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	06/30/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed report no later than two hours to the OSDH and other official agencies after an allegation of abuse was made for 1 (#3) of 5 sampled residents reviewed for abuse. The DON identified 101 residents resided in the facility. Findings: An undated facility policy titled Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, read in part, The facility will report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required. A care plan for Resident #3, dated 09/02/20, showed the resident had diagnoses which included chronic pain syndrome, rheumatoid arthritis, and major depressive disorder. The care plan showed Resident #3 needed assistance with daily care needs. A quarterly assessment for Resident #3, dated 05/14/26, showed the resident had a BIMS score of 11 which indicated they were moderately impaired cognitively. The assessment showed Resident #3 was incontinent of bowel and bladder. The assessment showed Resident #3 was dependent on staff for personal hygiene. An OSDH initial incident report, with an incident date of 05/17/26, showed an allegation of abuse for Resident #3. The report showed OSDH received the report on 05/20/26 at 11:41 a.m. There was no documentation Adult Protective Services or the Nurse Aide Registry was notified. An OSDH final incident report, with an incident date of 05/18/26, showed an allegation of abuse for Resident #3. The report showed Adult Protective Services and the Nurse Aide Registry was notified. There was no documentation Adult Protective Services or the Nurse Aide Registry was notified. On 06/26/26 at 12:33 p.m., the DON reviewed the investigative documentation for the incident for Resident #3. The DON stated the ADON reported and completed the investigation for the allegation of abuse for Resident #3. The DON stated the ADON did not report the allegation of abuse within the two-hour required time frame to the OSDH. The DON stated the ADON did not notify Adult Protective Services or the Nurse Aide Registry of the incident. The DON stated the ADON should have notified the OSDH within the two-hour time frame and the ADON did not know how to notify the Nurse Aide Registry regarding the incident. The DON stated they thought when the incident report was sent to the OSDH, Adult Protective Services was also notified. The DON stated they did not know the Adult Protective Services required a separate notification. On 06/26/26 at 2:00 p.m., the ADON reviewed the investigative documentation regarding the incident for Resident #3. The ADON stated they did not recall when or what day the allegation of abuse was reported. The ADON stated if the incident was a resident-to-resident incident or an injury was sustained the incident would be reported to the OSDH within two-hours, otherwise the incident could be reported within 24 hours. The ADON stated they did not know how to notify the Nurse Aide Registry of an incident regarding a certified nurse aide.

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

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	06/30/2026

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to thoroughly investigate an allegation of abuse for 2 (#1 and #3) of 5 sampled residents reviewed for abuse. The DON identified 101 residents resided in the facility. Findings: A facility policy titled Abuse, Neglect, and Exploitation, revised 11/2024, read in part, An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect or exploitation occur.Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations . Providing complete and thorough documentation of the investigation 1.A care plan for Resident #1, revised 10/10/25, showed the resident had diagnoses which included impulse disorder, persistent mood disorder, and anxiety disorder. A quarterly assessment for Resident #1, dated 03/29/26, showed the resident had a BIMS of 13 which indicated no cognitive impairment. The assessment showed Resident #1 did not have behaviors during the lookback period. An OSDH initial incident report, with an incident date of 05/24/26, showed Resident #1 was hit in the face by another resident. The report showed there was a small open area with a small amount of blood noted. On 06/26/26 at 11:05 a.m. the DON stated there were no documented resident or staff interviews for the incident on 05/24/26 regarding Resident #1. The DON stated per the incident it was a resident-to-resident abuse allegation. The DON stated there was no investigative interview documentation to determine what had occurred for the incident. On 06/26/26 at 11:52 a.m., the administrator stated it was not their practice to keep documented interviews obtained. They stated they just documented on the state incident report the investigation was completed.2. A care plan for Resident #3, revised 10/23/25, showed the resident had diagnoses which included chronic pain syndrome, rheumatoid arthritis, and major depressive disorder. A quarterly assessment for Resident #3, dated 05/14/26, showed the resident had a BIMS of 11 which indicated moderate impaired cognition. The assessment showed Resident #3 was incontinent of bowel and bladder. The assessment showed Resident #3 was dependent on staff for personal hygiene. An OSDH initial incident report, with an incident date of 05/17/26, showed an allegation of physical abuse for Resident #3. There was no documentation regarding interviews with the person who reported the allegation of abuse, the alleged perpetrator, or others who might have had knowledge of the allegation. On 06/25/26 at 2:50 p.m., the DON reviewed the investigative documentation for the allegation of abuse on 05/17/26 regarding Resident #3. The DON stated there were no documented resident interviews or staff interviews regarding the allegation of abuse. The DON stated the investigation was completed by another staff member. The DON stated they would have investigated the allegation of abuse differently. The DON stated they would have asked more questions, dated and signed the documents obtained, and completed interviews with staff. On 06/25/26 at 3:15 p.m. the administrator stated they were the abuse coordinator for the facility. The administrator stated they were responsible for the final review for an investigation for an allegation of abuse. The administrator stated they felt like a thorough investigation had been completed.