STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375284	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Village	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.

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. Based on record review and interview, the facility failed to develop a comprehensive care plan for 1 (#5) of 3 sampled residents reviewed for care plans.The DON identified 65 residents resided in the facility.Findings:An undated Comprehensive Care Plans policy, read in part, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.An admission record, dated 03/05/26, showed Res #5 had diagnoses which included depression and atrial fibrillation.An admission assessment, dated 03/18/26, showed Res #5 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making. The assessment showed Res #5 was always incontinent, was at risk for developing pressure ulcers, and received an opioid pain medication.Res #5's care plan, revised on 05/22/26, did not show focus areas or interventions related to incontinence, skin integrity, or pain management.On 06/04/26 at 1:55 p.m., the MDS coordinator stated a care plan should address care areas and preferences of the resident. They stated Res #5's care plan was not complete and did not address incontinent care, skin integrity, or pain management.On 06/04/26 at 3:45 p.m., the DON stated Res #5's care plan was incomplete.

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review and interview, the facility failed to assess, monitor, and intervene to prevent worsening pressure ulcers for 1 (#2) of 3 sampled residents reviewed for pressure ulcers.The DON identified 7 residents with pressure ulcers resided in the facility. Findings:An undated Pressure Injury Prevention and Management policy, read in part, Licensed nurses will conduct a full body assessment on all residents upon admission/readmission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. Findings should include type of wound, wound measurements (measured upon discovery and at least weekly thereafter), other wound characteristics (color, exudate, odor, pain, tissue type in wound bed), and treatment and interventions implemented.An admission note, dated 01/19/26, showed Res #2 had multiple wounds upon admission including a wound to the right buttock, wound to the left gluteal fold, a wound to the left great toe, deep tissue injury to right heel, scab on the right earlobe, wound to upper lip, and a small pea-sized wound to the top of the left foot.An admission record, dated 01/19/26, showed Res #2 had diagnoses which included a stage II pressure ulcer of the left buttock, dependence on renal dialysis, and diabetes mellitus.A physician's order, dated 01/21/26, showed to clean buttocks wound with normal saline, pat dry, apply Medi-honey (sterilized honey used in wound care), apply calcium alginate (antimicrobial wound gel), cover with abdominal pad, and secure with tape daily.An admission assessment, dated 01/26/26, showed Res #2 had a stage II pressure ulcer upon admission.A weekly skin screen, dated 01/26/26, read in part, Eschar and slough to wound to buttocks Stage 2 to [left] gluteal fold scab to [right] ear Scabbing to upper lip open callous like area to [left] great toe Open area to top of [left] foot [deep tissue injury] to [right] heel A skilled nurse note, dated 01/27/26 at 6:08 p.m., showed wound care was completed as ordered and the wounds seemed to be improving. A skilled nurse note, dated 01/28/26 at 5:17 p.m., showed the wounds were improving. A skilled nurse note, dated 01/29/26 at 2:28 p.m., showed the wounds were improving. A skilled nurse note, dated 01/30/26 at 6:04 p.m., showed wound care was provided and the wounds seemed to be improving. A skilled nurse note, dated 01/31/26 at 9:15 a.m., showed wound care was provided and the wounds seemed to be improving. A skilled note, dated 02/01/26 at 5:34 p.m., read in part, Wound to right buttock noted with 95% slough, wound edges noted to be granulated tissue. During wound cleansing resident skin noted to roll back from the edges. Evidence of deterioration. Large amount of brown odoris drainage noted to previous bandage. Small open area noted to right ear lobe, skin in bed beside resident head. Doctor notified, new order for betadine to right ear lobe daily. A skilled nurse note, dated 02/02/26 at 6:22 p.m., showed wound care was provided. A weekly skin screen, dated 02/03/26, read in part, Unstageable wound to sacral region diabetic wound to [left] great toe Open area to [right] ear lobe scabbing to upper lip A skilled note, dated 02/03/26 at 4:33 p.m., showed wound care was performed with large amounts of purulent drainage (pus). The note showed the physician was notified and orders were received to obtain a wound culture and for the wound care provider to assess the wound. A nurse note, dated 02/04/26 at 4:49 p.m., showed Res #2's family wanted the resident sent to the hospital for an evaluation and treatment. The note showed the physician was notified and an ambulance was called. An Emergency Department to Hospital admission form, dated 02/04/26, showed upon admission to the emergency department, Res #2 had a large unstageable decubitus ulcer with cellulitis and severe sepsis. An operative report, dated 02/05/26, showed Res #2 underwent an excisional debridement of skin, subcutaneous tissue, and muscle. The report showed the postoperative diagnosis was a stage IV sacral wound measuring 25 cm x 18 cm x 4 cm. A review of Res #2's medical record did not show an initial assessment of Res #2's wounds had been completed, or that the wounds had been reassessed during their stay. On 06/04/26 at 7:45 a.m., the ADON stated they had written the skilled note for Res #2, dated 02/01/26 at 5:34 p.m. They stated they could not recall if they notified the physician about the drainage from Res #2's wound. On 06/08/26 at 9:50 a.m., LPN #2 stated wounds should be thoroughly assessed to (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	determine if they were improving or declining. On 06/08/26 at 10:00 a.m., the DON stated Res #2's wounds were not adequately monitored and assessed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. The 2567 had been amended based on a determination resulting from an Informal Dispute Resolution (IDR). Existence of Immediate Jeopardy (IJ) has been removed. Based on observation, record review, and interview, the facility failed to:a. ensure supervision for residents who smoke and to secure smoking materials to prevent accident hazards for 1 (#5) of 3 sampled residents reviewed for smoking; andb. prevent elopement for 1 (#7) of 3 sampled residents reviewed for elopement.The DON identified 15 residents at risk for elopement resided in the facility.Findings:1. On 06/08/26 at 8:45 a.m., Res #5 was observed to have three packs of cigarettes and a lighter on their overbed table. On 06/09/26 at 9:54 a.m., Res #5 was observed to have cigarettes and a lighter on their overbed table.An undated Resident Smoking policy showed residents would be assessed to determine if they were safe to smoke either supervised or unsupervised. The policy showed smoking materials of residents requiring supervision would be secured by staff.A baseline care plan, dated 03/05/26, showed Res #5 received oxygen therapy and was a supervised smoker. A behavior note, dated 03/16/26 at 7:00 p.m., showed Res #5 was observed smoking in their room while receiving oxygen therapy. The note showed Res #5 was placed on supervised smoking and their smoking materials were secured by the nurse; the resident was not injured.A smoking assessment, dated 03/16/26, showed Res #5 was placed on supervised smoking for safety.An admission assessment, dated 03/18/26, showed Res #5 had a BIMS score of 15 which indicated intact cognition for daily decision making.On 06/08/26 at 8:50 a.m., CMA #1 stated residents on supervised smoking could only smoke during designated smoke breaks and their smoking materials were kept in the med room.On 06/08/26 at 9:30 a.m., CNA #3 stated supervised smokers should not have cigarettes and lighters in their room.On 06/08/26 at 10:00 a.m., the DON stated residents on supervised smoking should not have smoking materials in their room. They stated Res #5's family visited this weekend and probably left the smoking materials with the resident.On 06/09/26 at 10:05 a.m., housekeeper #1 stated Res #5 was a supervised smoker, and their smoking materials should be kept in the medication room. Housekeeper #1 stated they had observed smoking materials in Res #5's room in the past.On 06/09/26 at 10:10 a.m., CNA #2 stated Res #5 was a supervised smoker and should not have smoking materials in their room. CNA #2 stated they had observed smoking materials in Res #5's room in the past.On 06/09/26 at 10:15 a.m., the ADON stated Res #5 was allowed to keep their cigarettes in their room, but they should not have a lighter in their room.2. An admission record, dated 01/30/26, showed Res #9 had diagnoses which included dementia and asthma.A significant change assessment, dated 05/15/26, showed Res #9 had a BIMS score of 0, which indicated the resident was severely impaired in cognition for daily decision making, and could walk independently. An incident report form, dated 06/06/26 at 2:30 a.m., showed the facility received a call from the police stating Res #9 was next door in the grocery store parking lot. The report showed all exit doors were secured, and the resident was assessed for injuries and placed on one-to-one supervision with staff.On 06/09/26 at 2:50 p.m., the ADON stated they were on duty when Res #9 eloped. They stated they made rounds every two hours, and they were making rounds at 2:30 a.m. when the police called and reported Res #9 was next door in the parking lot. The ADON stated they had eight staff members on duty at the time Res #9 eloped and they had checked the resident's window and all the doors in the facility were secure.On 06/10/26 at 3:10 p.m., the DON stated all the doors and windows had been inspected, and they were not sure how Res #9 got out of the building.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to ensure medications were administered as ordered for 1 (#5) of 3 sampled residents reviewed for medications.The DON identified 65 residents resided in the facility.Findings:An admission record, dated 03/05/26, showed Res #5 had diagnoses which included epilepsy and heart failure.A physician's order, dated 03/05/26, showed Res #5 was to receive 750 mg of levetiracetam (an anticonvulsant medication) twice a day by mouth for epilepsy. The order was discontinued on 03/07/26.A nurse note, dated 03/07/26 at 2:04 p.m., showed Res #5 had seizure activity at 9:50 a.m., 11:55 a.m., and 12:21 p.m. The note showed hospice arrived at 2:00 p.m. to assess the resident.A physician's order, dated 03/07/26, showed Res #5 was to receive 1000 mg of levetiracetam twice a day by mouth for epilepsy.A nurse note, dated 03/08/26 at 4:44 p.m., showed Res #5 was had seizure activity throughout the day. The note showed hospice had been notified earlier in the morning the increased dose of levetiracetam was not available in the facility. The note showed the pharmacy had reported the medication would not be delivered until the following day.A nurse note, dated 03/08/26 at 5:00 p.m., showed the medication would be delivered later that night.A MAR, dated 03/2026, showed Res #5 received 750 mg of levetiracetam on 03/07/26 at 8:00 a.m. The MAR showed Res #5 was given 1000 mg of levetiracetam on 03/09/26 at 8:00 a.m. The MAR did not show Res #5 was given levetiracetam on 03/07/26 at 8:00 p.m., 03/08/26 at 8:00 a.m., or 03/08/26 at 8:00 p.m.On 06/05/26 at 12:00 p.m., the DON stated the facility did not have documentation the levetiracetam was administered to Res #5 on the evening of 05/07/26 or the two doses on 05/08/26.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure infection control was maintained for residents with indwelling urinary catheters for 1 (#8) of 3 sampled residents reviewed for infection control.The DON identified 5 residents with indwelling urinary catheters.Findings:On 06/04/26 at 2:25 p.m., Res #8 was observed in the lobby area of the facility seated in their wheelchair with their catheter drainage bag attached to the back of their wheelchair. The bottom of Res #8's catheter drainage bag and part of the drainage tubing was observed to be resting on the floor.On 06/04/26 at 2:57 p.m., Res #8 was observed in the outside smoking area. The bottom of the catheter drainage bag and part of the drainage tubing was observed to be resting on the floor.An undated facility policy titled Indwelling Catheter Use and Removal, read in part, If an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance to current professional standards that include . Insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures.An admission record, dated 01/24/25, showed Res #8 had diagnoses which included urine retention and diabetes mellitus.A quarterly assessment, dated 05/05/26, showed Res #8 had a BIMS score of 14, which indicated the resident was intact in cognition for daily decision making. The assessment showed Res #8 had an indwelling urinary catheter.On 06/04/26 at 2:45 p.m., CNA #1 stated catheter bags and drainage tubing should be kept off the floor.On 06/04/26 at 3:00 p.m., LPN #1 stated catheter bags and drainage tubing should be kept off the floor.On 06/04/26 at 3:45 p.m., the DON stated to maintain infection control, catheter bags and drainage tubing should not be in contact with the floor.