

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375381	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER Baptist Village of Oklahoma City		STREET ADDRESS, CITY, STATE, ZIP CODE 9700 Mashburn Blvd Oklahoma City, OK 73162	

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)
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>49701</p> <p>Based on record review and interview, the facility failed to prevent a CNA from physically restraining one resident (#4) of three sampled residents reviewed for abuse.</p> <p>A Resident/Guest Suite List, dated 10/15/24, documented 96 residents were residing at the facility and 30 of the residents were in memory care.</p> <p>Findings:</p> <p>An ABUSE, NEGLECT, MISTREATMENT AND MISAPPROPRIATION OF RESIDENT PROPERTY policy, dated February 20, 2024, read in part, Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.</p> <p>Resident #4 had diagnoses which included Alzheimer's, anxiety, depression, and cognitive communication deficit.</p> <p>A quarterly assessment, dated 07/07/24, documented the resident was severely cognitively impaired, and had wandered throughout their environment 4-6 of the last 7 days.</p> <p>An Incident Report Form, dated 09/23/24, documented that after receiving an allegation of abuse, camera playback was viewed, and CNA #1 was seen grabbing Resident #4 several times by the right arm and shirt to pull them down into a seated position. The CNA was terminated. A head-to-toe assessment was completed with zero redness, new bruising, swelling, or pain noted. Relevant History: Resident #4 resided in memory care and was independent with ambulation without an assistive device and walked frequently in their environment.</p> <p>On 09/25/24, an in-service was conducted regarding abuse, neglect, mistreatment, and misappropriation of resident property. There were 36 signatures of staff in attendance.</p> <p>On 10/15/24 at 3:36 p.m., a Performance Improvement Plan was provided that documented an in-service on abuse had been provided, and abuse would be included in their annual skills fair on 10/30/24.</p> <p>(continued on next page)</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
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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/16/24 at 10:12 a.m., the assistant administrator stated the way CNA #1 handled Resident #4 was inappropriate and CNA #1 was terminated as soon as the investigation substantiated the allegation. They stated an in-service was provided as soon as possible and a performance improvement plan was put into place.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49701</p> <p>Based on observation and interview, the facility failed to ensure enhanced barrier precautions were utilized for two of two (#1 and #3) residents observed with indwelling devices.</p> <p>A Resident/Guest Suite List, dated 10/15/24, documented 96 residents were residing at the facility.</p> <p>Findings:</p> <p>1. Resident #1 had diagnoses that included diabetes mellitus with peripheral angiopathy with gangrene.</p> <p>The initial MDS assessment, dated 09/17/24, documented Resident #1 was dependent upon staff for activities of daily living. They had a central line and were receiving antibiotics through it.</p> <p>2. Resident #3 had diagnoses that included cystitis and bacteremia.</p> <p>The quarterly MDS assessment, dated 08/27/24, documented Resident #3 was dependent upon staff for activities of daily living. They had an indwelling catheter.</p> <p>On 10/15/24 at 1:51 p.m., these resident rooms were observed to not have signage indicating enhanced barrier protections were required and there were no PPE carts observed nearby.</p> <p>On 10/15/24 at 1:59 p.m., LPN #1 stated they did not know what enhanced barrier precautions were, but they use precautions when a resident has extended-spectrum beta-lactamase (ESBL) or Clostridium difficile (CDIFF).</p> <p>On 10/15/24 at 2:30 p.m., Resident #3 stated that staff did wash their hands and wear gloves when providing catheter care but did not wear a gown.</p> <p>On 10/15/24 at 2:27 p.m., the DON stated enhanced barrier precautions are put into place when there is a confirmed diagnosis of a communicable disease.</p> <p>On 10/15/24 at 2:48 p.m., LPN #2 stated they did not know what enhanced barrier precautions were, but they knew what standard precautions and isolation precautions were.</p> <p>On 10/16/24 at 8:05 a.m., both resident rooms were observed to have enhanced barrier signage on the doors and PPE outside of the doors.</p> <p>On 10/16/24 at 8:10 a.m., Resident #1 stated staff did wash their hands and wear gloves when providing care for the central line, but the staff did not wear gowns. Resident #1 stated they had received their last dose of intravenous antibiotics yesterday.</p> <p>On 10/16/24 at 10:17 a.m., the assistant administrator stated they had put the enhanced barrier precautions into place as soon as it was brought to their attention that their understanding was incomplete.</p>		