STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375171	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Health Care Center	1709 South Main Broken Arrow, OK 74012

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to complete a quarterly assessment for 1 (#1) of 4 sampled residents reviewed for quarterly assessments. The DON identified 49 residents resided in the facility. Findings:A review of the clinical record showed an annual assessment dated [DATE] for Resident #1, a discharge with return anticipated dated 11/06/25 for Resident #1, and an entry dated 11/19/25 for Resident #1. There were no documented assessments since the admission assessment on 09/28/25. On 02/23/26 at 1:55 p.m., LPN #2 stated they were the second and most recently hired nurse to perform MDS assessments and care plans while the MDS coordinator was on leave. LPN #2 stated they were not aware Resident #1's quarterly MDS was due.On 02/23/26 at 2:15 p.m., the DON stated the quarterly assessment for Resident #1 was late due to the interim MDS nurse not performing their duties.

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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to update the plan of care for 1 (#1) of 4 sampled residents reviewed for their plan of care for elopement. The DON identified 49 residents resided in the facility. Findings:A care plan for Resident #1, dated 09/28/25, showed a concern for elopement. The care plan for elopement did not show it was reviewed or updated after elopements on 10/15/25, 11/06/25, 01/16/26, 02/08/26, or 02/09/26.On 02/19/26 at 5:38 p.m., LPN #1 reviewed the care plan for elopement and stated the interventions were not updated since the care plan for elopement was developed. On 02/23/26 at 1:55 p.m., LPN #2 stated they thought the DON had recently updated the care plan for elopement. On 02/23/26 at 2:15 p.m., the DON stated the care plan for Resident #1 was not updated due to the interim MDS nurse not performing their duties.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. On 02/19/26, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to provide supervision for a resident at high risk for elopement. Resident #1 eloped from the facility on five occasions. On 01/16/26, Resident #1 eloped and, while away from the facility, harmed themselves by intentionally burning the back of their hand with a cigarette lighter which resulted in multiple blisters to the back of their hand. On 02/08/26, Resident #1 eloped and was found by the local authorities at a residence the facility identified as a known drug house. For each elopement, the facility intervention was to initiate every 15-minute visual checks and no interventions were added to Resident #1's care plan. On 02/19/26 at 7:40 p.m., the OSDH was notified and verified the existence of the IJ related to elopement and self-harm.On 02/19/26 at 7:45 p.m., the administrator and DON were notified of the IJ situation. The IJ template was reviewed with the administrator and DON, and a copy was emailed to them at 7:50 p.m.On 02/20/26 at 5:05 p.m., an acceptable plan of removal was submitted to the OSDH. The plan of removal, read in part,Upon identification of Immediate Jeopardy related to elopement risk, the facility immediately implemented the following corrective actions:1. The identified resident was placed on continuous 1:1 supervision (line-of-sight monitoring) effective immediately on 02/19/26 at 20:50 [8:50 p.m.].2. The assigned 1:1 staff member: .Visual contact at all times.Is relieved by a designated backup staff member during all breaks to ensure uninterrupted supervision.Charge nurse assigns a backup sitter at the beginning of each shift .Backup staff documented on assignment sheet.No break is permitted without confirmed face-to-face handoff.Person appointed to 1:1 care will document q 15mins [sic] that they have eyes on resident and the resident's location on the 15 min checks sheet.a. Upon completion of 15 min check sheet, it will be turned into DON for approval.The level of supervision is a clinical decision based on ongoing assessment of risk and may be increased or decreased at any time to ensure resident safety.3. A secondary staff member has been assigned each shift as designated break coverage to ensure there is no lapse in supervision at any time.4. Door alarm functionality was immediately verified by maintenance and nursing staff.5. The resident's care plan was updated to reflect: .1:1 supervision .High elopement risk status .Supervision requirements6. All wandering risk assessments for the facility will be complete by 02/20/2026 at 1700 [5:00 p.m.]Staff Education ConductedAll staff were educated on: .Risk of elopement .What to do in case of elopement .Stay with resident no matter what .Call 911 .Ensure the resident is safely returned to facility .Notify the charge nurse .Change [sic] nurse will notify physician, administrator, DON, and family.1:1 sitter responsibilitiesFacility implemented a procedure to educate all staff. This implementation started on 02/19/2026 at 2050 [8:50 p.m.] and was completed on 02/20/2026 1100 [11:00 a.m.] except for [CNA #1] and [CNA #2] who were called and unable to be reached. They will not be allowed to clock in/work a shift until education is provided and understood.Attendance sheets maintained in education file.Care Plan RevisionEffective 02/19/2026 at 2100 [9:00 p.m.], the resident's comprehensive care plan was reviewed and updated by the interdisciplinary Team to reflect: .Identification of high elopement risk .Continuous 1:1 supervision (line-of-sight) .Designated break relief protocol (face-to-face handoff required) .Redirection techniques to be utilized .Monitoring frequency and documentation requirements .Following any additional exit-seeking behavior an investigation will be conducted and the findings from the investigation along with the findings a root cause analysis preformed [sic] by the interdisciplinary team will be used to update the residents care plan. The IJ was lifted, effective 02/21/26 at 3:00 p.m., when it was determined the facility completed all components of their plan of removal. This was determined through observations of 1:1 supervision and staff/resident interactions; record review of the 1:1 supervision, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	in-services, wandering risk assessments, and interventions; and interviews regarding in-service training, residents at risk for wandering/elopement, and interventions.The deficiency remained at an isolated level with the potential for more than minimal harm. Based on observation, record review, and interview, the facility failed to provide supervision to prevent elopement and self-harm for 1 (#1) of 4 sampled residents reviewed for supervision. The DON identified two residents who were high risk for wandering and/or elopement. Findings:On 02/17/26 at 11:55 a.m., Resident #1 was observed ambulating/pacing the hall and talking to themselves. Resident #1 slurred their words, making what they said intelligible. The resident paced slightly faster with each pass in front of the activity room door and their voice sounded higher in pitch with each pass.An admission assessment for Resident #1, dated 09/28/25, showed the resident was cognitively intact with a brief interview for mental status score of 14; felt down/depressed/hopeless several days of the last two weeks; exhibited delusions; wandered one to three days of the week; and their wandering placed the resident at significant risk of getting to a potentially dangerous place. The assessment showed Resident #1 felt it was important to be able to go outside to get fresh air, was independent with most activities of daily living, was continent of bowel and bladder, and had an active diagnosis of a progressive neurological condition. The assessment showed Resident #1 was diagnosed with Huntington's Disease, anxiety, and depression. The assessment showed the resident had a history of falls in the last two to six months prior to admission to the facility. The assessment showed Resident #1 received an antianxiety medication, antidepressant medication, an opioid, and anticonvulsant in the seven days leading up to the assessment. The assessment showed Resident #1 did not receive an antipsychotic medication since admission to the facility. A care plan, dated 09/28/25, showed Resident #1 was at risk of elopement and wandering related to their diagnosis of hallucinations. The interventions included:a. assess for fall risk,b. distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or book,c. identify patterns of wandering: was the wandering purposeful, aimless, or escapist; was the resident looking for something; did it indicate the need for more exercise; and intervene as appropriate,d. monitor for fatigue and weight loss, ande. provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. A wandering risk evaluation for Resident #1, dated 10/03/25, showed a risk score of 15 for the resident which indicated a high risk for wandering. A state reportable incident report for Resident #1, dated 10/15/25, showed the resident left the facility without notice, crossed the parking lot, and fell while ambulating through an adjacent field. The report showed the local authorities were contacted and assisted in the resident returning to the facility. The report showed the facility initiated visual checks every 15 minutes on the resident. The report, read in part, The facility will be implementing Q15 minute checks on [Resident #1]. Please lay eyes on [them] every 15 minutes every shift until stated otherwise. An incident note for Resident #1, dated 11/06/25, showed the nurse observed Resident #1 pacing the facility while talking to themselves. The incident note showed the nurse could hear Resident #1 speaking as though to someone named (name withheld) but no one was there. The incident note showed Resident #1's behavior continued to escalate. The incident note showed Resident #1 approached the nurse and asked that they talk in the resident's room. The incident note showed once in the room, Resident #1 stated they had video of 9name withheld) threatening them. The incident note showed when the video was played for the nurse, the nurse observed Resident #1 on the screen, acting as though they were (name withheld). The incident note showed Resident #1 confirmed the video looked like themselves but was really (name withheld). Resident #1 requested the nurse contact the FBI on their behalf. A short time later, Resident #1 asked the nurse what the FBI (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	had said and the nurse responded the FBI said they would get back with the nurse. The incident note showed Resident #1 then stated that was because (name withheld) blocked the nurse's call to the FBI as well. The incident note showed Resident #1's behavior continued to escalate throughout the day, and Resident #1 made threats toward others. The incident note showed Resident #1 was quoted as saying, I'm going to kick these workers [explicit language] and I might not be able to control myself by hurting these elderly people. The incident note showed the nurse contacted 911 from a landline business phone and Resident #1 yelled they were trying to have the resident committed. The incident note showed Resident #1 grabbed the base of the phone and jerked hard, pulling the phone line from the wall. The incident note showed the nurse walked to the back door and again contacted 911. While on the phone with the 911 dispatcher, the nurse overheard that Resident #1 had run out the front door of the facility. The incident note showed the nurse requested police be dispatched to assist in finding the resident. An incident note for Resident #1, dated 11/06/25 at 7:54 a.m., showed the local authorities reported they had found Resident #1 but determined Resident #1 was of sound mind and so they could not force Resident #1 to return to the facility. The local authorities were reported to have left Resident #1 at a local hotel. The incident note showed the nurse argued Resident #1 exhibited delusion and hallucination daily and threatened harm to the other residents and staff, but the officers maintained they could not bring the resident back as Resident #1 was of sound mind during their interactions with the resident. The incident note showed the administrator was at the hotel attempting to get Resident #1 to return to the facility and work with them on discharge plans, but Resident #1 was adamant they did not have to return because the local authorities had informed them, they did not have to do so. The incident note showed the facility was in communication with family who attempted to contact the resident by phone. A court order for Resident #1, dated 11/10/25, showed two family members were appointed special guardianship of the person and estate for Resident #1.A state reportable incident report for Resident #1, dated 11/11/25, showed the resident ran from the facility on 11/06/25 and was involuntarily admitted to the hospital for psychiatric evaluation and treatment. A nurse's progress note for Resident #1, dated 11/19/25, showed the resident returned to the facility from an inpatient psychiatric hospital. A behavior note for Resident #1, dated 01/16/26 at 6:00 p.m., showed the nurse was making rounds but was not able to locate Resident #1 in the facility. The behavior note showed the nurse contacted the resident's family who reported they were able to locate the resident. The behavior note showed family went to the location of Resident #1 and transported the resident back to the facility. The behavior note showed the facility checked on Resident #1 every 15 minutes as an intervention for elopement.A behavior note for Resident #1, dated 01/16/26 at 7:24 p.m., showed the resident returned to the facility with blisters to the back of their hand. The behavior note showed Resident #1 reported they had burned their hand with a cigarette lighter because they did not want to come back to the facility. A state reportable incident report for Resident #1, dated 01/16/26, showed nursing staff was unable to locate Resident #1 in the facility. The report showed family was able to locate the resident on their phone, picked up the resident, and returned Resident #1 to the facility. The report showed the facility checked on Resident #1 every 15 minutes as an intervention for elopement. The report did not show Resident #1 had blisters to the back of their hand from the resident burning themselves with a cigarette lighter. The weekly skin observation for Resident #1, dated 01/26/26, showed the resident had a wound to the back of the left hand. The weekly skin observation, read in part, Multiple blister sites from resident stating she burned self. A behavior note for Resident #1, dated 02/08/26 at 6:45 a.m., showed staff would not administer the resident's medication early and Resident #1 followed the medication aide down the hall and cursed at (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	them. Resident #1 then came to the nurses' station, demanded their medication, and threatened to call the police. The behavior note showed the nurse informed the resident they were not able to administer the medications early. The behavior note showed Resident #1 returned to their room and donned a hoodie before walking out the door. The behavior note showed the nurse and other staff drove up and down the street looking for the resident. The behavior note showed local authorities found the resident at a local residence. The behavior note showed the local authorities identified the residence as a known drug house. The behavior note showed Resident #1 returned to the facility and received their morning medications. A state reportable incident report for Resident #1, dated 02/08/26, showed the resident requested medication ordered as needed but was informed it was too early to administer the medication. The report showed Resident #1 announced they would leave the facility before walking out the front door. The report showed staff contacted the local authorities and followed the resident in a vehicle until police were able to locate Resident #1 and return them to the facility. The report showed Resident #1 was already on every 15 minute checks for an indefinite period of time. An incident note for Resident #1, dated 02/09/26 at 5:45 p.m., showed the resident eloped. The incident note showed at 4:30 p.m., Resident #1 asked for medication that was unavailable and to go for a walk. The incident note showed the CMA informed Resident #1 the medication was not due yet and they were busy and unable to go with the resident on a supervised walk. The incident note showed Resident #1 informed the CMA they would go for a walk by themselves. The incident note showed the facility realized Resident #1 was not in the building at 5:00 p.m.A state reportable incident report for Resident #1, dated 02/09/26, showed the resident requested medications that were not scheduled to give and was informed they would have to wait for the medication. Resident #1 requested a supervised walk outside and was denied by staff due to the staff member's responsibilities during resident mealtime. Resident #1 stated they would walk alone. The report showed the facility was unaware of Resident #1's elopement for 30 minutes. The family found the resident approximately one mile away at a local business and escorted the resident back to the facility. The report showed the facility initiated every 15 minute observation of Resident #1 for an indefinite period of time as an intervention.A nurse's progress note for Resident #1, dated 02/11/26, showed the burn wounds Resident #1 inflicted on themselves were healed.On 02/19/26 at 5:38 p.m., LPN #1 stated Resident #1 was pretty independent but needed supervision. LPN #1 stated Resident #1 liked to leave the facility without telling anyone which was ok when the resident was their own POA but now the resident was not their own POA and could not leave the facility. LPN #1 stated as one of the interventions, they performed every 15 minute checks on the resident, which started when the resident returned from their second elopement in two days. LPN #1 stated Resident #1 had a history of illicit drug use, and the resident exhibited drug seeking behaviors in the facility. LPN #1 stated what often triggered the resident's behavior was not getting medications when they wanted them. LPN #1 stated the resident would get angry and demand medications they could not have yet. LPN #1 stated having a staff member walk outside with the resident often helped. LPN #1 stated other things that helped included listening to music in the common area. LPN #1 stated if Resident #1 was too upset, the resident would call for an ambulance or just get up and walk away from the facility. On 02/19/26 at 5:55 p.m., the DON stated they did not investigate the elopements to determine the root cause of each elopement. The DON stated they did look at the cameras to see when and how the resident eloped. The DON stated the resident did not always exit through the front door and on 01/16/26, was observed on camera to watch the activity around a back door for a time before exiting through the back door. The DON stated when they asked the staff when the resident was last seen, the staff reported it had been 10-20 minutes earlier during the administration of a (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	medication, but when they reviewed the camera footage, the medication was administered an hour earlier. The DON stated that was the date the resident purposely burned themselves with a lighter. The DON stated the police report for the elopement on 02/08/26 identified the residence Resident #1 was found in was a known drug house. The DON reviewed documentation for observation of the resident every 15 minutes. The DON stated the intervention to observe the resident every 15 minutes did not seem to be an effective intervention.