STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375381	A. Building B. Wing	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baptist Village of Oklahoma City	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to protect 1 (#106) of 2 sampled residents reviewed for abuse. Resident #106 was physically abused by Certified Nurse Aide # 8 causing two red marks on their right leg that was tender to touch. This caused Resident #106 to be afraid of the CNA. The administrator identified 95 residents resided in the facility Findings: On 09/28/25 at 5:15 p.m., Resident #106 was observed being propelled in a wheelchair to the dining room located on the memory care unit for the evening meal. An abuse 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. An undated face sheet for Resident #106 showed they had diagnoses of chronic obstructive pulmonary disease, Alzheimer's, hypertension, and depression, A quarterly MDS, with an assessment reference date of 09/08/25 for Resident #106, showed they had a BIMS score of 05 which indicated severe cognitive impairment. The assessment showed Resident #106 required substantial assistance with chair to bed transfers and sit to stand. A behavior progress note, dated 09/20/25 at 8:35 p.m., read in part, Resident spitting, pinching, kicking, verbal abusive towards x3 CNAs refusing pericare and change Dristy [sic] clothing, unable to redirect, provided privacy. A nurse's progress note, dated 09/20/25 at 9:54 p.m., read in part, This nurse notified POA/SON [Name Deleted] of the allegations of the abuse and stated he would be by the community to see his [parent] on Sunday September 21, 2025. A nurse progress note, dated 09/20/25 at 10:17 p.m., read in part, Focus assessment rt allegation of assault. This Nurse observe x 2 red areas to the right leg , resident able to do Active ROM without pain denies pain, no s/s of distress noted call light in place. A signed statement from CNA #9, dated 09/20/25, read in part, I [CNA #9] was in the room with [CNA #8] and [Resident #106] and we were trying to change and [Resident #106] was getting aggressive and started hitting me and [CNA #8] and [CNA #8] grabbed [Resident #106's] face and twisted [their] head side to side and was grabbing [their] hands and twisting [their] fingers. Then [CNA #8] pulled [their] hair as well. After we got [them] into the bed, [Resident #106] was kicking [CNA #8] and [CNA #8] proceeded to punch [Resident #106] in the leg twice.When [CNA #8] punched [Resident #106] you could hear the punch hitting [their] leg. [CNA #8] hit [Resident #106] on the top part of [their] right leg.A signed statement from the DON, dated 09/20/25, showed the DON assessed Resident #106 for injuries from the allegation of being hit in the right leg, having hair pulled, hands being grabbed, and face being turned towards CNA #8. The statement read in part, DOHS asked [CNA #8] what happed in room [ROOM NUMBER]A with [Resident #106] tonight. [They] stated, '[Resident #106] tried to spit in my face and in reaction to the resident trying to spit in [their] face [they] hit [Resident #106].This nurse told [CNA #8] that is abuse and we will be calling the police, turning [them] into the nurse aide registry, and completing all required reports per state and federal regulations, [CNA #8] became very upset and angry and said 'you all are gonna have me arrested tonight and said [they] is leaving the community and walked toward the front doors to the receptionist desk and walked out the front door.A signed statement from LPN #5, dated 09/20/25, read in part, on 09/20/25 at aprox 2045 [8:45 p.m.] [CNA #9] reported to this nurse [CNA #8] hit resident on her leg twice, grab her hair and twisted. This nurse assess Resident observed X 2 red areas to right leg. This nurse keep eye on CNA #8 when became angry, upset left the unit. DON arrived at 2115 [9:15 p.m.] this nurse, DON and CNA #9 assess resident identify areas. A nurse's full skin assessment progress note, dated 09/21/25 at 9:15 p.m., read in part, At approximately this nurse completed a full head to toe skin assessment, [Resident #106] was noted to have two red areas on the right upper front part of [Resident #106] leg and one area [Resident #106] voiced was tender, no other skin abnormalities noted or voiced at this time. [Resident #106] was able to recall that [Resident #106] was hit and hair pulled at the time of the assessment, but was not able recall who did, but was able to state it was a guy. [Resident #106] was laughing and smiling during the entire assessment.A nurse's progress note, dated 09/23/25 at 5:34 a.m., read in part, Resident stayed up late in bed and finally fell asleep. Resident denied any pain or discomfort during the shift but only stated that areas on [their] R Tigh are tenders to touch.A nurse's progress note dated 09/23/25 at 10:15 a.m., showed the facility contacted a mental health provider to come out and evaluate Resident #106 for services after the physical abuse. The progress note also showed services were started within three for Resident #106 psychosocial well-being. A review of the memory care unit roster and skin sheets showed all residents that resided in the memory care unit received a skin assessment on 09/21/25. The skin assessments were used due to residents' cognition

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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. (continued on next page)

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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 - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, record review, and interview, the facility failed to provide safe resident transfers for 1 (#65) of 3 sampled residents reviewed for accidents. The administrator identified 95 resided in the facility. Findings: On 09/30/25 at 9:02 a.m., Resident #65 was observed to be transferred from the bed to the wheelchair. CNA #4, CNA #5, and CNA #6 were in the resident's room for the transfer. The bed was elevated, resident the repositioned from side to side with two-person max assist for personal care, peri-care and brief change. The head of bed was elevated to assist with transfer and positioning of resident. A gait belt was applied around resident, under resident chest area and upper body, it was loose fitting. During the transfer, Resident #65 was lifted under their arms for most of weight by CNA #5 and CNA #6, and the gait belt was used for positioning by CNA #4 into wheelchair. The pressure under the resident arms could cause undue stress to resident arms, under arm area and shoulders and was unsafe, as the resident center of gravity was below the staff lifting point. Resident #65 was unable to bear weight on their lower extremities, and their lower extremities were flaccid. Resident #65's arms were crossed at the center of the chest during the transfer. The resident moaned and groaned during the transfer with significant facial grimacing.A care plan, dated 09/26/25, with a functional activities section, read in part, it takes two staff assist to transfer at all times.On 09/30/25 at 9:02 a.m., during the transfer, Resident #65 was asked if they were hurting. They were unable to communicate their pain level.On 09/30/25 at 9:22 a.m., CNA #5 was asked if they felt like the transfer of resident #65 was a safe transfer for resident. CNA #5 stated they did the best they could to make it safe for the resident while getting the job done. CNA #5 was asked about education and training they had for resident transfers. CNA #5 stated they had in-services and hands on training, when hired and throughout the year. CNA #5 was asked what they would do if they felt they needed additional equipment to transfer a resident safely. CNA #5 stated they went to the charge nurse and reported difficulties they may have had and if there were any changes in the resident that may have caused them to need more assistance.On 09/30/25 at 9:24 a.m., CNA #6 was asked if Resident #64 had any recent changes that affected the amount of assistance that was required for the resident to transfer. CNA #6 stated the resident had declined over the past couple months and they were a total lift now and not able to help them at all. CNA #6 stated the hospice provider had stopped providing showers and only provided bed baths since they were not able to transfer them without being a full body lift with at least two to three staff members, and for concern for resident comfort and safety without a lift. CNA #6 was asked if they had reported the need for additional assistance with transfers such as a mechanical lift. They stated they had reported to the charge nurse and hospice staff several times over the past couple of months, and they did not feel it was safe for the resident or staff to continue with total lifts since resident was not able to help at all, and it seemed to hurt them during transfers. On 09/30/25 at 9:30 a.m., LPN #3 was asked about the process for evaluating the need for assistance with resident transfers. LPN #3 stated that transfer assistance was documented on the care plan that aides could see on the pocket care plan. LPN #3 stated the assessment was performed by the nurse on admission, and the resident needs were addressed on the care plan. LPN #3 stated the aides came to the charge nurse if there were changes or additional needs that may need to be addressed, then the charge nurse took the information to the weekly interdisciplinary team meetings and care planning meetings. If the interdisciplinary team felt changes needed to be made, they would assess the situation and update care plan. LPN#3 was asked about the training aides get for transferring residents. LPN #3 stated each new aide gets trained and it was also in annual education. LPN #3 was asked about Resident #65 and if they were aware of the difficulty aides had with transfers. LPN #3 stated the aides had come to them and they had discussed the need of a possible mechanical lift with hospice provider, and it was also taken to team meetings and ADON, but at the time they did not feel there needed to be a change in the resident transfer process. On 10/01/25 at 2:11 p.m., the DON was asked how they determined what transfer method was used for a resident. The DON stated they assessed the resident and cognition ability and assessed for whether they required multiple persons assist, stand by or if they were independent. The DON stated they would get physical therapy to assess if needed. The DON was asked if the need for additional assistance for transfers was discussed for Resident #65 in the last interdisciplinary team meeting. The DON stated last interdisciplinary team meeting note for Resident #65 was dated 09/10/25, and transfers were not documented as discussed in the meeting. The DON was asked who evaluated the resident for transfer assistance. The DON stated the ADON participated in that decision and there had been a change in ADON staff in the last few months.