications and will make adjustments as clinically indicated. Depakote (an anticonvulsant used for mood stabilizing) has been ordered for resident to address behavioral and mood stabilization needs. 4. Enhanced Supervision / One-on-One Monitoring The resident will be placed on one-on-one monitoring by a dedicated staff member from 8:00AM [sic] to 8:00PM [sic], 8:00 p.m. being bedtime for [Resident #1] along x 5 days, to ensure medication is effective. A 1:1 log sheet is	C1512		

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C1512	Continued From page 3 in place from 8:00 a.m. to 8:00 p.m. The four-night shift staff members will rotate rounds and will sit on the benches provided in the hallway ensure the exit door is in view. 30 minute checks will be implemented with a log to verify the checks are being made. The log sheets will be submitted to the DON at the end of each shift to ensure accuracy. All 1:1 log and 30 minute checks will be kept in a binder in the Don office for the QA team review. During this period, the Wellness Director/DON will observe and document medication absorption, side effects, and overall efficacy, and will report findings to the medical director. Building Safety and Security Interventions 1. Door and Keypad System Evaluation 2. [Name withheld] will be on-site to evaluate whether the rear/delivery door keypad and locking mechanism (location of the elopement incident) require replacement or further hardware repair. Current Door Status: Both doors with access outside the community will be operable with a badge. Keypads that are at the front entrance and back delivery door will be removed and replaced with the swipe system. Staff are monitoring door status every shift until the vendor completes a full assessment and replacement. All staff will not use the exit door to travel in and out of the building. Staff Training and Education 1. Elopement Prevention Training Revision New hire training will be updated immediately to include: Door monitoring procedures Alarm response expectations Proper supervision of at-risk residents 2. All-Staff In-Service All facility staff will receive mandatory in-service	C1512		

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C1512	Continued From page 4 training on security door response, monitoring, and elopement prevention by EOD 11/18/2025 any staff unable to attend will received 1:1 training via phone or in person. 1:1 training will be documented on the in-service sheet. Random staff review on training will take place weekly x 90 days to ensure staff are following the door protocol's and will be documented for the QA team to review. 3. Resident Elopement Risk Chart All residents will be assessed for elopement risk with the Elopement Risk form by 11/18/2025. A visual, accessible Elopement Chart will be created for at risk residents and posted in the med room & employee break room The chart will be updated as needed with any resident status changes and reviewed during shift report. QA: Will review all logs and door access and training and will meet weekly x 2 months then monthly x 3 months then quarterly." The IJ was lifted, effective 11/18/25 at 7:00 p.m., when all components of the plan of removal had been verified as completed. Observation of Resident #1 with one on one staff attention was made on 11/19/25. Observations of an elopement risk chart were made in the medication room and employee breakroom. Observations of exit doors showed keypads had been removed and a badge was required for exiting and entering. Records of one on one staff attention from 11/16/25 through 11/19/25 showed Resident #1 had a staff member with them at all times. Records of in-service staff training showed all staff, including administration, had received training in security door response, monitoring, and elopement prevention. Records of resident assessments showed all residents were reassessed for elopement risk. Resident #1's medical record showed they were assessed	C1512		

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C1512	Continued From page 5 by the physician and new medications for anxiety and mood were initiated. Interviews conducted with staff verified they received training in security door response, monitoring, and elopement prevention. Staff were able to identify residents who were at a high risk for elopement. The deficiency remained at an isolated level with the potential for more than minimal harm. Based on record review and interview, the center failed to prevent an elopement for 1 (#1) of 3 residents sampled for elopement. The general manager identified 38 residents resided in the center. Findings: On 11/16/25 at 3:30 p.m., the delivery door was observed to be secured from the outside. On 11/16/25 at 3:39 p.m., Resident #1 was observed in the center's common living room with other residents and CMA #1. On 11/16/25 at 4:00 p.m., Resident #1 was eating a cookie and kept attempting to shove the cookie in the surveyor's mouth, despite repeated attempts to redirect the resident. The surveyor had to take the cookie and pretend to eat it for Resident #1 to stop forcing it onto the surveyor. On 11/19/25 at 8:15 a.m., an observation of a badge swiping mechanism was made to all exit doors. The keypads had been removed. On 11/19/25 at 9:10 a.m., CMA #4 was observed following Resident #1 in the community. CMA #4 took Resident #1 outside.	C1512		

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C1512	Continued From page 6 A "Care Plan," dated 10/15/25, showed Resident #1 was being monitored three times daily for elopement. A "14-day Comprehensive Assessment," dated 10/31/25, showed Resident #1 was admitted to the center on 10/15/25 with a diagnosis of dementia. The comprehensive assessment showed Resident #1 was an elopement risk, their usual mood was agitated and anxious, and they had a history of aggression and combativeness. An untitled document, dated 10/31/25, read in part, "[Resident #1] is now to be on 30 minute checks for safety precautions/elopement risk. Please sign your name when laying eyes on [them] with the time and date." This document showed staff was visually observing Resident #1 every 30 minutes starting 10/31/25 indefinitely. Resident #1 was on 30 minute checks due to their previous elopement on 10/31/25. There was no negative outcome to Resident #1 related to the elopement on 10/31/25. A "Medication Administration Record," dated November 2025, showed Resident #1 was not taking any medications for anxiety, aggression, or combativeness. An "Observation Note," dated 11/09/25 at 4:16 p.m., read in part, "[Resident #1] started to walk back into the main TV area to the exit door and was pushing on it. [CMA #1] told [them] no, to come with me. [CMA#1] lead them down to [their] room, [they] walked ahead of me"... "went to the exit door and was pushing on it." On 11/11/25 at 2:32 p.m., OSDH received an incident report. The incident report, read in part, "[Resident #1] eloped from the community using	C1512		

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C1512	Continued From page 7 the secured employee code on 11/08/25 to exit the delivery door that's located at the rear of the community at 3:28 p.m. Resident brought back in the front door of community by a passer by at 3:38 p.m." The incident report showed Resident #1 was asked how they were getting out and Resident #1 typed in the code to the delivery door, opening the delivery door. The incident report did not state what immediate interventions were put into place to protect the resident from further elopements. No negative outcome was reported. An "Observation Note," dated 11/15/25 at 6:32 p.m., read in part, "Resident was observed exit seeking multiple times today." An untitled document, dated 11/17/25, read in part, "1 on 1 care for [Resident #1]." The document showed staff signatures for direct supervision for Resident #1 from 11/17/25 through 11/19/25. An "Elopement Prevention and Alarm Response" policy, dated 11/18/25, read in part, "The purpose of this policy is to establish strict procedures for preventing resident elopement and ensuring immediate and appropriate staff response to all alarms"..."All staff must respond immediately to all alarms under no exceptions." This policy was put into place in response to Resident #1's elopement. Each staff member signed a copy of the policy acknowledging receipt of the training. An "In-service Sign-in Sheet," dated 11/18/25, showed all staff had signed acknowledging training on elopement, not using the delivery door, protocols on all alarms, one on one staff presence for Resident #1, 30 minute and 15 minute checks for residents, and a two hour	C1512		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/19/2025
NAME OF PROVIDER OR SUPPLIER JASMINE ESTATES OF EDMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S BRYANT AVE EDMOND, OK 73034		
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C1512	Continued From page 8 checklist for all residents. A document titled "Transitional Care Management," dated 11/18/25, read in part, "[Resident #1] was evaluated for elopement risk and increased agitation." The document showed the physician started Resident #1 on Depakote 125 mg three times daily and added Ativan (an anxiolytic) 0.25mg three times daily. An "Invoice," dated 11/19/25, read in part, "Labor for emergency card reader installation: removed keypads from front door and back door. Installed new card readers for front and back door." On 11/16/25 at 3:49 p.m., CMA #1 was asked what Resident #1's normal mood and behavior were. They stated, "[Resident #1] gets anxious and then starts walking around a lot, going into other people's rooms." CMA #1 was asked if Resident #1 exit sought or had ever eloped. They stated yes, they did exit seek and Resident #1 eloped on 11/08/25. CMA #1 was asked if Resident #1 was on any medications for anxiety. They stated, "No." CMA #1 was asked to recall Resident #1's elopement from 11/08/25. They stated, "Another staff member was going on break, so when I heard the delivery door alarm, I looked and saw feet under the door. I just thought it was [CMA #2] going for [their] break." CMA #1 stated when they walked to the front of the building to give another resident their medications someone was at the front door with Resident #1, saying they found Resident #1 walking down the street. CMA #1 stated to prevent elopement after Resident #1 was returned to the center they had Resident #1 follow them around while giving medications to other residents and Resident #1 was on hourly checks.	C1512		

Oklahoma State Department of Health

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C1512	Continued From page 9 On 11/16/25 at 4:00 p.m., an interview with Resident #1 was attempted. Resident #1 was asked how they were doing and if they had a good day. Resident #1 responded, but it was unintelligible. Resident #1 was asked if they had left the center lately. They nodded their head, "Yes." Resident #1 was asked where they went and their response was unintelligible. On 11/16/25 at 4:40 p.m., CNA #1 was asked if Resident #1 had exit seeking behaviors. They stated Resident #1 did. CNA #1 was asked what interventions were in place to prevent elopement for Resident #1. They stated, "Communicating with each other frequently so we know where each other are. One staff member is on duty for the living room to watch the residents sitting in there at all times. We changed the door codes and had inservice. We monitor Resident #1 and others frequently." CNA #1 was unable to say how frequently, exactly. On 11/16/25 at 4:49 p.m., the general manager was asked if Resident #1 had seen a physician since the elopement on 11/08/25. They stated, "No." On 11/16/25 at 4:53 p.m., CMA #3 was asked to recall Resident #1's elopement on 11/08/25. They stated they were on their break and only knew Resident #1 eloped. They were asked if Resident #1 was exit seeking on 11/08/25 prior to their elopement. They stated, "Constantly." CMA #3 stated keeping Resident #1 distracted was the intervention for preventing another elopement. They stated, "[Resident #1] was exit seeking earlier today, so I had [them] help me fold laundry." CMA #3 stated on 11/08/25 after Resident #1's elopement that CMA #2 sat one on one with the resident. They stated, "I don't know	C1512		

Oklahoma State Department of Health

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C1512	Continued From page 10 for how long. We check on [Resident #1] every 30 minutes on paper, but we all keep our eyes on him now." On 11/16/25 at 5:30 p.m., CMA #2 was asked if Resident #1 was exit seeking on 11/08/25 prior to their elopement. They states yes, Resident #1 had been exit seeking that day. CMA #2 stated, "I saw [Resident #1] at 3:00 p.m. up front doing an activity. At 3:24 p.m., I saw [them] walking down the music hall. I left for my break and got a call at 3:49 p.m. that a passerby had just brought [Resident #1] back to the building." CMA #2 stated the general manager instructed them to have staff sit with Resident #1 for the rest of the night. CMA #2 stated the center changed the door codes on the keypads because they were able to observe Resident #1 enter the staff's code to open the exit door after they eloped. CMA #2 stated, "Three to five days prior to [Resident #1's] elopement they put a screamer on the delivery door so that any time it opened we'd know it was a resident going out. When [CMA #1] heard the door when I went out for break [they] thought it was me. If [CMA #2] would have gone out right then [they] would have seen it was the resident." CMA #2 was asked how often Resident #1 was exit seeking. They stated on the weekends they would exit seek three to five times per day and staff would try to sit one on one with them. On 11/19/25 at 9:15 a.m., CMA #5 was asked what the center's policy was for when a door alarm sounded. They stated, "Check the door and surrounding areas immediately for an elopement." CMA #5 stated they were last educated on elopement and door response on 11/18/25. On 11/19/25 at 9:19 a.m., CNA #2 was asked	C1512			

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER JASMINE ESTATES OF EDMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S BRYANT AVE EDMOND, OK 73034		
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C1512	Continued From page 11 what the center's policy was for when a door alarm sounded. They stated, "Respond immediately to the door alarm and communicate with staff." CNA #2 verified Resident #1 had one on one staff attention and their last elopement and door response in-service was 11/18/25. On 11/19/25 at 9:22 a.m., CMA #4 stated they were last educated on elopement and door response during in-service on 11/18/25. They stated the policy for responding to door alarms was to respond immediately. On 11/19/25 at 9:26 a.m., CNA #3 was asked what the center's policy was for door alarms and elopements. They stated to respond to door alarms immediately, be aware of where the residents are, and check surrounding areas for any elopement. CNA #3 verified their last education regarding door alarm response and elopement was on 11/18/25.	C1512		



Policy & Procedure Addendum

Elopement / Missing Resident – High-Risk Exit-Seeking Behaviors

Jasmine Estates Memory Care – Operational Manual

Purpose

This addendum supplements the existing Elopement/Missing Resident Policy to establish clear, immediate interventions and monitoring requirements for residents exhibiting high-risk exit-seeking behaviors, with the goal of ensuring resident safety and regulatory compliance.

Policy

Any resident identified as exhibiting high-risk exit-seeking behaviors will be immediately placed on enhanced supervision and intervention until the behavior is resolved or the resident is safely transitioned to a more appropriate care environment.

Procedure

1. Immediate Monitoring

- The resident must be placed on 30-minute (½-hour) documented monitoring, 24 hours per day, effective immediately upon identification of high-risk exit-seeking behaviors.
- Monitoring will continue until appropriate interventions are initiated and deemed effective, or until the resident is transferred or discharged.
- All monitoring must be clearly documented in accordance with facility documentation standards.

2. Family Notification and Coordination

The resident's responsible party/family must be contacted immediately and informed of:

- The identified high-risk behaviors.
- The enhanced monitoring in place.
- The need for additional interventions.

The facility will advise and coordinate one-on-one caregiver services through a licensed third-party provider.

3. Medical Director Evaluation

An immediate evaluation by the Facility Medical Director must be requested. The purpose of the evaluation is to determine whether:

- A medication adjustment or increase is clinically appropriate.
- New medications or interventions should be implemented to address the behaviors.

- All recommendations and orders must be followed and documented.

4. Staff Communication

All staff on every shift must be informed of the resident's exit-seeking behaviors. Shift-to-shift communication and Alis observation chart notes must include:

- Current behaviors observed.
- Monitoring requirements.
- Specific protocols or redirection strategies.

5. Escalation of Care

If the facility determines that it cannot safely manage the resident's exit-seeking behaviors, the resident will be:

- Sent to the Emergency Room (ER) for further medical and psychiatric evaluation.
- Evaluated for possible recommendation to a geriatric psychiatric facility.
- Family/responsible party must be notified prior to or immediately following transfer, as appropriate.

6. Failure of Interventions and Discharge

If all above interventions fail to adequately manage the resident's exit-seeking behaviors and ensure safety:

- The facility will contact the family/responsible party.
- The family will be advised of the need for immediate discharge due to inability to safely meet the resident's needs.
- Discharge will be conducted in accordance with state regulations, resident rights, and facility discharge procedures.

7. Documentation Requirements

- 30-minute monitoring logs.
- Family notifications and communications.
- Medical Director evaluations and orders.
- Staff notifications and shift reports.
- Transfer or discharge documentation, if applicable.



Jasmine Estates

Missing Resident / Elopement Prevention (emergency door monitoring & alarm response) Updated 11/18/2025

All staff must remain vigilant and proactive in monitoring residents, particularly those identified as having exit-seeking behaviors. The following guidelines are to be followed to prevent and appropriately respond to any potential elopement situation:

Resident Awareness & Monitoring

- Staff must stay informed of all residents who exhibit exit-seeking behaviors.
- Any updates or changes to a resident's care plan, especially those related to safety risk or exit-seeking will be communicated promptly.
- Constant awareness and observation of resident behavior is critical.

Walkie Use & Communication

- Walkies are mandatory and must be carried and used at all times during shifts.
- Walkies are to be used for proper communication between team members in order to ensure a swift and coordinated response to all situations, including potential elopements.
- Always respond to walkie calls promptly and keep the volume at an appropriate level to hear and communicate clearly.

Redirecting Exit-Seeking Behaviors

Staff should use the following **redirection techniques**:

- Calmly engage the resident in conversation to shift their focus.
- Offer to take a walk with the resident in a safe area.
- Provide a preferred activity or item of interest.
- Kindly remind them that it is not time to leave and redirect them back to a supervised area.

Door Alarm Protocol

- Respond **immediately** to any door alarm.

- If an alarm sounds and no resident is visible in the area:
 - **One** staff member must immediately exit the building to check the exterior perimeter.
 - **Remaining staff** must conduct a head count and visually confirm that all residents are accounted for.
 - Communicate findings clearly over the walkie system.

If a Resident Exits the Building

- **No more than two 2 staff members** should respond to retrieve the resident. (This ensures adequate supervision of remaining residents inside the building).
- Use calm language and a warm tone to encourage the resident to return.
- Notify team members using walkies to coordinate support as needed.

Notification & Documentation

- If an elopement occurs, the **Wellness Director must be notified immediately.**
- Follow all instructions provided by the Wellness Director.
- The incident must be documented thoroughly in ails.

Door Monitoring & Alarm Response

Purpose:

To ensure all staff understand their responsibilities in monitoring secured doors and responding immediately and appropriately to any door alarms to prevent elopement and maintain resident safety.

1. Door Monitoring Expectations

- All secured doors (including rear/delivery, side exits, and courtyard gates) must be checked at the start of every shift, and monitored regularly throughout the shift/s
- **Staff must ensure:**
 - Door is fully closed and latched
 - Keypad or locking mechanism is functional
 - No objects are blocking or preventing the door from securing properly
 - Any malfunction must be reported immediately to the nurse on duty and the manager, and documented per facility protocol.
- Staff may not prop open secured doors at any time for any reason.

2. Alarm Response Procedure

When a door alarm sounds, staff must follow the Immediate Response Protocol:

1. Stop what you are doing and respond immediately.
Staff must proceed directly to the alarming door.
- 2. Assess the area.**
 - Determine whether a resident is present or has exited.
 - Check for residents nearby who may be attempting to exit.
 - Clear any obstructions or safety risks.
- 3. Re-secure the door.**
 - Ensure the door is fully shut and locked.
 - Confirm the alarm system resets properly.
- 4. Account for all residents in the immediate area.**
If a resident is missing or unaccounted for, initiate the facility's elopement protocol immediately.
- 5. Notify appropriate personnel.**
 - Notify the nurse on duty
 - Notify management on duty
 - Document the event per policy (time, door location, cause, actions taken)

3. Staff Responsibilities

- Respond to every alarm—no exceptions.
- Never assume another staff member is responding.
- Maintain awareness of residents identified as high-risk for elopement.
- Follow all reporting and documentation procedures without delay.
- Ask for help if you are unable to leave your assigned residents; another staff member must respond immediately.

4. Importance of Compliance

Failure to follow door monitoring and alarm response procedures places residents at risk for harm and may result in disciplinary action. Consistent monitoring and prompt alarm response are essential and mandatory for resident safety and regulatory compliance.

Staff Acknowledgment

I acknowledge that I have read and understand the **Missing Resident / Elopement Prevention In-Service** policy. I agree to follow the procedures outlined above and to remain alert and proactive in preventing and responding to elopement risks within the community.

Signature: _____

Printed Name: _____

Date: _____

Quiz – Missing Resident / Elopement Prevention

Circle or write the correct answer.

1. **What must all staff carry and use at all times during their shift?**
 - a) Cell phone
 - b) Clipboard
 - c) Walkie
2. **When a door alarm sounds, what is the first action staff should take?**
 - a) Continue their current task
 - b) Stop what they are doing and respond immediately
 - c) Wait to see if another staff member responds
3. **If an alarm sounds and no resident is visible at the door, what must occur?**
 - a) Turn the alarm off and return to duties
 - b) One staff checks the exterior perimeter while remaining staff conduct a head count
 - c) Wait a few minutes to see if the resident returns
4. **How many staff may leave the building to retrieve a resident who has exited?**
 - a) One
 - b) Two (maximum)
 - c) As many as needed
5. **What must staff do before beginning their shift regarding secured doors?**
 - a) Ask another staff member if the doors were checked
 - b) Check all secured doors to ensure they are closed, latched, and functioning
 - c) Only check the front entrance
6. **What should staff do if a secured door or alarm is not working properly?**
 - a) Ignore it unless it becomes a bigger problem

- b) Try to fix it themselves
- c) Report it immediately to the nurse and manager, then document

7. **True or False: Staff may prop open a secured door if they stay nearby.**
8. **Name one technique you can use to redirect an exit-seeking resident:**
9. **After responding to a door alarm, what should staff do once the door is secured?**
 - a) Return to their previous task immediately
 - b) Ensure the alarm resets and account for all residents in the area
 - c) Silence the alarm without checking the area
10. **Who must be notified immediately if an elopement occurs?**

Employee Signature (quiz completion): _____

Date: _____

