STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375109	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Villa Care & Rehab Center	1244 Woodland Loop Drive Bartlesville, OK 74006

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review and interview, the facility failed to ensure staff announced their presence in a resident's room while the resident was using the bathroom for 1 (#2) of 3 sampled residents reviewed for dignity.The DON reported 77 residents resided at the facility.Findings:An undated facility policy titled Resident Rights, read in part, Prior to entering a resident room, always knock and identify yourself. CNA #1's signature was written on the bottom of the policy document under a statement of acknowledgment and agreement to comply with the policy. CNA #1's signature was dated 10/06/23.An undated facility training document titled Course Results Report showed CNA #1 had completed and passed a training course on resident rights on 02/25/25.A progress note for Res #2, dated 02/25/25 at 6:28 p.m., showed the resident had been angry about something that occurred in their bathroom and the resident threatened to contact the state about whatever had occurred. The note showed the resident repeatedly told staff members to leave them alone before they did so.On 08/14/25 at 7:27 a.m., CNA #1 was asked if they were aware of an incident regarding Res #2 and privacy issues. CNA #1 stated on 02/25/25 there had been an incident where they and two nurse aide students had entered the resident's room without alerting them the students were there. CNA #1 stated they had knocked on the resident's door and entered the room with the students. They stated they had said Hey to the resident and the resident replied back in the same manner. They stated the resident's bathroom door was open, and they went to the door. CNA #1 stated the resident was on the toilet and when they looked up the resident saw all of them and became angry. They stated the resident said they did not want them (the students) to watch them and that they did not want an audience. CNA #1 stated they repeatedly apologized to the resident and sent the students from the room. They stated the resident remained upset and angry about the incident the rest of the day. CNA #1 was asked their thought on how the resident would have felt about the incident. CNA #1 stated if they were in a nursing home they would be ok with the students being there. They stated at the time they thought they had provided the resident with privacy and treated them with dignity, but afterward they rethought about what had occurred. They stated they now know they did not provide the resident with privacy and had not treated the resident in a dignified manner.On 08/14/25 at 8:42 a.m., the DON was asked to describe the incident that had occurred regarding Res #2 and CNA #1 on 02/25/25. The DON stated CNA #1 had entered the resident's room without informing the resident who was coming into the room. They stated the resident was on the toilet at the time and was upset the CNA and students had seen them on the toilet. They then stated the nurse aides had been trained upon hire and during the year about resident rights. They had been instructed to knock on a resident's door and announce themselves before entering. The DON stated they had been told by CNA #1 they had entered Res #2's room without telling them the students were coming into the room. They stated CNA #1 and the students should have informed the resident they were all entering the room.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to ensure a thorough investigation was completed following the discovery of an injury of unknown origin for 1 (#3) of 3 sampled residents reviewed for injuries of unknown origin.The administrator identified one resident with an injury of unknown in the past six months. Findings:Res #3's progress notes were reviewed for the period 04/01/25 through 04/31/25. The review showed no documentation of a bruise having been found on Res #3.A skin assessment for Res #3, dated 04/11/25, conducted by LPN #2, showed the resident did not have a bruise on their forehead at that time.An undated incident report showed Res #3 had been found to have a bruise on their forehead and the injury was of an unknown origin. A time stamp on the incident report showed the Oklahoma State Department of Health had received the incident report on 04/12/25.A facility policy titled Abuse, Neglect, and Exploitation, dated 04/29/25, read in part, The facility will initiate an investigation at the time of any finding of potential abuse or neglect to determine cause and effect and protection to any alleged victims to prevent harm during the continuance of the investigation.On 08/13/25 at 1:38 p.m., the administrator was asked about their investigation of Res #3's bruised forehead discovered on 04/12/25. They stated they could not interview residents in the case of Res #3 as they lived in a memory care unit. They stated they did interview staff, and they had written statements from two hospice employees that had worked with Res #3 and the facility nurse (LPN#1) who was on duty when the bruise was found. They were asked if they had spoken with any other facility staff who worked with the resident. They stated they had talked to some staff members, but had not documented any of those interviews. They stated they should have documented their investigation. They were asked if they had discovered when or how the resident's forehead was bruised. They stated they had not discovered what had occurred or when.On 08/14/25 at 11:24 a.m., LPN #2 was asked if they had worked with Res #3 around the time the resident had been found to have a bruised forehead. They stated they had, and they had performed a head-to-toe skin assessment of Res #3 on 04/11/25. They stated they did not observe any injury to the resident's forehead on that date. LPN #2 was asked if they had been interviewed about Res #3's bruised forehead. They stated no one had spoken to them about it. They were asked if the administrator or DON had talked to them about the injury after it was found. They stated they had not talked to them about it.On 08/14/25 at 12:41 a.m., the DON was asked if the facility had discovered what had happened to Res #3 that caused the bruise. They stated they had not. The DON stated they had not conducted a thorough investigation and should have interviewed and documented more interviews with the facility staff.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents and their representatives were provided with a written notice of transfer prior to transferring to an acute care hospital for 3 (#1, 4, and #7) of 3 sampled residents reviewed for discharges.The DON identified 64 residents had been transferred from the facility to a hospital on and between 02/14/25 and 08/14/25.Findings:A facility policy titled Discharge/Transfer-Involuntary, dated 11/01/18, read in part, If transferred to another health care facility upon order of the physician, a transfer form is completed, and a copy is sent with the resident.1.A progress note for Res #1, created date 03/27/25 at 4:39 p.m., written by the administrator, showed they were called to the facility on [DATE] at 10:55 a.m. by the ADON who reported Res #1 was being aggressive. The note showed Res #1 had been transferred to an acute care hospital on [DATE].On 08/13/25 at 9:30 a.m., the DON was asked what information was sent with a resident when they transferred to a hospital. They described the process for transferring and the forms that went with the resident. They did not mention a written letter of transfer. The DON was asked if Res #1 had received a written notice of transfer when they were transferred to a hospital on [DATE]. The DON stated the facility had not given Res #1 or their representative a written notice of transfer for that transfer.2.A progress note for Res #4, dated 07/25/25 at 11:24 a.m., showed Res #4 had been found with decreased blood oxygen saturation and decreased level of consciousness. The note showed the resident was transferred to an acute care hospital.3.A progress note for Res #7, dated 08/05/25 at 6:01 p.m., showed Res #7 had reported unusual physical discomfort and was found to have difficulty standing. The note showed the resident was transferred to an acute care hospital.On 08/13/25 at 9:50 a.m., the DON was asked if Res #4 or their representative had received a written notice of transfer when the resident was sent to an acute care hospital on [DATE], and if Res #7 or their representative had been given a written notice of transfer when the resident was sent to an acute care hospital on [DATE]. The DON stated there were no written notices of transfer given to any of those individuals.On 08/14/25 at 12:44 a.m. the DON was asked to explain when the facility would give a written notice of transfer to a resident. They explained they had been unaware they were required to give a written notice of transfer to residents or their representatives prior to being transferred to a hospital. They stated they had not been giving those statements at the facility.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on record review and interview, the facility failed to ensure a resident received a head-to-toe physical assessment after being found to have an injury of unknown origin for 1 (#3) of 3 sampled residents reviewed for injuries of unknown origin.The administrator identified one resident who was found to have an injury of unknown origin from 03/01/25 through 08/13/25.Findings:An addendum to a final incident report written by the facility administrator, dated 05/15/25, showed the administrator had become aware of Res #3's bruised forehead on 04/12/25, after a family member of the resident showed the bruise to them.On 08/14/25 at 10:35 a.m., the DON was asked for the progress notes related to the bruise found on Res #3's forehead on 04/12/25. They stated they did not know why, but there were no progress notes regarding the resident's bruise. They stated there were no skin assessments for that day in Res #3's medical record. The were asked who the nurse on duty was that day. The DON stated LPN #1 was on duty that day.On 08/14/25 at 10:40 a.m. , LPN # 1 was asked if they had been on duty when the bruise on Res #3's head was found. They stated they were on duty on the day the bruise to Res #3's forehead was found. They were asked to describe what they saw and did when the bruise was discovered. They stated they did not recall exactly, but it was one of the resident's family members who pointed out the bruise. LPN #1 was asked if they could describe the bruise. They stated it was about nickel size and looked several days old. They were asked if they had found any other injuries that day. LPN #1 stated they had not assessed the rest of Res #3's body that day. They stated that at that time they were not aware they should have assessed the rest of the body when they discovered a new injury. They were asked where the documentation of the resident's forehead assessment. They stated at that time they had been unaware that they should have documented their assessment so, they had not documented their observations of Res #3 on that day. On 08/14/25 at 12:46 p.m., the DON stated LPN #1 had not followed their training and should have assessed Res #3 to ensure there were no other injuries.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on record review and interview, the facility failed to ensure a resident received medications as prescribed by a nurse practitioner for 1 (#1) of 3 sampled residents reviewed for unnecessary medications. The DON identified 77 residents were prescribed and administered medications in the facility.Findings:A facility policy titled Physician Orders, dated 09/28/22, read in part, To provide guidance and ensure Physician Orders are transcribed and implemented in accordance with Professional Standards, State and Federal Guideline, .Physician orders shall be provided by Licensed Practitioners (Physicians, Nurse Practitioners, and Physician's Assistants) authorized to prescribe Orders.A medication order written by NP#1, dated 03/20/25, showed Res #1's Seroquel (an antipsychotic medication) order was to be decreased to 25mg at bedtime and Trazadone (an antidepressant medication) 50mg at bedtime was to be started as a new medicine for the resident.A March 2025 MAR for Res #1 showed on 03/20/25, 03/21/25, and 03/22/25 the resident had been administered Seroquel 50mg once daily at bedtime although the medication was ordered to be reduced to 25mg at bedtime on 03/20/25 by NP #1. The MAR also did not have the medication Trazadone 50mg added to it although the medication had been ordered by NP #1 on 03/20/25. This resulted in Res #1 not receiving doses of the Trazadone on 03/20/25, 03/21/25, and 03/22/25.On 08/13/25 at 11:23 a.m., the DON was asked about Res #1's order for Seroquel that was prescribed for dementia. The DON stated they had an order to decrease the medication from 50mg to 25mg from a nurse practitioner, dated 03/20/25. They stated the resident arrived with that order and they intended to wean them off the medication. They stated they were off when the order came in, but the ADON was on duty.On 08/13/25 at 11:33 a.m., the DON was asked why Res #1's current MAR showed the resident had continued to receive Seroquel 50mg at bedtime when NP #1 had ordered it to be reduced to 25mg at bedtime. The DON stated that prior to taking some time off they had instructed the ADON to hold off implementing any psychotropic medications (medications use to treat various mental health disorders) while they were gone. They were asked why Trazadone 50mg at bedtime was not added to the resident's medication regimen when it had been ordered by NP#1. They stated they told the ADON they would take care of those orders when they returned. They stated by the time they had returned from their time off, Res #1 had been discharged from the facility.On 08/13/25 at 11:41 a.m., the ADON was asked why they had not implemented the medication orders from NP #1 for Res #1 on 03/20/35. The ADON stated they were told by the DON not to implement psychotropic medications while they were off work. They stated they put those in a folder for the DON to take care of when they returned. On 08/14/25 at 12:37 p.m., the DON stated they felt it was probably not in the best interest of the resident to hold those orders until they had returned from their time off.