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	12/03/2025

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 - Immediate jeopardy to resident health or safety 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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A past noncompliance Immediate Jeopardy (IJ) situation was determined to exist effective 11/07/25 related to the facility's failure to provide supervision to prevent elopement.Based on observation, record review, and interview, the facility failed to ensure a resident requiring increased visual checks was not neglected for 1 (#1) of 3 sampled residents reviewed for neglect.LPN #1 identified 119 residents resided in the facility. The DON identified 21 residents at risk for elopement. Findings:On 11/18/25 at 5:46 a.m., window alarms were observed in all rooms on hall 500, the secured dementia unit.On 11/18/25 at 10:46 a.m., CNA #1 demonstrated a window alarm to be functioning by raising the window. The alarm sounded upon the window being raised.On 11/18/25 at 10:53 a.m., the fence outside the secured dementia unit was observed. There was a chain link fence. In some areas there was also a wooden fence. The chain link fence was less than 6 feet tall and the wooden fence was 6 feet.An undated admission record for Resident #1 showed the resident admitted to the facility on [DATE] with diagnosis which included Wernicke's encephalopathy.Resident #1's care plan, revised 10/29/25, showed Resident #1 was insisting on leaving and had told a family member they were walking home if the family member did not come and get them. The care plan showed Resident #1 was then placed on a secured dementia unit and increased visual checks. A revision of the care plan on 11/07/25 showed window alarms were ordered and would be put in place upon arrival and staff education was completed on elopement.Resident #1's admission assessment, dated 11/03/25, showed the resident had a BIMS score of 8 which indicated moderate cognitive impairment, and they were independent with ambulation. The assessment showed Resident #1 was a wandering risk.Resident #1's hospital record, dated 11/07/25, showed Resident #1 flagged down a police officer on the side of the road with complaints of leg pain and weakness. The record showed the police called an ambulance service who took Resident #1 to the hospital. The record showed at approximately 6:50 a.m. EMS contacted the facility and reported Resident #1 was in their custody and the resident would be returned to the facility. The record showed Resident #1 returned to the facility at 8:40 a.m. The record showed healing abrasions to Resident #1's anterior shins bilaterally.A Nurse Charting Note, dated 11/07/25 at 8:58 a.m., showed Resident #1 had abrasions noted to knees bilaterally, not bleeding, scab noted, minor bruising noted to top of hand. The note showed Resident #1 voiced no pain.An Abuse, Neglect, Misappropriation & Prevention Program policy, effective 11/07/25, read in part, Adequate staffing and supervision must be maintained at all times.A Resident Monitoring/Behavior Sheet reviewed showed Resident #1 was placed on one-on-one monitoring from 11/07/25 through 11/13/25. One-on-one stopped when the window alarms were installed in all rooms located on hall 500. Nurse Competencies reviewed showed competencies were completed with nursing staff on 11/07/25 through 11/25/25.In-services reviewed showed on 11/10/25 at 2:00 p.m., the facility conducted in-services on abuse response/rounding tool and care plan management.A Quality Assurance and Performance Improvement on 11/11/25 showed interventions which included door/window alarm testing, rounding log review, staff education on elopement, rounds, and care planning.An untitled monitoring log showed window alarms were monitored on 11/12/25 through 11/30/25.On 11/18/25 at 11:08 a.m., Resident #1 stated they had gone across the hall, went out the window, and crawled under the fence. They stated they got out front and walked down the street. They stated they realized how far the walk was, so they flagged down a policeman. They stated, I shouldn't have done it, I shouldn't have left.An undated written statement from CNA #1 showed they had only seen Resident #1 at the beginning of the shift. They stated they had only checked on some residents and not all.On 12/01/25 at 11:59 a.m., CNA #1 stated that increased rounds would be maybe every hour instead of two.On 12/01/25 at 1:20 p.m., CMA #2 stated they had seen Resident #1 at the beginning of the shift. They stated they conducted rounds at 6:00 a.m. and not at 3:00 a.m. They stated Resident #1 was continent, so they had not conducted rounds on them. CMA #2 stated they could not remember what time the other rounds had been conducted and between rounds they had been watching television.On 12/02/25 at 11:17 a.m., assistant police chief stated the responding officer had picked up Resident #1 three miles from the facility on 11/07/25 at 5:33 a.m.On 12/02/25 at 12:47 p.m., Resident #1 pointed out the window and stated they went under the fence right there at the end. Resident #1 stated they were unsure how far they walked, but they went pretty far.On 12/02/25 at 3:41 p.m., the former administrator stated they reviewed the camera on 11/07/25. They stated rounds were not completed every two hours, the hall was dark, and the medication aide and the nurse were both sleeping On 12/02/25 at 3:43 p.m., the

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A past noncompliance Immediate Jeopardy (IJ) situation was determined to exist effective 11/07/25 related to the facility's failure to provide implement interventions for a resident with a known history of elopement.Based on record review and interview, the facility failed to implement care plan interventions for 1 (#1) of 3 sampled residents reviewed for care plan interventions with a known history of elopement risk.LPN #1 identified 119 residents resided in the facility. The DON identified 21 residents at risk for elopement.Findings:A Routine Resident Checks (Rounding Policy), dated 11/07/25, read in part, It is the policy of this facility to ensure the safety, well-being and supervision of all residents through consistent, documented routine resident checks (rounds) conducted at least every two (2) hours and more frequently as indicated by resident condition, care plan, or risk status. Increased Visual Checks - Enhanced frequency of rounding (e.g., every 15-60 minutes) for residents identified as high risk for falls, elopement, behavior changes, or medical instability.An undated admission assessment for Resident #1 showed the resident was admitted to the facility on [DATE] with diagnosis which included Wernicke's encephalopathy.Resident #1's care plan, revised 10/29/25, showed Resident #1 was insisting on leaving and had told a family member they were walking home if the family member did not come and get them. The care plan showed Resident #1 was then placed on a secured dementia unit and increased visual checks. Resident #1's admission assessment, dated 11/03/25, showed the resident had a BIMS score of 8 which indicated moderate cognitive impairment, and they were independent with ambulation. The assessment showed Resident #1 was a wandering risk.Resident #1's hospital record, dated 11/07/25, showed Resident #1 flagged down a police officer on the side of the road with complaints of leg pain and weakness. The record showed the police called an ambulance service who took Resident #1 to the hospital. The record showed at approximately 6:50 a.m. EMS contacted the facility and reported Resident #1 was in their custody and the resident would be returned to the facility. The record showed Resident #1 returned to the facility at 8:40 a.m. The record showed healing abrasions to Resident #1's anterior shins bilaterally.Resident #1's care plan, revised 11/07/25, showed window alarms were ordered and would be put in place upon arrival and staff education was completed on elopement.Nurse Competencies reviewed showed competencies were completed with nursing staff on 11/07/25 through 11/25/25.In-services reviewed showed on 11/10/25 at 2:00 p.m., the facility conducted in-services on abuse response/rounding tool and care plan management.A Quality Assurance and Performance Improvement on 11/11/25 showed interventions which included door/window alarm testing, rounding log review, staff education on elopement, rounds, and care planning.On 12/01/25 at 1:23 p.m., CMA #2 stated they had not done rounds at 3:00 a.m. They stated rounds were done at 6:00 a.m. They stated were unsure if any other rounds were done. They stated they were at the nurse's station during most of their shift watching television. On 12/01/25 at 1:25 p.m., CMA #2 stated they had probably not followed the resident's care plan.On 12/03/25 at 2:10 p.m., the interim administrator stated they viewed the video and they had seen an employee at the desk with their head down.On 12/10/25 at 2:12 p.m., the interim administrator stated they would expect staff to ensure residents were safe and accounted for during their shifts. On 12/03/25 at 4:19 p.m., the minimum data set coordinator stated increased visual checks would be each time you go by them, maybe every hour.On 12/03/25 at 4:31 p.m., corporate nurse consultant stated there were failures that night.