STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375117	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hills Living Center	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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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 - Actual harm Residents Affected - Few	The Immediate Jeopardy (IJ) has been removed based on a determination resulting from an Informal Dispute Resolution (IDR).On 09/18/25 at 1:23 p.m., a past non-compliance Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to protect residents from physical abuse. Resident #2 was involved in an altercation with Resident #1 resulting in a fist fight and Resident #1 falling to the ground. Resident #2 continued to sit on and hit Resident #1. Resident #1 lost their balance during the altercation and fell to the floor resulting in a fracture of their left femur.Based on record review and interview, the facility failed to ensure a resident was protected from physical abuse inflicted by another resident for 1 (#1) of 4 sampled residents reviewed for abuse.The administrator identified 117 residents resided in the facility. Findings:An undated facility policy titled Abuse and Neglect Policy, read in part, The Abuse/Neglect Policy of this facility will be implemented to ensure all residents entrusted in our care will be free from mental, verbal, or physical abuse. It is our goal to provide quality care to our residents.1. An undated diagnoses report showed Resident #1 had diagnosis which included displaced intertrochanteric fracture of left femur.Resident #1's quarterly assessment, dated 08/08/25, showed Resident #1 had a BIMS score of 8, which indicated moderately impaired cognition and the resident was independent with sit to stand transfers.A nursing note, dated 09/01/25 at 11:47 p.m., read in part, [Resident #1] had fight with [Resident #2] at TV area. [Resident #1] was beaten by [Resident #2]. [Resident #1] was in w/c before [they] were attacked. It was reported that [they] hit [Resident #2] which [led] to [them] being attacked.A Quality Assurance & Performance Improvement form, dated 09/01/25, showed the residents were separated and assessed. Family, physician, Adult Protective Services, law enforcement, and the DON were notified of the incident. Interviews and safe surveys were completed. In-services were conducted.An Oklahoma State Department of Health final report, for an incident dated 09/02/25, showed Resident #1 observed to be in altercation with Resident #2. Resident #2 was on the floor hitting Resident #1 in different parts of the body. Resident #2 was throwing objects at Resident #1. Staff intervened. Emergency transport was called. The police department was called. Resident #2 had scrapes that were cleaned and dressed. Resident #1 was sent to the emergency room to be evaluated. Resident #2 was placed on every 15-minute checks. Resident #2 was transferred to a mental health facility for psychiatric evaluation and treatment. Resident #1 was sent to the emergency room following the altercation due to complaints of left leg pain after losing their balance during the altercation and falling on their left side. Evaluation confirmed a left femur fracture, and surgical repair was completed.A Every 15-minute Safety Monitoring form, initiated on 09/02/25 at midnight, showed Resident #2 remained on monitoring until 09/04/25 at 5:45 p.m.Resident #1's care plan, revised on 09/05/25, read in part, [Resident #1] had fight with [Resident #2] at TV area. Resident #1 was beaten by [Resident #2]. [Resident #1] was in w/c before [they] were attacked. It was reported that [they] hit [Resident #2] which [led] to [them] being attacked.On 09/17/25 at 11:38 a.m., Resident #1 stated Resident #2 came from behind and started hitting them in the face. Resident #1 stated they went to the ground and hurt their leg.09/17/25 at 11:40 a.m., Resident #1 stated they did not know why Resident #2 hit them, as they were just sitting there watching television when it happened. 2. An undated diagnoses report showed Resident #2 had diagnoses which included anxiety (onset date 06/01/25) and major depressive disorder (onset date 07/05/24).Resident #2's quarterly assessment, dated 07/16/25, showed the resident had a BIMS score of 12, which indicated moderate cognitive impairment.A nursing note, dated 09/01/25, showed at approximately 9:20 p.m. Resident #2 was observed to be in an altercation with Resident #1 and was observed to be on the floor in the day room with Resident #2 striking Resident #1 in different areas of the body.A nursing note, dated 09/04/25, showed Resident #2 was transferred to a mental health facility at approximately 5:30 p.m.Resident #2's care plan, revised on 09/05/25, read in part, [Resident #2] observed to be in an altercation with [Resident #1] and was observed to be on the floor in the day room with [Resident #1] striking [Resident #1] in different areas of [their] body. Resident [#2] was continuing to be confrontational even after staff intervened.At the time of exit Resident #2 remained out of the facility.An In-Service Topic form, dated 09/08/25, showed the facility conducted a behavior management in-service with all staff.An In-Service Topic form, dated 09/08/25, showed the facility conducted an assessing psychosocial effects in-service and a timely reporting in-service with staff.An In-Service Topic form, dated 09/09/25, showed the facility conducted a response to resident-to-resident in-service with staff.On 09/17/25 at 1:32 p.m., the administrator stated the process for involving QAPI was to put interventions in place immediately and discuss during the QAPI meeting. They