

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER Oak Hills Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 West Georgia Jones, OK 73049	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>48344</p> <p>Based on record review and interview, the facility failed report an allegation of abuse to OSDH for one (#5) of four sampled residents reviewed for abuse.</p> <p>The Administrator identified 118 residents resided in the facility.</p> <p>Findings:</p> <p>The Abuse Investigation and Reporting policy, revised 07/17, read in part, All alleged violations involving abuse .will be reported by the facility administrator, or his/her designee, to the following persons or agencies: The State licensing/certification agency responsible for surveying/licensing the facility.</p> <p>Resident #5 had diagnoses which included alcoholic hepatic failure without coma and bipolar disorder.</p> <p>A nursing note, dated 04/03/24 at 9:39 p.m., read in part, nurse heard screaming and yelling, ran to the front and saw Resident #5 yelling in [name withheld] face and attempted to hit them. Resident #5 smelled of alcohol. Residents were separated by staff, Resident continue to be combative, yelling and attempting to attack other residents. Resident escorted to room; police notified. Police arrived and calm resident down for a few minutes, resident then ran back into TV and continued to make threatening remarks towards other residents. Resident escorted back to room. Administration notified.</p> <p>There was no documentation an incident report was filed to OSDH.</p> <p>On 10/21/24 at 11:11 a.m., the Administrator stated they were the abuse coordinator.</p> <p>On 10/21/24 at 11:16 a.m., the Administrator reviewed the nursing note for Resident #5. They stated the incident would be considered abuse and should be reported. They stated they were not aware of the incident.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>48344</p> <p>Based on record review and interview, the facility failed to ensure labs were obtained as ordered by the physician for one (#7) of three sampled residents reviewed for lab results.</p> <p>The Administrator identified 118 residents resided in the facility.</p> <p>Findings:</p> <p>The LAB POLICY AND PROCEDURE policy, dated 09/19/24, read in part, All laboratory tests will be done as ordered by the physician in a timely manner and the results reported to the physician.</p> <p>Resident #7 had diagnoses which included hypokalemia and hyponatremia.</p> <p>A physician's order, dated 04/23/24, documented CMP monthly one time a day every 28 days starting 05/09/24 related to hypokalemia.</p> <p>There was no documentation the CMP lab was obtained in June, August, and September 2024.</p> <p>On 10/18/24 at 12:35 p.m., the DON reviewed Resident #7's labs. They stated the CMP was ordered monthly. They stated the labs were not obtained monthly as ordered by the physician.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>48344</p> <p>Based on observation and interview, the facility failed to ensure an ice machine was maintained in a sanitary manner for one of one ice machine observed.</p> <p>The Administrator identified 117 residents who received nourishment from the kitchen.</p> <p>Findings:</p> <p>On 10/17/24 at 11:44 a.m., the ice machine by the dining room was observed to have white and brown residue on the silver aluminum body and the black cup stand/drain. The side of the ice machine by the wall had white and brown residue.</p> <p>On 10/17/24 at 11:47 a.m., the CDM stated they cleaned the ice machine daily. They stated the ice machine had coffee stain and hard water stain.</p> <p>On 10/17/24 at 11:48 a.m., the CDM removed the black ice dispenser and it had moderate amount of a white residue build up. They stated it was hard water stain.</p> <p>On 10/17/24 at 11:55 a.m., the CDM started cleaning the ice machine.</p> <p>On 10/17/24 at 12:33 p.m., Resident #3 stated the ice machine needed to be cleaned more frequently.</p> <p>On 10/17/24 at 1:06 p.m., the side of the ice machine had the same white and brown residue observed earlier.</p> <p>On 10/17/24 at 1:13 p.m., the CDM stated they had cleaned the ice machine.</p> <p>On 10/17/24 at 1:14 p.m., the CDM was asked if they had cleaned the side of the ice machine, the CDM stated, No.</p>