STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375382	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baptist Village of Owasso	12600 East 73rd Street North Owasso, OK 74055

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the form CMS - 10055 was provided to residents with accurate information for 3 (#81, 82, and #103) of 3 sampled residents reviewed for beneficiary notices. LPN #2 stated 44 residents had discharged from skilled services between 01/01/25 and 06/23/25. Findings: 1. An undated face sheet for Res #81 showed the resident was admitted to the facility on [DATE]. A form CMS-10055, dated 12/31/24, showed Res #81 was informed the last day of their skilled services would be 12/31/24. This was the date of their admission to the facility and the form did not provide the cost of the skilled services listed. 2. An undated face sheet for Res #82 showed the resident was admitted to the facility on [DATE]. A form CMS-10055, dated 03/25/25, showed Res #81 was informed the last day of their skilled service would be 03/25/25. This was the date of their admission to the facility and the form did not provide the cost of the skilled services listed. 3. An undated face sheet for Res #103 showed the resident was admitted to the facility on [DATE]. A form CMS-10055, dated 12/06/24, showed Res #103 was informed the last day of their skilled services would be 12/06/24 . This date was prior to their admission date to the facility and the form did not provide the cost of the skilled services listed. On 06/27/25 at 1:00 p.m., LPN #1 stated they were the staff member who reviewed form CMS-10055 with the residents. They were asked what the purpose of the form was. They stated the purpose of the form was to document what their insurance covered and what day the coverage would start. They were informed the document was to alert residents of the upcoming end of coverage for skilled services paid by Medicare and to inform them of the services and costs if they chose to continue those services after coverage had ended. LPN #1 stated they were unaware that was the purpose of the form. They stated they had filled out the form incorrectly by putting in the admission dates instead of ending dates and excluding the cost of services on the forms. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/27/25 at 1:17 p.m., the administrator stated the date on CMS-10055 was not for the beginning of services but the last covered date. The administrator stated the form was to inform the residents of costs and options for continuing those services if they chose to do so. The administrator stated the form was to allow residents to make good financial decisions.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure a resident was not prescribed psychotropic medications for dementia for 1 (#69) of 5 sampled residents reviewed for unnecessary medications. The pharmacist stated 45 residents at the facility were prescribed antidepressant medications (antidepressants are psychotropic medications). Findings: A facility policy titled Baptist Village Communities Psychotropic Medication Policy and Procedure, dated 02/20/24, read in part, The indication for any psychotropic medication will be thoroughly documented in the clinical record to include an appropriate supporting diagnosis and identification of behavioral symptom(s) being treated. A physician's order for Res #69, dated 05/15/25, showed the resident had been prescribed sertraline (psychotropic medication approved for the treatment of depression) 25 mg once daily for dementia. A medication administration record, dated 06/01/25 through 06/30/25, showed Res #69 had been administered one sertraline 25 mg tablet each day starting on 06/01/25 and ending on 06/25/25 for a total of 25 doses. On 06/25/25 at 9:16 a.m., the facility's contracted pharmacist was asked if sertraline had been approved for the treatment of dementia. They stated it had not been approved for dementia, and they were trying to stay away from using psychotropics for those with dementia. On 06/25/25 at 9:56 a.m., LPN #3 was asked why Res #69 had been prescribed sertraline. They stated the active diagnosis was dementia without behavioral disturbances. They were asked for what specific symptom had the resident been prescribed the medication. They stated they did not know, but the resident was seeing a contracted behavioral service. They were asked if sertraline was approved to treat dementia. They stated they did not know. On 06/25/25 at 10:16 a.m., NP #1 stated Res #69 was taking an antidepressant for dementia and those medications were not approved for dementia. They stated the resident did have signs of depression and was seeing a behavioral health group for that. On 06/25/25 at 10:03 a.m., the DON was asked if antidepressants or any psychotropic medication had been approved for the treatment of dementia. They stated they did not know off hand, but did know they were used for various mental health disorders.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure discharge assessments were completed for 1 (#72) of 5 sampled residents reviewed for assessments. The administrator reported the facility census was 74. Findings: A discharge note, dated 02/22/25, showed Res #72 was discharged on 02/22/25. A face sheet, dated 06/25/25, showed Res #72 was admitted on [DATE]. The face sheet also showed the resident had diagnoses which included sepsis and anemia. A review of Res #72's health record did not show a discharge MDS had been completed. On 06/25/25 at 2:49 p.m., MDS coordinator #1 stated a discharge MDS had not been completed upon Res #72's discharge. They also stated they were unsure why the discharge MDS was not completed.

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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 a comprehensive care plan was updated after a resident had a fall that resulted in an injury for 1 (#69) of 18 sampled residents whose care plans were reviewed. The DON reported that 74 residents at the facility had care plans. Findings: A facility policy titled Comprehensive Care Plan Policy and Procedure, dated 02/20/24, read in part, The comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS). It will be updated quarterly, annually, with significant change, or as needed/identifies as preference changes occur or health need warrants. Res #69's care plan, dated 09/17/24, was reviewed. The care plan had a problem of falls, with past falls listed as 10/17/24, 10/27/24, 11/10/24, 12/08/24, 12/19/24, and 01/17/25. There were no falls, goals for fall prevention, or correlated interventions after 01/17/25. An admission MDS assessment, dated 04/01/25, showed Res #69 had a diagnosis of dementia and a BIMS score of 5 which indicated the resident's cognition was severely impaired. The assessment further showed the resident required supervision to stand from a chair and moderate physical assistance to walk up to 10 feet. A progress note, dated 04/27/25 at 3:13 p.m., showed staff had witnessed Res #69 rise from their chair and started walking which resulted in the resident falling to the floor striking their left hip and shoulder. On 6/27/25 at 11:40 a.m., LPN #4 was asked to describe their process for creating and updating comprehensive care plans. LPN #4 stated they updated the care plan every three months. LPN #4 stated they had updated Res #69's care plan in March 2025. LPN #4 stated the care plan showed the last fall the resident had was in January 2025, but they did have a fall in April 2025. LPN #4 was asked why the fall in April was not listed. LPN #4 stated they had been waiting for an incident report that would have new interventions on it, but so far the incident report had not made it back to them. LPN #4 was asked how they had been getting the incident reports with the interventions. LPN #4 stated the former DON had a system in place where they would get the reports to them. LPN #4 stated it ended when the former DON stopped working at the facility. LPN #4 stated they did not create interventions and still depended on those coming to them from the incident reports. LPN #4 stated the fall that occurred in April 2025 and new interventions should have been entered into the care plan. On 06/27/25 at 12:49 p.m., the DON was asked to describe the process for updating care plans. They stated, giving falls as an example, the charge nurse would assess what had occurred and add new interventions as appropriate. The DON stated in the case of Res #69's fall in April 2025, the former DON's system for updating care plans had ended with their employment and Res #69's fall had been missed. They stated not updating a care plan of a fall with injury went against their current procedures.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident did not fall from a mechanical lift during a transfer and failed to inspect the facility's mechanical lifts and slings as recommended by the manufacturer for 1 (#80) of 2 sampled residents reviewed for accident hazards The DON identified 21 residents who were routinely transferred by use of a mechanical lift. Findings: On 06/25/25 at 4:00 p.m., a mechanical lift sling the administrator identified as the one used with Res #80 when they slid out onto the floor on 06/16/25, was inspected by this surveyor. One of the blue colored loops on the sling had a cut or tear approximately ¾ inches in length from the edge and was approximately half the total width of the loop. Along the edges of the cut/tear, the material was evenly frayed with no loose fibers. There was no discoloration or other wear around the cut/tear. The remainder of the sling showed no signs of damage or wear. On 06/27/25 at 8:52 a.m., a visual and hands-on inspection of the facility's four mechanical lifts (including the one identified by the administrator as the one used when Res #80 fell) was completed by this surveyor. Each was clean, showed no signs of exterior damage, and did operate without any concerning noises or movements. An operator's manual for the brand of mechanical lifts the facility used, dated 12/2021, showed the slings used with the mechanical lifts must be inspected by a nurse or rehabilitation staff monthly for damage and excessive wear. The manual showed a permanent record of the monthly inspections should be kept by the facility and an inspection form was in the operator's manual. A facility policy titled Environmental Services Policy and Procedure, dated 02/20/24, read in part, BVC environmental team members will ensure that all necessary equipment is in working order and all necessary supplies are on hand. An admission MDS, dated [DATE], showed in Section C Res #80 had a BIMS score of 14 which indicated the resident's cognition was not impaired. The assessment showed in Section GG the resident was dependent on staff for transfers with the staff supplying all of the physical effort. A hospital imaging report, dated 06/16/25 at 11:41 a.m., showed Res #80 had a CT scan (a medical imaging procedure uses X-rays and computer technology to create detailed images of the body) performed. The report showed in the findings that the resident had a small subarachnoid hemorrhage (bleeding between the brain and the tissue that surround it). A progress note, dated 06/16/25 at 3:15 p.m., showed that on that date, Res #80 had been observed by LPN #1 to have been in a mechanical lift sling with their head laying on the leg of the lift and their legs still in the sling which was lifted above the floor. The note further described the sling having been broken on the upper right side. The note further showed the resident was transferred by ambulance to a hospital. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A progress note, dated 06/17/25 at 11:34 a.m., showed LPN #3 had spoken to an ICU nurse at the hospital where Res #80 had been transferred. The note showed LPN #3 was told by the hospital ICU nurse Res #80 had a small brain bleed. On 06/24/25 at 10:00 a.m., Res #80 was asked if they had fallen recently. The resident stated they had fallen from a mechanical lift but could not recall the exact date. Res #80 was asked to describe the details of the fall. The resident stated they could not recall any details of the fall other than it was from a mechanical lift. Res #80 was asked what they were wearing. The resident stated they could not recall. Res #80 was asked to describe the staff's performance during that incident. The resident replied the staff had done a good job getting them to a hospital. Res #80 stated they were satisfied with their care and felt safe at the facility. On 06/25/25 at 3:39 p.m., the administrator stated the two CNA's who had been operating the mechanical lift when Res #80 had fallen were CNA #3 and CNA #4. The administrator stated the staff member who was responsible for ensuring the mechanical lift slings were in good condition and trained the staff on the use of the mechanical lifts was CNA #1. The administrator was asked about CNA #1's training related to the mechanical lifts. The administrator stated CNA #1 had read the operator's manual before instructing other staff. On 06/25/25 at 3:40 p.m., the DON stated they had observed and checked off on CNA #1's proficiency in the use of the lifts. On 06/27/25 at 9:47 a.m., CNA #4 was asked to describe what had occurred the day Res #80 had fallen during the transfer with the mechanical lift on 04/16/25. The CNA stated before using the sling, they had inspected it and had not seen the broken loop. CNA #4 stated when they placed the sling on the lift, they used the blue loops for the head and green loops for the bottom. The CNA stated once the resident was inside the sling, they lifted the resident from the bed and moved the lift to a position where they could lower the resident into a chair. CNA #4 stated it was at that time the resident had slid from the sling onto the floor. CNA #4 stated they then went to alert LPN #1 about the fall. The CNA stated the resident had been wearing pajamas made from very slick material and believed that was why the resident slid out of the sling. On 06/27/25 at 10:13 a.m., LPN #1 was asked to describe the events of Res #80's fall on 06/16/25. The LPN stated they had been called to Res #80's room by CNA #4 and when they entered, they observed Res #80 with their head on the ground and feet in the sling of the mechanical lift. LPN #1 stated when they entered the room, the sling was not connected to the lift on the end where the resident's head would been. The LPN stated they had assessed the resident and facilitated their transfer to a hospital. LPN #1 stated the resident was conscious during the time they were in the room. LPN #1 stated the hospital had found Res #80 had a brain bleed and the resident was in the ICU for a few days before returning to the facility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 06/27/25 at 10:24 a.m., CNA #3 was asked to describe the events around Res #80 fall on 06/16/25. The CNA stated they had assisted CNA #4 transfer Res #80 from their bed to a chair. CNA #3 stated they were at the resident's feet and CNA #4 was on the resident's left side with one hand on the sling next to the resident's head and their other hand on the controls of the lift. The CNA stated the blue loops of the sling where the resident's head was and green loops where their feet were. CNA #3 stated when they maneuvered the lift from the bed toward the chair, they heard a popping sound and observed the resident slide from the sling headfirst. The CNA stated the resident's head ended up on the floor and their feet remained in the sling. CNA #3 stated the blue loop on the sling where CNA #4 had been holding it was found to have a break. CNA #3 was asked if any of the sling loops had come free of the lift. The CNA stated all the loops had remained attached to the lift when the resident had slid out of the sling. On 06/27/25 at 10:51 a.m., the maintenance supervisor stated Maintenance #1 was supposed to do monthly checks on the mechanical lifts, but they were not done in April 2025 or May 2025. On 06/27/25 at 11:00 a.m., Maintenance #1 was asked to describe their care of the mechanical lifts and slings. They stated there was a time when all of the mechanical lifts they used were rented and they believed they were not supposed to inspect those. Maintenance #1 stated they guess they were wrong about that. Maintenance #1 stated they did not inspect the mechanical lifts in April 2025 and May 2025 because they were rentals. They stated they knew the monthly inspections of the mechanical lifts and the slings were recommended by the manufacturer. Maintenance #1 stated they did not inspect the slings which were done by the nurses. They stated the sling used when Res #80 fell from the mechanical lift had been taken out of service that day and removed from the building. On 06/27/25 at 11:19 a.m., CNA #1 stated they had conducted inspections of the mechanical lift slings during the past year, but they had never documented those inspections. CNA #1 stated there was no documentation of sling inspections before June 2025.

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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 EBP were in place during catheter care for 1 (#73) of 2 sampled residents reviewed for indwelling urinary catheters. The DON reported 6 residents in the facility with indwelling urinary catheters. Findings: On 06/27/25 at 10:55 a.m., CNA #2 was observed providing catheter care to Res #73. The CNA was not observed to be wearing a gown. A sign was observed on the resident's door that showed the resident was on EBP. A facility policy titled Baptist Village Communities Policy and Procedure for Personal Protective Equipment Use to Prevent Spread of Multidrug-resistant Organisms, dated 02/20/24, read in part, For EBP, team members will employ targeted gown and glove use during high contact resident care activities. EBP may be indicated for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status. An admission assessment, dated 05/27/25, showed Res #73 had a BIMS score (a test for cognitive function) of 12, which was indicative of moderate cognitive impairment. The assessment showed Res #73 had an indwelling urinary catheter. On 06/24/25 at 9:20 a.m., Res #73 stated the staff usually did not wear gowns while providing care. On 06/27/25 at 11:10 a.m., CNA #2 stated they should have been wearing a gown while providing catheter care to Res #73. On 06/27/25 at 11:15 a.m., LPN #1 stated a gown should be worn while providing direct care to a resident on EBP. On 06/27/25 at 12:05 p.m., the DON stated a gown should be worn while providing catheter care.