

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 10/31/2024
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>48344</p> <p>Based on observation, record review, and interview, the facility failed to maintain a clean and homelike environment for two (#2 and #3) of three sampled residents reviewed for clean, comfortable, and homelike environment.</p> <p>The administrator identified 122 residents resided in the facility.</p> <p>Findings:</p> <p>The Homelike Environment policy, revised 02/21, read in part, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The policy also read, .clean beds and linens that are in good condition.</p> <p>1. Resident #3 had diagnoses which included diabetes.</p> <p>On 10/30/24 at 10:50 a.m., Resident #3 was observed in bed with their eyes closed. The white fitted sheet had a large brown ring towards the HOB. The resident's white blanket had a large light brown ring.</p> <p>On 10/30/24 at 10:54 a.m., CNA #3 went into Resident #3's room. They woke the resident up and told them they would be stripping their bed. CNA #3 told the resident's son they now had bottom sheets.</p> <p>On 10/30/24 at 10:57 a.m., CNA #3 asked Resident #3 if they had an accident last night. They removed the bed linens. The mattress had a large wet spot in the middle. CNA #3 wiped the mattress then sprayed it with a solution. They stated they would be back to make the bed.</p> <p>On 10/30/24 at 11:29 a.m., CNA #3 stated Resident #3 recently became incontinent. They stated the bed sheet had a brown ring. CNA #3 stated it was the first time they went into the resident's room this shift.</p> <p>On 10/30/24 at 11:32 a.m., CNA #3 stated there was an opportunity for staff to observe the bed linen and change them. They stated they were out of bottom sheets since 8:00 a.m.</p> <p>1. Resident #2 had diagnoses which included cellulitis of right lower limb.</p> <p>(continued on next page)</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/30/24 at 12:30 p.m., CNA #1 was asked which bed belonged to Resident #2. They pointed to an unmade bed with a pillow.</p> <p>On 10/30/24 at 1:36 p.m., Resident #2's bed remained unmade.</p> <p>On 10/30/24 at 1:36 p.m., CNA #1 stated beds were made in the morning. They stated Resident #2's bed should have been made.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48344</p> <p>Based on observation and interview, the facility failed to ensure soiled linen were not placed on the floor to prevent the spread of infection for one of five rooms observed for clean, comfortable, and homelike environment.</p> <p>The administrator identified 122 residents resided in the facility.</p> <p>Findings:</p> <p>On 10/31/24 at 3:07 p.m., bed linen were observed on the floor in room [ROOM NUMBER]. There was a wet pad with brown fecal matter, a wet fitted sheet, a flat sheet, a blanket, and a gown.</p> <p>On 10/31/24 at 3:13 p.m., CNA #1 stated they had changed a resident in room [ROOM NUMBER] and the linen barrel was full. They stated they went to help another resident and were planning on coming back to pick up the dirty linens. CNA #1 stated the process was to put dirty linens in the barrel.</p> <p>On 10/31/24 at 3:16 p.m., CNA #2 stated if the barrel was full, linens were to be put in a plastic bag and transported to the dirty utility room.</p>		