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	08/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Village	310 W Taft Ave Sapulpa, OK 74066

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 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.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 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, andd. have monitoring in place to evaluate effectiveness of water pathogen program.The administrator reported 64 residents resided in the facility. FindingsA 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.

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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 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide a neutral and fair arbitration process and agree to arbitrator and venue. Based on record review and interview, the facility failed to ensure the arbitration agreement provided the selection of a neutral arbitrator for 3 (#2, 11, and #71) of 3 sampled residents whose arbitration agreements were reviewed.The administrator identified 63 residents had signed binding arbitration agreements. Findings:An undated Policy and Procedure for Arbitration, read in part, Arbitration: A binding process where a neutral third party [arbitrator] hears and resolves disputes outside of court.Arbitrator Selection: Arbitration will be conducted by a neutral, qualified arbitrator agreed upon by both parties.1. An Arbitration Agreement, signed by Resident #2's representative, on 05/09/24, did not show a neutral arbitrator would be utilized.An admission assessment, dated 05/17/25, showed Resident #2 had BIMS score of 15, which indicated the resident was cognitively intact for daily decision making.2. An Arbitration Agreement, signed by Resident #11 on 07/29/24, did not show a neutral arbitrator would be utilized.A quarterly assessment, dated 04/10/25, showed Resident #11 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making.3. An admission assessment, dated 06/28/25, showed Resident #71 had a BIMS score of seven, which indicated the resident was severely impaired in cognition for daily decision making.An Arbitration Agreement, signed by Resident #71's representative, on 07/21/25, did not show a neutral arbitrator would be utilized.On 08/07/25 at 2:23 p.m., the administrator stated they had reviewed the facility's arbitration agreement and stated they did not know why it did not contain verbiage a neutral arbitrator would be utilized.

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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. Based on record review and interview, the facility failed to ensure quarterly assessments were completed within 14 days of the assessment reference date for 3 (#6, 27, and #28) of 20 sampled residents whose assessments were reviewed. The administrator identified 64 residents resided in the facility. Findings: 1. A quarterly assessment, dated 06/17/25, showed a BIMS assessment had not been conducted for Resident #6 and the assessment had been completed on 07/12/25. On 08/10/25 at 10:12 a.m., the MDS coordinator stated they were unable to complete the BIMS assessment because they had completed the quarterly assessment late and they were outside of the timeframe to obtain a BIMS score. They stated the quartely MDS was completed late for Resident #6 because the previous MDS coordinator had resigned, they did not have access to complete MDS assessments for a while, and they had gotten behind. 2. A quarterly/discharge return not anticipated assessment, dated 07/01/25, showed Resident #27 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making, and the assessment had been completed late on 07/20/25. On 08/10/25 at 10:15 a.m., the MDS coordinator stated the previous MDS coordinator had resigned and they had not had access to complete MDS assessments. 3. A quarterly assessment, dated 06/29/25, showed Resident #28 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making, and the assessment had been completed late on 07/20/25. On 08/10/25 at 10:19 a.m., the MDS coordinator stated the quarterly assessment for Resident #28 was completed late because they had not had access to complete MDS assessments after the previous MDS coordinator had resigned.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on record review and interview, the facility failed to ensure assessments were submitted/transmitted within 14 days of completion for 2 (#27 and #28) of 20 sampled residents whose assessments were reviewed.The administrator identified 64 residents resided in the facility.Findings: 1. A quarterly/discharge return not anticipated assessment, dated 07/01/25, showed Resident #27 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making, and the assessment had been completed late on 07/20/25. An MDS 3.0 NH Final Validation Report, dated 08/05/25, showed the quarterly/discharge return not anticipated assessment for Resident #27, dated 07/01/25, had been submitted late. On 08/10/25 at 10:15 a.m., the MDS coordinator stated the quarterly/discharge return not anticipated had been submitted/transmitted on 08/05/25. The MDS coordinator stated they had not known how to transmit/submit assessments so the regional office had been transmitting them. 2. A quarterly assessment, dated 06/29/25, showed Resident #28 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making, and the assessment had been completed late on 07/20/25. An MDS 3.0 NH Final Validation Report, dated 08/05/25, showed the quarterly assessment for Resident #28, dated 06/29/25, had been submitted late. On 08/10/25 at 10:19 a.m., the MDS coordinator stated the quarterly assessment for Resident #28 had been submitted/transmitted late on 08/05/25. They stated the regional office had been submitting/transmitted assessments until they had learned the program for submission/transmission.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure assessments were accurate for 1 (#2) of 20 sampled residents whose assessments were reviewed. The administrator identified 64 residents resided in the facility. Findings: An admission assessment, dated 05/17/25, showed Resident #2 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making, had a diagnosis of hemiplegia, and was taking an anticoagulant during the seven-day look back period. A medication administration record, dated 05/01/25 through 05/31/25, did not show Resident #2 had received an anticoagulant medication during the look back period. On 08/10/25 at 10:05 a.m., the MDS coordinator reviewed the admission assessment, physician orders, and the medication administration record and stated the assessment had been coded in error regarding the anticoagulant medication. They stated Resident #2 had not been ordered or received an anticoagulant medication during the look back period for the assessment.

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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 ensure care plans were updated for 1 (#2) of 20 sampled residents reviewed for care plans. The administrator identified 64 residents resided in the facility. A care plan, dated 05/09/25, did not include restorative care for Resident #2.An admission assessment, dated 05/17/25, showed the Resident #2 had diagnoses which included hemiplegia and hemiparesis and a BIMS score of 15 which indicated the resident was cognitively intact. A restorative care order dated, 07/07/25, showed a resting hand splint was to be applied daily to the right hand and removed after 6-8 hours. A progress note, dated 07/07/25, documented restorative care treatment with the application of a splint to Resident #2's right hand. On 08/10/25 at 10:01 a.m. the admissions coordinator stated Resident #2 was on restorative care and the restorative aide provided the care. The admissions coordinator was asked who completed the restorative care on days the aide was not in the facility. The admission coordinator stated they would need to train someone. On 08/10/25 at 11:03 a.m., MDS coordinator #1 stated when restorative care adds a resident to their care list, they update the care plan to include the restorative care. The MDS coordinator stated Resident #2's care plan had not been updated to include restorative care.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on record review and interview, the facility failed to complete a performance review of nurse aides, hired over one year ago, at least once every 12 months for 1 (CNA #1) of 2 reviewed for performance reviews. Human resources identified 13 CNAs have been employed over one year. Findings:Review of employee training records showed one of two employee files did not have an annual performance review or skills assessment completed in past year.On 08/10/25 at 9:40 a.m., CNA #1 was asked if they had an annual performance review or skills checklist completed in past year. CNA #1 stated they only worked on the weekends and had not done anything like that, that they were aware of.On 08/10/25 at 10:05 a.m., the administrator stated they had not been doing annual evaluations until recently. On 08/10/25 at 2:36 p.m., the administrator in training stated performance and skills assessments had not been consistently done before their arrival a few months ago. The administrator in training stated they have been trying to get them all completed, but they were not sure if they had all been updated.