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	11/26/2025

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 - Minimal harm or potential for actual harm Residents Affected - Some	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 free from abuse for 1 (#2) of 3 sampled residents reviewed for abuse.The DON identified 115 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 admission Record showed Resident #2 had diagnoses which included major depressive disorder and anxiety disorder.Resident #2's annual assessment, dated 09/18/25, showed the resident's cognition was intact with a BIMS score of 15. No behaviors were documented on the assessment.An Incident Report Form, dated 09/29/25, read in part, Resident [#2] went to kitchen to ask that [their] cup be washed out. [Certified Dietary Manager] told resident [Resident #2] 'hang on a minute.' Resident [#2] began cussing and using profanity and called [Certified Dietary Manager] a [explicit] and [Certified Dietary Manager] reciprocated calling Resident [#2] a [explicit]. Cup was thrown by resident [Resident #2] towards employee. Staff immediately intervened to cease altercation. No physical injuries noted to resident. Employee suspended. Investigation initiated . Investigation concluded. Abuse substantiated. Interviews with staff completed. Interview with resident completed. Interviewed other residents about this employee, no other reports of abuse noted. Family member at drink station when incident happened, family member with statement of what was witnessed. No other residents witnessed incident. After viewing facility camera footage, verbal abuse and incident confirmed. [Certified Dietary Manager] terminated. Safe surveys completed and no other allegations reported. Trauma assessment completed. [Name withheld} counseling to visit with resident. Abuse Policy in-service completed with all staff. Incident reviewed in morning meeting and will be reviewed at next scheduled QAPI meeting.On 10/22/25 at 3:09 p.m., Resident #2 stated, they went to the kitchen to ask for their cup to be washed, the certified dietary manager grabbed them and hit them in the arm with the door. The certified dietary manager grabbed my hand, it was annoying. They called me a [explicit]. I called them a [explicit] back. They were just rude and ignored me. I did not like that. On 10/23/25 at 8:53 a.m., dietary aide #1 stated they had witnessed the resident get upset due to the certified dietary manager taking a minute to assist them. It was probably frustrating. They both used the B word. I knew the resident said it first, but that did not make it right.

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