STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375525	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franciscan Villa	17110 East 51st Street Broken Arrow, OK 74012

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure the interdisciplinary team determined a resident could safely self-administer a topical medication for 1 (#2) of 6 sampled residents reviewed for medication administration.The administrator identified 86 residents resided in the facility. On 03/09/26 at 1:06 p.m., Resident #2 was observed to have antifungal cream on their bedside table.An undated Resident Self-Administration of Medication policy read in part, A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered.The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment Form, which is placed in the resident's medical record.A physician's order for Resident #2, dated 10/12/25, showed antifungal external cream 2%. Apply to groin topically every shift for redness.A quarterly assessment, dated 12/27/25, showed that Resident #2 had a BIMS score of 13 indicating intact cognition; had diagnoses which included hemiplegia or hemiparesis and chronic kidney disease stage 3.There was no self-administration of medication assessment or physician order to self-medicate found in the electronic medical record.On 3/11/26 at 8:55 a.m., LPN #1 stated they did not know who gave Resident #2 their antifungal cream. LPN #1 stated if the residents were cognitively intact, they could get an order for the resident to apply the creams themselves. LPN #1 stated Resident #2 did not have an order to self-apply, but they could call the physician and get one. On 3/11/26 at 10:15 a.m., the administrator stated they were unable to locate a medication self-administration assessment for Resident #2.

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interview, the facility failed to ensure that a resident's behavior was monitored and documented according to the physician's order for 1 (#1) of 1 sampled resident reviewed for behavior monitoring.The administrator identified 86 residents resided in the facility.An undated Suicide Threats, policy, read in part, If the resident remains in the facility, staff will monitor the resident's mood and behavior and update care plans accordingly, until a physician has determined that a risk of suicide does not appear to be present. Staff shall document details of the situation objectively in the resident's medical record.An admission assessment for Resident #1, dated 01/11/26, showed the resident had a depression score of 8 which indicated mild depression and intact cognition.A physician order for Resident #1, dated 01/13/26, showed Oxycodone (an opioid) 10-325 mg every 6 hours for pain.A Brief Trauma Questionnaire for Resident #1, dated 01/20/26, showed the resident had denied any history of being in a war zone, a serious car accident, a major natural disaster, a life-threatening illness, physically beaten, pressured into unwanted sexual contact, violent death of someone close to them, or a situation where they feared serious injury or death to themselves or others.A quarterly RN pain assessment for Resident #1, dated 01/26/26, showed the pain medication for Resident #1 was effective and their tolerable pain level was a 3. The assessment showed Resident #1 requested to have their tizanidine (a muscle relaxer) changed to alternate with the Oxycodone (opioid) and Tylenol (pain reliever) to allow for pain medications every 3 hours.On 02/12/26, the psychiatric nurse ordered changes to Resident #1's medications. Austedo XR (for involuntary movement disorders) increased from 24 mg to 30 mg by mouth daily. Aricept (for dementia) was discontinued due to ineffectiveness and Namenda (for dementia) 5 mg twice daily by mouth was started. Effexor (major depression) decreased from 150 mg to 75 mg by mouth daily for 14 days, then discontinued. Wellbutrin XL (major depression) 150 mg to start in 7.On 02/24/26, Vraylor 1.5 mg (for mild depression) was discontinued by the psychiatric nurse.On 03/04/26 at 6:44 p.m., a behavior note written by the ADON documented the suicide hotline had notified the facility Resident #1 had called and reported feeling isolated and contemplating ending their life. The note showed the ADON was notified by the suicide hotline Resident #1 had disclosed hoarding acetaminophen with the intent to use it for self-harm. The note showed immediate interventions were conducted. The note showed Resident #1 expressed a desire to get out of bed for at least one hour after lunch, either in the common area or the activities hall, to increase social interaction. The note showed Resident #1 requested a shower, aligning with their scheduled shower day, and the aide was instructed to assist with bathing. The note showed Resident #1 acknowledged having the acetaminophen but confirmed it was unused. The note showed family member #1 was present during the discussion, was asked to take the bottle home, and was informed that acetaminophen was ordered and remained available at the facility as needed. The note showed the psychiatric nurse was notified and would visit Resident #1during the next rounding. The note showed the director of nursing had also been informed and was aware of the situation. The note showed an order for behavior monitoring was put into place.An Incident/Accident Report, dated 03/04/26 at 10:00 p.m., showed the ADON was notified by the suicide hotline Resident #1 was contemplating ending their life. The report showed during the assessment, the ADON discovered Resident #1 had a bottle of acetaminophen (a pain reliever) at the bedside and expressed a desire for more activities and a change in their shower schedule. The ADON noted family member #1 was at Resident #1's bedside. The ADON educated Resident #1 and family member #1 that medications were not permitted to be kept at the bedside, and family member #1 agreed to remove them. The ADON agreed to assist with activities and get the shower schedule changed. The ADON notified the DON and they determined Resident #1 no longer had access to means for self-harm. The psychiatric nurse was notified and behavior monitoring was ordered. The suicide hotline called again later (same day) and LPN #3 immediately went to assess Resident #1 who was found to have family member #1 at their bedside. Resident #1 and family member #1 told LPN #3 the crisis had passed and (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	declined to go to the hospital for an evaluation. LPN #3 made sure Resident #1 had the call light. Shortly after, Resident #3 (Resident #1's roommate) reported Resident #1 was shaking a pill bottle and threatening to take them all. LPN #3 found Resident #1 with an empty pill bottle and 911 was called to transport Resident #1 to the hospital.On 03/04/26 at 10:06 p.m., an order to monitor episodes of sadness, suicidal tendencies, suicidal thoughts, agitation, document all findings and notify the provider immediately was transcribed by the ADON. The order had a start time of 7:00 p.m. A nurse progress note written by LPN #3 for Resident #1, dated 03/04/26 at 10:55 p.m., documented Resident #1 had called the crisis line and stated they were going to overdose. The note showed LPN #3 checked on Resident #1 who was in the room with family member #1 at the bedside. The note showed Resident #1 stated they were fine and did not want to go to the hospital, but they were hungry. The note showed Resident #1 was offered a snack. The note showed Resident #1 wanted to be pulled up in bed, so LPN #3 with the assistance of family member #1 pulled Resident #1 up in bed and provided the call light. The note showed LPN #3 called the crisis line back to let them know Resident #1 was okay. The note showed about 20 minutes later, Resident #1's roommate came out and told staff Resident #1 was shaking a pill bottle and talking on the phone saying they were going to take them all. The note showed LPN #3 entered the room and found the pill bottle empty. The note showed Resident #1 stated they had the acetaminophen in their table for a month. The note showed Resident #1 was sent to emergency room for evaluation and the ADON was notified.On 03/09/26 at 12:32 p.m., Resident #3 stated they went to the nursing station because their roommate had the bottle in their hand saying they were going to take them all and do whatever it took to get out of the facility. Resident #3 stated Resident #1 had never previously threatened to self-harm prior to that day. Resident #3 stated Resident #1's family member was there earlier, but not at the time Resident #1 said they were going to overdose. Resident #3 stated after LPN #3 and another staff member came and assessed Resident #1, the ambulance arrived soon after. On 03/09/26 at 3:19 p.m., family member #2 stated via phone interview Resident #1 received a bed bath around 6:00 p.m. on that night. Family Member #2 stated Resident #1 was hurting more that day and the pain medications were not cutting it. Family Member #2 stated Resident #1 had told family member #1 to bring the acetaminophen for their back. Family member #2 stated [Resident #1] did not want to live that way anymore, and had historically gone back and forth on whether they wanted to give up or stay alive for their family. Family member #2 stated I don't know if anyone in the facility knew [Resident #1] was suicidal, but before I put [Resident #1] in the facility, [Resident #1] used to say [they] was tired of it and didn't know if [they] could do it.On 03/10/26 at 8:45 a.m., the administrator stated the ADON was terminated for not following protocol. The administrator stated they were unable to find behavior monitoring documentation. The administrator stated family member #1 had been instructed to take the medication home, but they forgot. The administrator stated Resident #1 was assessed and because they were bed bound and staff believed the family member would do as they agreed and take the medication home, they believed the risk had been removed.On 03/10/26 at 10:04 a.m., CNA #1 stated they were instructed to give Resident #1 a bed bath around 5:45 p.m. and the bath took around 45 minutes. CNA #1 stated Resident #1 was not acting suicidal during the bed bath, but Resident #1 did often complain of pain and wanted to be repositioned in the bed. CNA #1 stated family member #1 returned to the room and assisted CNA #1 to move Resident #1 up in bed. CNA #1 stated Resident #1 denied further needs, so they left Resident #1 with family member #1 at their bedside. CNA #1 stated they observed a bottle of Tylenol on the bedside table but was told the family member #1 was going to take it home with them. CNA #1 stated Resident #1 always wanted more pain medications but would fall asleep mid-sentence. CNA #1 stated they believed they left the room around 6:45 p.m.On 03/10/26 at 10:31 a.m., family member #1 stated via phone Resident #1 was in a lot of pain and really depressed and had a bottle of aspirin that I forgot to take home with me. Family Member #1 stated they left to get something to eat and were notified of the overdose in less than half an hour after they left the facility. Family Member #1 stated they knew Resident #1 wasn't happy and was hurting all the (continued on next page)

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