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	01/14/2025

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270 Based on record review and interview, the facility failed to ensure a discharge MDS assessment was transmitted in the required time frame for one (#76) of 27 sampled residents reviewed for MDS assessments. The administrator stated 82 residents resided at the facility at the time of entry. Findings: A facility policy titled MDS 3.0, dated 04/25/19, read in part, The Minimum Data Set (MDS) is a standardized comprehensive assessment of all residents in Medicare or Medicaid certified facilities mandated by federal law (P.L.100-203) to be completed and electronically transmitted to CMS in compliance with the guidelines provided in the MDS 3.0 RAI User's Manual. An admission record found in the electronic health record of Resident #76 documented the resident was admitted to the facility on [DATE]. A minimum data set discharge reporting form, dated 09/20/24, documented Resident #76 discharged from the facility on 09/20/24 and was not anticipated to return. A review of Resident #76's electronic health record revealed a discharge MDS was not transmitted in the required time frame. On 01/13/25 at 3:41 p.m., MDS coordinator #1 stated the discharge MDS for Resident #76 was transmitted late. They stated it had been transmitted on 01/11/25. They stated they believed they made an incorrect selection on the electronic form that gave the choice to sent or not send the document to CMS. They stated they discovered the error when they received a report from a regional employee and it documented the discharge record had not been submitted. They stated they also ran that particular report monthly and did so in December 2024, but did not see the error on that or previous reports.

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
	375109	A. Building B. Wing	01/14/2025

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 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. 42171 Based on observation, record review, and interview, the facility failed to ensure physician orders were followed for insulin administration for one (#31) of one sampled resident reviewed for insulin administration. The DON reported 19 residents received insulin. Findings: Resident #31 had diagnoses which included diabetes mellitus and major depressive disorder. A physician order, dated 04/10/23, documented Resident #31 was to receive insulin aspart per a sliding scale. For a blood sugar between 150 and 175 the resident was to receive one unit of insulin. For a blood sugar between 176 and 200 the resident was to receive two units of insulin. For a blood sugar of 201 to 225 they were to receive three units of insulin. On 01/13/25 at 11:07 a.m., LPN #1 was observed performing a finger stick blood sugar on Resident #31. The residents blood sugar was 213 milligrams per deciliter. LPN # was then observed to inject two units of insulin subcutaneously into Resident #31's abdomen. On 01/13/25 at 11:20 a.m., LPN #1 stated according to the sliding scale order, the resident should have received three units of insulin, but they had only administered two units of insulin. On 01/13/25 at 11:40 a.m., the DON stated physician orders should be followed.

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	01/14/2025

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 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** 34270 Based on record review and interview, the facility failed to ensure a certified nurse aide did not attempt to transfer a resident from a bed to a wheelchair by themselves for a resident that required a two person lift for one (#16) of three sampled residents reviewed for falls. The DON stated there were 19 residents at the facility that required two staff members for transfers. Findings: A facility policy titled Fall Management, read in part, To provide an environment that remains as free of accident hazards as possible. The Facility will complete a Morse Fall Scale Evaluation on Residents to determine who are at risk for falling and to develop appropriate interventions to provide supervision and assistive devices to prevent to minimize further Falls and/or reduce injuries. Resident #16 had diagnoses which included hemiplegia and hemiparesis. A care plan intervention, dated 08/05/24, documented the resident required the assistance of two staff members when transferred. A quarterly MDS assessment, dated 10/11/24, documented the resident was dependent on staff for tranfers between their bed and a chair. A care plan intervention, dated 10/21/24, documented the resident required a mechanical lift for all transfers. An incident note, dated 12/16/24 at 7:30 p.m., documented CNA #1 had assisted the resident to transfer from a bed to a wheelchair and the resident's legs gave out and they had to be lowered to the floor. A nurses note, dated 12/18/24 at 10:45 a.m., documented Resident #16 had been seen by a physician and complained of left ankle pain and the ankle was swollen. The note further documented an order for an x-ray of the ankle. A nurses note, dated 12/20/24 at 1:04 p.m., documented the results of Resident #16's ankle x-ray was sent to the physician. A risk note, dated 12/23/24 at 3:46 p.m., documented interdisciplinary team met to discuss Resident #16's recent fall that had resulted in an ankle fracture. On 01/14/25 at 11:22 a.m., RN #1 was interviewed via telephone. They stated when Resident #16 fell on [DATE], CNA #1 attempted to transfer the resident from their bed to a wheelchair without assistance of other staff. RN #1 stated the resident required a two person assist with tranfers. (continued on next page)

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	01/14/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	On 01/14/25 at 11:27 a.m., the DON stated Resident #16 was not suppose to be transferred by one person. They stated CNA #1 needed to be educated on how to find the information on how to transfer particular residents. They stated the CNA had not followed facility policy on transferring residents.

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	01/14/2025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 34270 Based on observation, record review, and interview, the facility failed to ensure a resident was provided education on the use of bed rails and given the option to consent or decline the use of bed rails prior to their attachment to the bed for one (#72) four sampled residents reviewed for accident hazards. The DON identified 16 residents had bed rails attached to their assigned beds. Findings: Resident #72 had diagnoses which included muscle wasting and atrophy. A care plan focus for ADL self-care deficit, dated 06/07/24, documented an intervention on 09/15/24 was bilateral U rails were to be used to assist the resident with positioning. A Safety Device Evaluation Tool, dated 10/11/24, documented Resident #72 had an assist bar attached to their bed. A MDS five day assessment, dated 11/28/24, documented the resident was cognitively intact. On 01/12/25 at 10:03 a.m., Resident #72 was observed in bed. The bed was observed to have grab bar type rails (referred to as U rails) attached to each side of their bed about shoulder level. The resident stated they did not recall anyone discussing the pros or cons of using the rails and did not recall giving consent to use them. On 01/13/25 at 12:57 p.m., the DON stated they did not have documentation the resident had been educated on the dangers associated with the use of bed rails and did not have documentation the resident had given consent for the use of bed rails. They stated they would need to do better in this area and would go over it with the QAPI team. On 01/13/25 at 1:56 p.m., the regional nurse stated they did not have a facility policy regarding the use of bed rails, but they used the posted CMS guidelines for the use of assistive devices.

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	01/14/2025

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 42171 Based on record review and interview, the facility failed to ensure involuntary movement assessments were completed for a resident receiving an antipsychotic medication for one (#31) of five sampled residents reviewed for unnecessary medications. The DON reported eight residents received antipsychotic medications. Findings: Resident #31 had diagnoses which included major depressive disorder and repeated falls. A care plan intervention, initiated 04/27/23, read in part, EPS: Assess for EPS, TD, psuedoparkinsonism. A quarterly assessment, dated 10/31/24, documented Resident #31 routinely received an antipsychotic medication. A physician order, dated 12/12/24, documented the resident was to receive aripiprazole (an antipsychotic medication) 2.5 mg by mouth every day. On 01/13/25 at 11:48 a.m., the DON stated they did not complete involuntary movement assessments for residents receiving antipsychotic medications.