

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375284	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/10/2025
NAME OF PROVIDER OR SUPPLIER Arbor Village		STREET ADDRESS, CITY, STATE, ZIP CODE 310 W Taft Ave Sapulpa, OK 74066	
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 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on record review and interview, the facility failed to provide an environment free of accident hazards for 1 (# 69) of 20 sampled residents reviewed for accident hazards. The administrator identified 84 residents resided in the facility. Findings:A quarterly assessment, dated 02/24/25 ,showed Resident #69 had diagnoses which included anxiety and vascular dementia, and a BIMs score of 5 which indicated the resident was severely cognitively impaired for daily decision making. An elopement evaluation, dated, 03/04/25, showed a score of 9 which put Resident #2 at risk for elopement. The evaluation showed Resident #2 had a history of walking around the facility but did not exhibit exit seeking behaviors. A progress note, dated 04/24/25 at 7:00 p.m., showed dietary staff notified nursing staff Resident #2 had fallen outdoors. The progress note showed Resident #2 was transported to a hospital for evaluation. A facility incident report to the Oklahoma Stated Department of Health, dated 04/24/25, showed Resident #2 exited the facility through a propped open door and fell on the uneven ground. The report showed the resident was assessed and treated for injuries at a local hospital.On 08/07/25 at 2:20 p.m., the administrator in training #1 reported the investigation was completed by the previous administrator. They stated the investigation showed a kitchen staff member propped a side door open to take out the trash. Resident #2 walked out the propped open door, stumbled and fell resulting in cuts and abrasions. The administrator in training #1 stated the kitchen staff who propped open the door was educated on resident safety, facility policies and protocols, and allowed to return to work. On 08/07/25 at 2:20 p.m., the admissions coordinator reported the staff member should not have left the door propped open. They stated there was a reason the door was locked in the first place. They (cook #1) broke facility protocols for protecting the safety of the resident. On 08/10/25 at 1:37 p.m., [NAME] #1 stated they propped open the door to take the trash out of the kitchen, and Resident #69 walked out of the open door and fell on the ground. [NAME] #1 stated it was the first time they had propped open the door to take out the trash. They stated the door was propped open for less than a minute. [NAME] #1 stated they regretted propping open the door and would not do it again.</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: 375284
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on record review and interview, the facility failed to: a. review infection prevention control policies and procedures at least annually, b. assess locations Legionella and other opportunistic waterborne pathogens can grow and spread, c. implement measures to prevent the growth of waterborne pathogens, and d. have monitoring in place to evaluate effectiveness of water pathogen program. The administrator reported 64 residents resided in the facility. Findings A facility policy titled Legionella Surveillance, implemented on 08/22/22, did not include a plan for assessing, evaluating and monitoring the measures to prevent the growth of waterborne pathogens. On 08/07/25 at 2:20 p.m., the infection prevention coordinator was asked about annual review of policies. They stated they were not current and had not been reviewed in a few years. On 08/10/25 at 10:05 a.m., the administrator was asked about the annual review of infection control policies. They stated they could not find any documentation of any reviews. On 08/07/25 at 2:20 p.m., the infection prevention coordinator was asked about the facility assessment and evaluation for Legionella or waterborne pathogens. They stated there was not a facility assessment or evaluation in place. On 08/10/25 at 10:05 a.m., the administrator was asked if there was any documentation a facility assessment or evaluation related to Legionella or waterborne pathogens had been completed. They stated there was not any documentation they were aware of showing this had been done.</p>