STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375116	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Lake Villa	103 Har-Ber Road Grove, OK 74344

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and interview, the facility failed to ensure a resident was not sexually abused for 1 (#48) of 2 sampled residents reviewed for sexual abuse.The DON identified 65 residents resided in the facility.On 04/23/26, an immediate jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure Res #48 was not sexually assaulted by Res #17 on 03/11/26. This failure caused Res #48 to be fearful living at the facility.On 04/23/26 at 4:30 p.m., the OSDH was notified and verified the existence of the IJ related to the sexual assault of Res #48 by Res #17.On 04/23/26 at 4:33 p.m. the administrator and DON were notified of the IJ situation and provided with the IJ template.On 04/29/26 at 8:27 a.m., an acceptable plan of removal was approved by the OSDH. The plan of removal, read in part, Resident #17 and resident #48 were immediately separated upon finding of incident. On 4/24/26 resident [Resident #17] was placed on 1:1 supervision until resident was discharged from facility at approximately 3:30pm on 4/24/2026 per POA's choice. Resident #48 was seen by Geri-psych nurse practitioner on 4/24/26 to address psychosocial needs. Plan of care updated. During the process of investigating the allegation of abuse on resident #17 and resident #48, interviews with residents and staff, record reviews and policy reviews were conducted. [Administrator], Grand Lake Villa Abuse Coordinator/Administrator, has been re-educated on revised/updated Abuse Policy on 4/24/26 by [name withheld], Director of Operations for [company name withheld]. On 4/27/2026, [Administrator] was quizzed on the Abuse and Neglect Policy by [Director of Operations]. On 4/24/26, at our mandatory in-service, [name withheld], Director of Operations for [company name withheld] and [name withheld], Administrator/Coordinator for Grand Lake Villa, reviewed the updated/revised Abuse Policy line by line. Each staff member received a paper copy of the policy and signed acknowledgement of this education. On 4/27/26, Grand Lake Villa staff were given a written quiz regarding the abuse policy to verify understanding and compliance. All residents and family members were provided with a copy of the revised/updated Abuse Policy along with Resident's Rights via in person (resident), and by mail (family) on 4/27/2026. All staff were questioned if they were aware of any current abuse in the facility or if they were aware of any current resident relationships in the facility, any concerns were immediately addressed. On 4/28/26, all residents that are lacking capacity were provided skin assessments to ensure no signs or symptoms of abuse. All residents that have capacity were asked if they were ever abused sexually, mentally, or physically while in the facility on 4/27/2026. Competent residents were asked if they were currently in a relationship with another resident in the facility or if they had plans to begin a relationship with another resident in the facility. On 4/28/26, the facility formally adopted and implemented a capacity to consent assessment and a policy addressing both consensual and non-consensual sexual relations among residents, in accordance with resident rights and safety standards. On 4/29/26 all staff were provided a copy of the consensual and non-consensual resident sexual relations policy and signed an acknowledgement of receipt.The IJ was lifted on 04/29/26 at 2:37 p.m., when all components of the plan of removal had been reviewed and verified:a. documentation was reviewed and interviews with 19 facility staff and five residents were conducted to verify Res #17 was placed on 1:1 observations and discharged from the facility, Res #48 had been seen by mental health professionals, Res #48's (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Grand Lake Villa	103 Har-Ber Road Grove, OK 74344

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	care plan had been updated, and an investigation to determine the validity of the allegation and identify any other possible instances of abuse had occurred,b. documentation and interviews were conducted to verify the administrator had been re-educated and quizzed on the abuse and neglect policies,c. documentation was reviewed and interviews with 19 facility staff were conducted to verify each staff member had been re-educated and tested on the facility's abuse and neglect policies,d. documentation was reviewed and interviews with 19 facility staff and five residents were conducted to verify staff, residents, and families were provided copies of the updated abuse and neglect policies,e. documentation was reviewed and interviews with 19 facility staff and five residents were conducted to verify staff and residents were aware of any resident relationships at the facility,f. documentation was reviewed and interviews with 19 facility staff and five residents were conducted to verify residents had been assessed for signs of possible abuse and if relationships between residents existed, andg. documentation was reviewed and interviews with 19 facility staff members were conducted to verify each staff member had been aware of the new abuse and resident relationship policies.The deficient practice remained at an isolated level with potential for more than minimal harm that is not immediate jeopardy.Findings:A policy titled Abuse - Neglect - Misappropriation - Mistreatment Policy, dated 02/16/24, read in part, It is the policy of Grand Lake Villa that the residents of this facility will be free from abuse, neglect, mistreatment, and misappropriation of property.A quarterly assessment, dated 12/30/25, showed Res #48 had a BIMS score of 14 (BIMS is a cognitive screening tool used to assess memory, orientation, and decision-making skills and a BIMS score of 14 indicated the resident's cognitive abilities were intact).A health status note, authored by RN #1, dated 03/11/26 at 7:53 p.m., showed LPN #3 had found Res #17 touching Res #48 inappropriately through Res #48's clothing. The note showed RN #1 had separated the two residents, RN #1 had asked Res #48 if they were ok with the other resident touching them, and Res #48 had replied, No. The note showed the DON had been contacted about the incident.A health status note, authored by the SSD, dated 03/12/26 at 8:53 a.m., showed the SSD and DON had confronted Res #48 about the resident's previous sexually suggestive actions and speech toward Res #17. The note showed Res #48 was told they had a BIMS score of 14 and was oriented times four (a medical term that suggests cognitive awareness) and they should no longer make advances toward Res #17. The note showed Res #48 denied the accusations and tried to hit the staff members.An initial incident report, dated 04/22/26, showed an incident of alleged abuse where Res #17 had their hand on Res #48's body in their private area on 03/11/26 and the incident was reported to the OSDH and local law enforcement on 04/22/26.On 04/22/26 at 3:18 p.m., RN #1 stated they had been the person that had confronted Res #17 and Res #48 on 03/11/26 after LPN #1 had witnessed what they thought was a sexual act. RN #1 stated they separated the two and reported the incident to the DON.On 04/22/26 at 3:27 p.m., LPN #1 stated RN #1's note, dated 03/11/26 at 7:53 p.m., was accurate to what they had seen. LPN #1 would not state what they had seen during the interview, but referred to RN #1's progress note, dated 03/11/26 at 7:53 p.m., that described the incident.On 04/23/26 at 7:31 a.m., the DON stated they had heard Res #48 refer to Res #17 as their (term of endearment withheld) in the past prior to the incident. The DON stated they had told Res #48 not to say that and did so because of Res #17's limited cognition.On 04/23/26 at 9:38 a.m., the DON stated they had not reported the incident to the OSDH or law enforcement at the time they found out about the incident on 03/11/26. The DON stated they had not interviewed staff or residents to determine if other potential victims existed. The DON stated they had instructed Res #17 and Res #48 to stay away from each other and were not allowed to eat with each other. The DON stated Res #48 was upset with the rules, but followed them. The DON stated after the incident had occurred, they had contacted their corporate headquarters and together they decided it was not necessary to report the incident to the OSDH or law enforcement.A health status note, authored by LPN #1, dated 04/24/26 at 2:44 p.m., showed Res #17 had been discharged from the facility.A psychiatric evaluation note, dated 04/24/26 at 2:53 p.m., showed Res #48 had been evaluated because of the incident on 03/11/26 (continued on next page)

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	375116	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Lake Villa	103 Har-Ber Road Grove, OK 74344

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	where the resident had been inappropriately touched by another resident. The note showed Res #48 appeared more agitated than normal and reported fearfulness and not feeling safe. The note showed facility staff had reported the resident had become more isolative since the incident. The note showed Res #48's Zoloft (an antidepressant medication) was increased from 50 mg once daily to 100 mg, once daily because of the resident's increased irritability and anxiety.

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review and interview, the facility failed to ensure the facility's abuse policy had been implemented after an allegation of abuse for 1 (#48) of 2 sampled residents reviewed for abuse.The DON identified 65 residents resided in the facility.On 04/23/26, an immediate jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure Res #48 was not sexually assaulted by Res #17 on 03/11/26. This failure caused Res #48 to be fearful living at the facility.On 04/23/26 at 4:30 p.m., the OSDH was notified and verified the existence of the IJ related to the facility not implementing their abuse policy related to sexual assault.On 04/23/26 at 4:33 p.m. the administrator and DON were notified of the IJ situation and provided the IJ template.On 04/29/26 at 8:27 a.m., an acceptable plan of removal was approved by the OSDH. The plan of removal, read in part, [name withheld], Grand Lake Villa Abuse Coordinator/Administrator, has been re-educated on revised/updated Abuse Policy on 4/24/26 by [name withheld], Director of Operations for [company name withheld]. On 4/27/2026, [Administrator] was quizzed on the Abuse and Neglect Policy by [Director of Operations]. On 4/24/26, at our mandatory in-service, [name withheld], Director of Operations for [company name withheld] and [name withheld], Administrator/Coordinator for Grand Lake Villa, reviewed the updated/revised Abuse Policy line by line. Each staff member received a paper copy of the policy and signed acknowledgement of this education. On 4/28/26, all residents that are lacking capacity were provided skin assessments to ensure no signs or symptoms of abuse. All residents that have capacity were asked if they were ever abused sexually, mentally, or physically while in the facility on 4/27/2026. Competent residents were asked if they were currently in a relationship with another resident in the facility or if they had plans to begin a relationship with another resident in the facility. On 4/27/26 - MDS Coordinator, [name withheld], examined progress notes for all residents over the last 30 days to determine if there were any additional allegations of abuse. Administrator/DON will ensure Abuse Policy and Procedures are followed and implemented per policy when incidents arise to protect residents during investigations of alleged abuse per CMS regulations. All residents and family members were provided with a copy of the revised/updated Abuse Policy along with Resident's Rights via in person (resident), and by mail (family) on 4/27/2026. On 4/28/26, the facility formally adopted and implemented a capacity to consent assessment and a policy addressing both consensual and non-consensual sexual relations among residents, in accordance with resident rights and safety standards.The IJ was lifted on 04/29/26 at 2:37 p.m., when all components of the plan of removal had been reviewed and verified:a. documentation and interviews were conducted to verify the administrator had been re-educated and quizzed on the abuse and neglect policies,b. documentation was reviewed and interviews with 19 facility staff were conducted to verify each staff member had been re-educated and tested on the facility's abuse and neglect policies,c. documentation was reviewed and interviews with 19 facility staff and five residents were conducted to verify residents had been assessed for signs of possible abuse and if unknown relationships between residents existed,d. progress notes were reviewed for documentation of possible abuse having occurred and the MDS coordinator was interviewed to determine if they had reviewed the progress notes,e. the administrator and DON were interviewed to determine they understood to implement the abuse policy when allegations of abuse are made,f., documentation was reviewed and interviews with 19 facility staff and five residents were conducted to verify staff, residents, and families were provided copies of the updated abuse and neglect policies, andg. documentation was reviewed and interviews with 19 facility staff members were conducted to verify each staff member had been aware of the new abuse and resident relationship policies.The deficient practice remained at an isolated level with the potential for more than minimal harm that is not immediate jeopardy. Findings:A policy titled Abuse - Neglect - Misappropriation - Mistreatment Policy, dated 02/16/24, read in part, The facility will implement policy and procedures to prevent abuse, neglect or misappropriation of property of our resident. This included but not limited to.The facility (continued on next page)

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	will provide protection for resident in the case of any allegations of abuse, neglect, or misappropriation of property.They facility will conduct an investigation in a timely manner.A quarterly assessment, dated 12/30/25, showed Res #48 had a BIMS score of 14 (a BIMS score of 14 indicated the resident's cognitive abilities were intact).A health status note, authored by RN #1, dated 03/11/26 at 7:53 p.m., showed LPN #3 had found Res #17 touching Res #48 inappropriately through Res #48's clothing. The note showed RN #1 had separated the two residents, RN #1 had asked Res #48 if they were ok with the other resident touching them, and Res #48 had replied, No. The note showed the DON had been contacted about the incident.An initial incident report, dated 04/22/26, showed an incident of alleged abuse where Res #17 had their hand on Res #48's body in their private area on 03/11/26 and the incident was reported to the OSDH and local law enforcement on 04/22/26.On 04/23/26 at 9:38 a.m., the DON stated they had not reported the incident to the OSDH or law enforcement at the time they found out about the incident on 03/11/26. The DON stated they had not interviewed staff or residents to determine if other potential victims existed. The DON stated they had instructed Res #17 and Res #48 to stay away from each other and were not allowed to eat with each other. The DON stated Res #48 was upset with the rules but followed them. The DON stated after the incident had occurred, they had contacted their corporate headquarters and together they decided it was not necessary to implement the abuse policy in that situation.

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review an interview, the facility failed to ensure a thorough investigation of an allegation of sexual abuse was conducted for 1 (#48) of 2 sampled residents reviewed for abuse.The DON identified 65 residents resided in the facility.On 04/23/26, an immediate jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure Res #48 was not sexually assaulted by Res #17 on 03/11/26. This failure caused Res #48 to be fearful living at the facility.On 04/23/26 at 4:30 p.m., the OSDH was notified and verified the existence of the IJ related to the facility not thoroughly investigating and reporting the sexual assault of Res #48 by Res #17.On 04/23/26 at 4:33 p.m. the administrator and DON were notified of the IJ situation and provided the IJ template.On 04/29/26 at 8:27 a.m., the plan of removal was approved by the OSDH. The plan of removal, read in part, Resident #17 and resident #48 were immediately separated upon finding of incident. On 4/24/26 resident [Resident #17] was placed on 1:1 supervision until resident was discharged from facility at approximately 3:30pm on 4/24/2026 per POA's choice. Resident #48 was seen by Geri-psych nurse practitioner on 4/24/26 to address psychosocial needs. Plan of care updated. During the process of investigating the allegation of abuse on resident #17 and resident #48, interviews with residents and staff, record reviews and policy reviews were conducted. [name withheld], Grand Lake Villa Abuse Coordinator/Administrator, has been re-educated on revised/updated Abuse Policy on 4/24/26 by [name withheld], Director of Operations for [company name withheld]. On 4/27/2026, [Administrator] was quizzed on the Abuse and Neglect Policy by [Director of Operations]. On 4/24/26, at our mandatory in-service, [name withheld], Director of Operations for [company name withheld] and [name withheld], Administrator/Coordinator for Grand Lake Villa, reviewed the updated/revised Abuse Policy line by line. Each staff member received a paper copy of the policy and signed acknowledgement of this education. On 4/27/26, Grand Lake Villa staff were given a written quiz regarding the abuse policy to verify understanding and compliance. All staff were questioned if they were aware of any current abuse in the facility or if they were aware of any current resident relationships in the facility, any concerns were immediately addressed. On 4/28/26, all residents that are lacking capacity were provided skin assessments to ensure no signs or symptoms of abuse. All residents that have capacity were asked if they were ever abused sexually, mentally, or physically while in the facility on 4/27/2026. Competent residents were asked if they were currently in a relationship with another resident in the facility or if they had plans to begin a relationship with another resident in the facility. On 4/27/26 - MDS Coordinator, [name withheld], examined progress notes for all residents over the last 30 days to determine if there were any additional allegations of abuse. Administrator/DON will ensure Abuse Policy and Procedures are followed and implemented per policy when incidents arise to protect residents during investigations of alleged abuse per CMS regulations.The IJ was lifted on 04/29/26 at 2:37 p.m., when all components of the plan of removal had been reviewed and verified:a. documentation was reviewed and interviews with 19 facility staff and five residents were conducted to verify Res #17 was placed on 1:1 observations and discharged from the facility, Res #48 had been seen by mental health professionals, Res #48's care plan had been updated, and an investigation to determine the validity of the allegation and identify any other possible instances of abuse had occurred,b. documentation and interviews were conducted to verify the administrator had been re-educated and quizzed on the abuse and neglect policies,c. documentation was reviewed and interviews with 19 facility staff and five residents were conducted to verify staff, residents, and families were provided copies of the updated abuse and neglect policies,d. documentation was reviewed and interviews with 19 facility staff and five residents were conducted to verify staff and residents were aware of any resident relationships at the facility,e. documentation was reviewed and interviews with 19 facility staff and five residents were conducted to verify residents had been assessed for signs of possible abuse and if relationships between residents existed,f. progress notes were reviewed for documentation of possible abuse having (continued on next page)

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	occurred and the MDS Coordinator was interviewed to determine if they had reviewed the progress notes, andg. the administrator and DON were interviewed to determine they understood to implement the abuse policy when allegations of abuse were made.The deficient practice remained at an isolated level with the potential for more than minimal harm that is not immediate jeopardy. Findings:A policy titled Abuse - Neglect - Misappropriation - Mistreatment Policy, dated 02/16/24, read in part, The facility will implement policy and procedures to prevent abuse, neglect or misappropriation of property of our resident. This included bun not limited to.The facility will provide protection for resident in the case of any allegations of abuse, neglect, or misappropriation of property.They facility will conduct an investigation in a timely manner.A health status note, authored by RN #1, dated 03/11/26 at 7:53 p.m., showed LPN #3 had found Res #17 touching Res #48 inappropriately through Res #48's clothing. The note showed RN #1 had separated the two residents, RN #1 had asked Res #48 if they were ok with the other resident touching them, and Res #48 had replied, No. The note showed the DON had been contacted about the incident.An initial incident report, dated 04/22/26, showed an incident of alleged abuse where Res #17 had their hand on Res #48's body in their private area on 03/11/26 and the incident was reported to the OSDH and local law enforcement on 04/22/26.On 04/22/26 at 3:18 p.m., RN #1 stated they had been the person that had confronted Res #17 and Res #48 on 03/11/26 after LPN #1 had witnessed what they thought was a sexual act. RN #1 stated they separated the two and reported the incident to the DON.On 04/23/26 at 9:38 a.m., the DON stated after they became aware of the alleged sexual abuse of Res #48 by Res #17, they had not investigated the incident. The DON stated they had contacted their corporate headquarters and together they decided the incident did not require being reported to OSDH.A psychiatric evaluation note, dated 04/24/26 at 2:53 p.m., showed Res #48 had been evaluated because of the incident on 03/11/26 where the resident had been inappropriately touched by another resident. The note showed Res #48 appeared more agitated than normal and reported fearfulness and not feeling safe. The note showed facility staff had reported the resident had become more isolative since the incident. The note showed Res #48's Zoloft (an antidepressant medication) was increased from 50 mg once daily to 100 mg, once daily because of the resident's increased irritability and anxiety.

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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 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on record review and interview, the facility failed to ensure facility staff had been trained in the Quality Assurance and Performance Improvement program for 103 of 103 employees of the facility.The assistant director of nursing identified 103 employees worked in the facility.Findings:An undated Quality Assurance / Assessment and Performance Improvement Plan, read in part, All staff, including contracted staff, are educated on the principles of QAPI. QAPI is included in the orientation of new employees and in the annual education that all staff are required to attend.An undated Inservice Schedule, was reviewed. The schedule did not included training on the subject of QAPI.On 04/28/26 at 11:43 a.m., the DON stated the facility had not conducted any training with all their staff on QAPI. The DON stated they had reviewed their records and found no documentation of the facility staff being trained in QAPI. The DON stated they had looked at their annual training list and did not find QAPI listed as one of the subjects.

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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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on record review and interview, the facility failed to ensure residents understood binding arbitration agreements before signing them for 2 (#55 and #56) of 2 sampled residents reviewed for binding arbitration agreements.The DON identified 65 residents resided in the facility.Findings:1. An Arbitration of Disputes document in the assessment agreement, dated 09/29/25, read in part, Any and all claims, controversies, disputes, disagreements or demands of any kind .arising out of or in any relating to the Agreement, including the interpretation of this Agreement, or the Residents stay at, or the care of services provided by, the Facility shall be resolved exclusively by binding arbitration. The document showed Res #56's name printed in the resident representative's section of the signature page of the admission agreement. The SSD signed in the facility's representative area of the signature page.An admission assessment, dated 10/05/25, showed Res #56 had a BIMS score of 15 (a BIMS score of 15 indicated the resident's cognition was intact and was able to make decisions of daily living).On 04/22/26 at 8:06 a.m., Res #56 stated they did not recall giving anyone permission to sign an arbitration agreement for them. Res #56 stated because of their condition when they were admitted to the facility, they were not in their right mind to sign any documents.2. An Arbitration of Disputes document in the assessment agreement, dated 04/08/26, read in part, Any and all claims, controversies, disputes, disagreements or demands of any kind .arising out of or in any relating to the Agreement, including the interpretation of this Agreement, or the Residents stay at, or the care of services provided by, the Facility shall be resolved exclusively by binding arbitration. The document showed Res #55's name printed in the resident representative's section of the signature page of the admission agreement. The resident's signature was not on the signature page. The SSD signed in the facility's representative area of the signature page.An admission assessment, dated 04/15/26, showed Res #55 had a BIMS score of 14 (a BIMS score of 14 indicated the resident's cognition was intact and was able to make decisions of daily living).On 04/22/26 at 8:33 a.m., Res #55 stated they did not recall signing an arbitration agreement and did not get an explanation of what they had signed when they admitted . They stated they just signed where they were told to sign.On 04/22/26 at 8:37 a.m., the SSD stated they had not received any training on arbitration agreements, and they were the one who oversaw them because they were part of the admission packet. They stated each resident had the opportunity to read the documents in the admission packet, but they did not recall any resident reading the entire document. The social services director stated regarding Res #56 they had read the admission documents to them and signed for them because the resident was too shaky at the time.

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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 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide a neutral and fair arbitration process and agree to arbitrator and venue. Based on record review and interview, the facility failed to ensure binding arbitration agreements did not pre-determine the arbitrator for arbitration proceedings for 2 (#55 and #56) of 2 sampled residents binding arbitration agreements reviewed for binding arbitration agreements.The DON identified 65 residents resided in the facility.Findings:1.An Arbitration of Disputes document in the assessment agreement, dated 09/29/25, read in part, The parties' intend that the Arbitration Services shall be Judicial Arbitration and Mediation Services, Inc (JAMS) or its successor. If JAMS is unable or unwilling to service as the Arbitration Service, the parties' intent [sic] that the National Arbitration Forum ('NAF') or its successor shall serve as the Arbitration Service. The document showed Res #56's name printed in the resident representative's section of the signature page of the admission agreement. The SSD signed in the facility's representative area of the signature page.2.An Arbitration of Disputes document in the assessment agreement, dated 04/08/26, read in part, The parties' intend that the Arbitration Services shall be Judicial Arbitration and Mediation Services, Inc (JAMS) or its successor. If JAMS is unable or unwilling to service as the Arbitration Service, the parties' intent [sic] that the National Arbitration Forum ('NAF') or its successor shall serve as the Arbitration Service. The document showed Res #55's name printed in the resident representative's section of the signature page of the admission agreement. The SSD signed in the facility's representative area of the signature page.On 04/22/26 at 8:37 a.m., the SSD stated they had not received training in arbitration agreements and oversaw them because it was a part of the admission paperwork they go over with the new residents. They stated they were unaware of the particulars of the regulations that covered the arbitration agreements.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375116	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Lake Villa	103 Har-Ber Road Grove, OK 74344

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interview, the facility failed to include the estimated cost of services on a SNF ABN form CMS-10055 for 1 (#69) of 3 sampled residents reviewed for beneficiary notices.The DON identified 29 residents had been discharged from skilled services within the last six months. Findings:A document titled Form Instruction Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055 (2018), dated 2018, read in part, Estimated Cost Section. In this section, the SNF enters the estimated cost of the corresponding care that may not be covered by Medicare. The SNF should enter an estimated total cost or a daily, per item, or per service cost estimate.A CMS-10055 form for Res #69, dated 03/25/26, showed the resident's representative had indicated on the form they wanted to continue the skilled services mentioned on the form and they may be responsible for the costs if Medicare denied the claim. The form showed physical therapy, occupational therapy, daily skilled nursing care, and speech therapy as the services that may not be covered by Medicare after 04/14/26. The area on the form to show the resident or their representative the estimated cost of those services was blank.On 04/21/26 at 11:18 a.m., the SSD stated they had known Res #69's ABN did not have an estimated cost because corporate did not know what to put because they did not know how much the insurance would pay. The SSD stated they used to put in a set dollar amount, but now just left that portion of the form blank.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375116	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Lake Villa	103 Har-Ber Road Grove, OK 74344

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to report an alleged incident of sexual abuse to the OSDH within the required two-hour time frame for 1 (#48) of 1 sampled resident reviewed for abuse.The DON identified 65 residents resided in the facility.Findings:An abuse policy titled Abuse - Neglect - Misappropriation - Mistreatment Policy, dated 02/16/24, read in part, The facility will send a report to all reporting agencies as required by OSDH guidelines. The facility will send a report to the ODSH on form 283 within 2 hours of being notified of any allegation.A health status note authored by RN #1, dated 03/11/26 at 7:53 p.m., showed LPN #3 had found Res #17 touching Res #48 inappropriately through Res #48's clothing. The note showed RN #1 had separated the two residents, RN #1 had asked Res #48 if they were ok with the other resident touching them, and Res #48 had replied, No. The note showed the DON had been contacted about the incident.An initial incident report, dated 04/22/26, showed an incident of alleged abuse had occurred on 03/11/26 and was reported to the OSDH and the local law enforcement on 04/22/26.On 04/23/26 at 9:38 a.m., the DON stated they had not reported the incident to the OSDH or law enforcement at the time they found out about the incident on 03/11/26. The DON stated after the incident had occurred, they had contacted their corporate headquarters and together they decided it was not necessary to report the incident to the OSDH or the law enforcement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375116	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Lake Villa	103 Har-Ber Road Grove, OK 74344

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure a quarterly assessment accurately reflected a resident's fall history for 1 (#2) of 17 sampled residents reviewed for MDS assessment accuracy.The DON identified 65 residents resided in the facility.Findings:A quarterly assessment, dated 01/08/26, showed Res #2 had not had any falls. A health status note, dated 01/19/26 at 7:51 p.m., showed Res #2 had been found lying on the floor. The note showed no injuries were found on the resident.An incident note, dated 02/22/26 at 1:58 p.m., showed Res #2 had been found on the floor of their room. The note showed no injuries were found on the resident.An incident note, dated 03/05/26, showed Res #2 had been found on the floor of their room. The note showed no injuries were found to the resident.An incident note, dated 03/24/26, showed Res #2 was found on the floor of the locked unit's television room and the resident had a small hematoma on their head.A health status note, dated 04/09/26, showed Res #2 had been found lying on the floor after they were hit by a door someone had opened. The note showed the resident did not sustain any injuries.A quarterly assessment, dated 04/10/26, showed Res #2 had one no-injury fall since the last quarterly assessment, dated 01/08/26. The assessment showed the resident had not had any falls with minor injuries.A care plan, revised date 04/15/26, showed Res #2 had falls on 01/29/26, 02/22/26, 03/05/26, 03/24/26, and 04/10/26. On 04/21/26 at 1:09 p.m. certified medication aide #2 stated Res #2 had three for four falls in the last couple of months and one of those caused a bump on their head.On 04/21/26 at 1:44 p.m., MDS coordinator #1 observed Res #2's quarterly assessment, dated 04/10/26 and stated they saw one non-injury fall had been documented on the assessment. MDS Coordinator #1 reviewed Res #2's medical records and stated the care plan showed the resident had multiple falls that had not been recorded on the quarterly assessment, dated 04/10/26. MDS Coordinator #1 stated the assessment was not accurate.On 04/21/26 at 3:12 p.m., the DON stated the facility did not have a policy for MDS assessment accuracy but used the Resident Assessment Instrument Manual for the requirements they expected their staff to follow.