STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375119	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage at Brandon Place Health & Rehabilitation	13500 Brandon Place Oklahoma City, OK 73142

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 45583 Based on observation, record review, and interview, the facility failed to ensure a call light was within reach of a resident for one (#1) of three sampled residents observed for call lights in reach. The administrator identified 74 residents resided in the facility. Findings: A Call Lights: Accessibility and Timely Response policy, dated 05/2024, read in part, The purpose of this policy is to assure the facility is adequately equipped with a call light to allow residents to call for assistance. The policy also read, All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light. The policy also read, Each resident will be evaluated for unique needs and performances to determine any special accommodations that may be needed in order for the resident to utilize the call system. The policy also read, Staff will ensure the call light is within reach of resident and secured, as needed. Resident #1 had diagnoses which included weakness and congestive heart failure. Resident #1's care plan for activities of daily living performance/deficits, revised 09/20/23, documented encourage to use call bell for assistance. Resident #1's quarterly resident assessment, dated 08/28/24, documented the resident had severe cognitive impairment. On 11/27/24 at 9:16 a.m., Resident #1 was observed in bed and the call light button was observed to have been tucked under the foot of the bed. The call light was not within reach of the resident. On 11/27/24 at 9:27 a.m., CNA #2 stated the policy for call lights was to have them close to the resident at all times. CNA #2 stated Resident #1 was able to use the call light and that morning the resident used it and they had tended to them. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/27/24 at 9:30 a.m., CNA #2 went into Resident #1's room for the call light and reached towards the foot of the resident's bed where the call light button was clipped to the bottom of the blanket. CNA #2 stated, They turned it upside down. CNA #2 removed the call light and clipped it near Resident #1's right hand. CNA #2 stated the resident could not have reached the call light and repeated that someone put the blanket on upside down. On 11/27/24 at 9:32 a.m., CNA #2 was asked how the resident would reach the call light with it upside down on the cover at the foot of the bed. They had no verbal response. 48344

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. 48344 Based on record review and interview, the facility failed to ensure residents' property was not misappropriated for three (#3, 4, and #7) of three sampled residents reviewed for misappropriation. The administrator identified 74 residents resided in the facility. Findings: An undated ABUSE, NEGLECT, EXPLOITATION AND MISAPPROPRIATION OF PROPERTY PROHIBITION policy, read in part, The Facility will ensure a safe environment for residents by prohibiting abuse, neglect, exploitation and misappropriation of resident property with mechanisms for reporting, investigating, and protecting residents from actual or potential harm. 1. Resident #7 had diagnoses which included hypertensive heart disease with heart failure. A nursing note, dated 08/03/24 at 1:50 p.m., documented the resident reported someone had moved their card in their wallet. They looked at their online banking and noticed that on 08/01/24 there were two withdrawals. One withdrawal was for $440 and one was for $500. An Initial State Reportable Incident form, dated 08/03/24, documented an allegation of misappropriation of resident property. It documented Resident #7 reported their bank card had been compromised and two different transactions were withdrawn for the sum of $900. It documented further information to follow. Resident #7's discharge assessment return anticipated, dated 11/07/24, documented the resident had memory problems. A Final State Reportable Incident form, dated 08/16/24, documented the resident was advised not to give cards or cash to staff at anytime to purchase outside items. It documented the staff member remained on suspension. 2. Resident #4 had diagnoses which included combined systolic and diastolic heart failure. Resident #4's quarterly resident assessment, dated 09/19/24, documented the resident's cognition was intact. A concern form, dated 10/25/24, documented Resident #4 asked for their bank card. The resident stated there was a charge on their bank account that was not theirs. A nursing note, dated 10/28/24 at 4:53 a.m., read in part, Resident came to the Administrator with concerns about their bank statement and money being taken through the use of their debit card over the past two years. Upon investigation, it was determined large amounts were taken by current and previous employees. This was reported to the State, APS, and Oklahoma police for investigation. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Initial and final State Reportable Incident form, dated 11/6/24, documented an allegation of misappropriation of resident property. It documented Resident #4's bank statement showed fraudulent activity. It documented two staff members were identified. 3. Resident #3 had diagnoses which included cerebral infarction. Resident #3's quarterly resident assessment, dated 09/27/24, documented the resident had moderate cognitive impairment. An Initial State Reportable Incident form, dated 11/5/24, documented an allegation of misappropriation of resident property. It documented the resident inquired about their debit card. The resident stated a staff member had their card in the safe. There was no card to be found in the safe. It documented the staff member was terminated for previous reportable of misappropriation. On 12/05/24 at 2:28 p.m., the administrator and VP of clinical services stated residents' cards were locked up in the social services office or business manger's office per preference. They stated residents could keep cards at bedside and a lock could be added to their nightstand. On 12/05/24 at 2:28 p.m., the VP of clinical services stated to protect residents from future misappropriation of funds, all cards were now locked in the business manager's office. They stated all purchase receipts from social services would be verified and kept by the business office manager.

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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 - Few	Respond appropriately to all alleged violations. 48344 Based on record review and interview, the facility failed to conduct a thorough investigation after an allegation of misappropriation of resident property for one (#7) of three sampled residents reviewed for misappropriation of resident property. The administrator identified 74 residents resided in the facility. Findings: An undated ABUSE, NEGLECT, EXPLOITATION AND MISAPPROPRIATION OF PROPERTY PROHIBITION policy, read in part, The Facility will ensure a safe environment for residents by prohibiting abuse, neglect, exploitation and misappropriation of resident property with mechanisms for reporting, investigating, and protecting residents from actual or potential harm. Resident #7 had diagnoses which included hypertensive heart disease with heart failure. A nursing note, dated 08/03/24 at 1:50 p.m., documented the resident reported someone had moved their card in their wallet. They looked at their online banking and noticed that on 08/01/24 there were two withdrawals. One withdrawal was for $440 and one was for $500. An Initial State Reportable Incident form, dated 08/03/24, documented an allegation of misappropriation of resident property. It documented Resident #7 reported their bank card had been compromised and two different transactions were withdrawn for the sum of $900. It documented further information to follow. A Final State Reportable Incident form, dated 08/16/24, documented the resident was advised not to give cards or cash to staff at anytime to purchase outside items. It documented the staff member remained on suspension. The facility investigation did not identify the staff member who was suspended. The report to OSDH did not include supplemental documentation regarding the investigation. Resident #7's discharge assessment return anticipated, dated 11/07/24, documented the resident had memory problems. On 12/09/24 at 11:13 a.m., the VP of clinical services stated they could not determine all the steps that were taken to investigate the misappropriation or who was the suspended staff in the state reportable. They stated the investigation should include safe surveys and staff in-services. On 12/09/24 at 12:09 p.m., the VP of Clinical Services stated they do not believe a thorough investigation was completed.

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48344 Based on record review and interview, the facility failed to ensure a resident who experienced pain received treatment for pain for one (#2) of three sampled residents reviewed for pain management. The VP of clinical services identified 46 residents had orders for pain management in the facility. Findings: The Administering Pain Medications policy, revised 10/10, read in part, The pain management program is based on a facility-wide commitment to resident comfort. The policy also read, .Acute pain should be assessed every 30 to 60 minutes after the onset and reassessed as indicated after analgesic relief is obtained .Administer pain medication as ordered .document the following in the resident's medical record: results of the pain assessment; medication; dose; route of administration; and results of the medication. Resident #2 was admitted on [DATE] and had diagnoses which included pain, dementia, and displaced comminuted fracture of shaft of humerus, left arm, subsequent encounter for fracture with routine healing. A baseline care plan, dated 10/03/24 at 4:56 p.m., documented Resident #2 was cognitively impaired and their pain level was a five with the PAINAD scale. A physician's order, dated 10/03/24, documented Oxycodone HCL (analgesic opioid medication) 5 mg give one tablet by mouth every six hours as needed for pain. A physician's order, dated 10/03/24 at 8:00 p.m., documented morphine sulfate solution (analgesic opioid medication) 20 mg per ml give 0.5 ml sublingual every four hours as needed for pain and air hunger. A pain assessment, dated 10/03/24 at 10:35 p.m., documented Resident #2's pain was at a 10 on a numerical scale. Resident #2 did not receive pain medication with the assessment above. There was no documented follow up pain assessment per facility policy with the assessment above. A narcotic count sheet, documented morphine 100 mg per ml was available at the facility on 10/04/24 at 12:05 a.m. A nursing note, dated 10/04/24 at 4:11 a.m., documented Resident #2 was in bed awake, calm, and denied any needs. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	A physician's order, dated 10/04/24 at 5:15 a.m., documented morphine sulfate solution 100 mg per 5 ml give 0.5 ml orally every two hours as needed for pain and shortness of breath. A pain assessment, dated 10/04/24 at 5:41 a.m., documented Resident #2's pain was at a 10 on a numerical scale. The October 2024 MAR documented the morphine was initialed as given at 5:41 a.m. An Initial State Reportable Incident form, dated 10/27/24, documented an allegation of abuse/mistreatment. It documented an investigation was started based on a (social media name withheld) post. A Final State Reportable Incident form, dated 11/05/24, documented an allegation of abuse/mistreatment with an incident date of 10/04/24. It documented the family alleged the facility did not treat the resident's pain. The deficiency was determined to be a past noncompliance. The record review and interview below support a past noncompliance. An In-Service Training Form, dated 10/27/24, documented the facility provided ongoing training to staff over pain management, new resident admission process, and abuse. The facility conducted pain and new admit audits on residents for the month of November 2024. A QA summary form, dated 11/21/24, documented pain management was reviewed. On 12/04/24 at 1:16 p.m., ACMA #1 stated the process for pain management was to report to the nurse a residents complaint of pain and to administer pain medication if available. They stated if the resident did not have ordered pain medication they would let the nurse know so an order can be received from the provider. They stated they would stay with the resident until the resident received pain medication and offer non-pharmacological interventions. On 12/04/24 at 1:21 p.m., ACMA #1 stated it was unacceptable for a resident not to be offered pain medication if their pain rating was a 10 on a numerical scale. They stated a rating of 10 meant the resident was in a lot of pain. On 12/04/24 at 2:22 p.m., the VP of clinical services stated the staff should have notified hospice for a STAT order of pain medication for the resident with a rating of 10 on a numerical scale. They stated they could not locate a follow up pain assessment for the assessment conducted on 10/03/24 at 10:35 p.m. On 12/04/24 at 2:43 p.m., the VP of clinical services stated they conducted pain audits on all residents and new admits. They stated the facility did a staff in-service on pain and addressed the pain management in QAPI. The staff interviewed stated they had pain training in the month of November 2024.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 48344 Based on record review and interview, the facility failed to ensure labs were not collected without a physician order for one (#6) of three sampled residents reviewed for lab services. The administrator identified 74 residents resided in the facility. Findings: The Lab and Diagnostic Test Results-Clinical Protocol policy, revised 09/2012, read in part, The physician will identify and order diagnostic and lab testing based on diagnostic and monitoring needs. Resident #6 had diagnoses which included chronic peripheral venous insufficiency and nonrheumatic mitral valve insufficiency. A lab report, dated 10/13/24, documented a CBC, CMP, HbA1c and prothrombin time with INR were collected. There was no physician order to collect the labs. On 12/05/24 at 12:43 p.m., the VP of clinical services stated they could not locate a lab order for the labs collected on 10/13/24 for Resident #6. On 12/05/24 at 12:46 p.m., the VP of clinical services stated the facility's process for laboratory services was to receive an order from the provider, contact the lab, verify completion, retrieve results, notify the physician, and follow up on new orders if indicated.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45583 Based on record review and interview, the facility failed to ensure resident identifiable records were not released to the public. The administrator identified 74 residents resided in the facility. Findings: A Resident Rights Guidelines for All Nursing Procedures policy, dated 10/2010, read in part, Staff must have appropriate in-service training on resident rights, including; Confidentiality of protected health information; A HIPAA Training Program policy, dated 04/2007, read in part, All facility personnel, including business associates, are required to attend our facility's HIPAA compliance training program. On 11/27/24 at 3:24 p.m., the previous administrator stated the process for releasing medical records was that once the request form was signed it would go to the corporate office. They stated the corporate office then would decide if there would be a charge and then would send out the records themselves. They stated records were not sent out unless the corporate office stated to do so. They stated the corporate office gave direction to send the records for Resident #1 by email to their daughter per their request. On 11/27/24 at 3:30 p.m., the previous administrator stated there were a couple of other resident records mixed in with Resident #1's records. They previous administrator stated they sent the records to corporate for their review and when they approved to send it, the previous administrator did not review before they sent the records to the family. The previous administrator stated they should have reviewed the record before sending and that it went against the policy. The exposed residents names were not provided. 48344