

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 03/17/2025
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>35749</p> <p>Based on record review and interview, the facility failed to ensure a resident's personal funds were not misappropriated for 1 (#4) of 4 sampled residents reviewed for abuse.</p> <p>The assistant director of nursing identified 112 residents resided in the facility.</p> <p>Findings:</p> <p>An undated Abuse and Neglect policy, read in part, no resident shall be subject to abuse.</p> <p>Resident #4 had diagnoses which included bipolar and anxiety.</p> <p>An Incident Report Form, dated 03/12/25, read in part, Reported to this admin [administrator] by SSD [social service director]. Resident called [their] card and realized the balance was very low and stated [they] should have about \$1000 .Resident then stated, 'I should have never given [CNA #5] my card [SSI debit card]' . Various charges noted today: [nail salon] \$145, [gas station] \$70, 2 ATM [automated teller machine] withdrawals \$43 and \$62, [cell phone carrier] \$74.</p> <p>On 03/13/25 at 1:20 p.m., Resident #4 stated a couple of months ago, CNA #5 asked if they could borrow some money. They stated CNA #5 knew they received SSI. Resident #4 stated they gave CNA #5 the card and told them they could use it for gas and groceries, but that was not what it was used for.</p> <p>On 03/17/25 at 10:25 a.m., Resident #4 was asked if they got their nails done. They stated, No. Resident #4 was asked if they paid a bill to a phone carrier. They stated, No. Resident #4 was asked if they made purchases at the grocery store. They stated they loved the grocery store, but did not get to go there.</p> <p>On 03/17/25 at 10:40 a.m., the administrator stated a medication aide let Resident #4 use their phone to order food. The administrator stated Resident #4 checked the last few transactions made on the SSI debit card and knew some of the charges were not made by them. The administrator was asked what the policy was for misappropriation. They stated, Termination, it's a form of abuse.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 375117	If continuation sheet Page 1 of 1