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	05/07/2026

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

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. Based on observation, record review, and interview, the facility failed to provide treatment and care for a resident with a wound vac for 1 (#1) of 1 sampled resident reviewed for a wound vac. The DON identified one resident with a wound vac. Findings:On 05/05/26 at 12:00 p.m., Resident #1 was observed lying in a bariatric bed with an air mattress in place watching television. Resident #1 had a wound vac to the abdomen, the dressing was not dated, and the wound vac machine was turned off.An undated admission record showed Resident #1 had diagnoses which included local infection of the skin and subcutaneous tissue, type 2 diabetes mellitus, pressure ulcer of contiguous site of back, buttock, and hip stage 2.An undated facility policy titled Negative Pressure Wound Therapy, read in part, Whenever therapy cannot be resumed within two hours, remove the dressing and apply a moist wound dressing. Notify physician for specific orders.A treatment administration record, dated 04/21/26, showed a treatment for a midline abdomen surgical wound. The order showed the staff was to cleanse the wound with full strength Dakins solution, pat dry, apply barrier wipes to peri wound skin, allow to dry, apply cut strips of hydrocolloid (a wound care dressing) along peri wound edges, lightly pack undermining from 10 to11 o'clock with half inch cut strip of white vac foam then fill in the wound bed with black foam, secure with vac drape followed by track pad then set negative pressure wound therapy every Tuesday and Friday morning. A physician order, dated 05/05/26, showed an as needed order for wound care to the midline abdomen surgical wound. The order showed if wound vac was leaking, blocked or off more than two hours, the entire vac dressing must be removed, cleanse with full strength Dakins solution, pat dry, dampen Kerlix (a wound dressing) with Dakins solution, them lightly pack wound bed, cover with dry gauze, secure with tape, and change dressing as needed daily.On 05/05/26 at 12:30 p.m., LPN #1 stated the wound vac was turned off this morning when they started their shift around 7:15 a.m. LPN #1 stated they turned the wound vac on, but the wound vac was not working correctly. LPN #1 stated they did not know how long the wound vac had been turned off or if infection had built up under the dressing. LPN #1 stated they informed the DON the wound vac was not working correctly and the DON stated they would take care of it.On 05/05/26 at 2:25 p.m., LPN #1 stated they changed the wound vac for Resident #1. LPN #1 stated the wound vac was still not working correctly. On 05/05/26 at 2:45 p.m., LPN #1 stated per the physician orders the wound vac should have been removed and a dressing applied after the wound vac had not worked for two hours. LPN #1 stated they should have followed the physician order. On 05/06/26 at 1:00 p.m., the DON stated LPN #1 should have followed the physician order and notify the physician about the wound vac not working correctly. The DON stated LPN #1 did not follow the physician order for the wound vac care.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to provide pressure ulcer treatments to promote healing and prevent infection for 1 (#1) of 3 sampled residents reviewed for pressure ulcers. The DON identified three residents with pressure ulcers. Findings:On 05/05/26 at 12:42 p.m., CNA #1 and CNA #2 were observed to enter Resident #1's room to provide incontinent care. CNA #2 positioned Resident #1 on their side and CNA #1 washed Resident #1's buttock. There was packing in the pressure ulcer, but no dressing covering the wound. Bowel was on the edges and inside edges of the pressure ulcer. When CNA #1 was rolling the soiled linen to discard CNA #1 also caught the packing that was in the pressure ulcer wound bed. CNA #1 removed the packing part of the dressing with the soiled linen. CNA #1 did not tell the nurse about the resident's dressing (packing) being removed.On 5/06/26 at 10:17 a.m., the ADON was observed to complete wound care to the bilateral gluteal folds for Resident #1. There was no dressing covering the pressure ulcer wounds. An undated admission record showed Resident #1 had diagnoses which included local infection of the skin and subcutaneous tissue, type 2 diabetes mellitus, obesity, pressure ulcer of contiguous site of back, buttock, and hip stage 2, depression, and anxiety disorder.An on-site wound visit report, dated 04/29/26, showed Resident #1 had a stage 4 pressure ulcer to the right gluteal fold that measured 6.6cm length x 12cm width x 3cm depth. The report showed Resident #1 had a stage 4 pressure ulcer to the left gluteal fold that measured 8cm in length x 12.5cm in width x 3.7cm in depth. The report showed Resident #1 had a stage 3 pressure ulcer to the right buttock that measured 2cm in length x 2cm in width x 0.1cm in depth.A physician order, dated 04/30/26, showed staff was to clean the right gluteal fold wound with Dakins quarter strength solution, pat dry, soak 4x4 gauze in wound solution and apply to wound, cover with a dressing, and secure with tape for a stage 4 wound. A physician order, dated 04/30/26, showed staff was to clean the left gluteal fold wound with Dakins quarter strength solution, pat dry, soak 4x4 gauze in wound solution and apply to wound, cover with a dressing, and secure with tape for a stage 4 wound. On 05/05/26 at 12:30 p.m., LPN #1 stated they were not to use tape on Resident #1. LPN #1 was unsure why they were not to use tape on Resident #1.On 05/05/26 at 2:45 p.m., LPN #1 stated the physician orders to use tape to secure the dressings to the gluteal folds, must be new orders. LPN #1 stated per the physician order they should have used tape to secure the dressing and cover the pressure ulcer to the gluteal fold.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to follow enhanced barrier precautions and perform hand hygiene to prevent the development of infections for 1 (#1) of 3 sampled residents reviewed for infection control.The DON identified 55 residents resided in the facility and 13 residents with enhanced barrier precautions. Findings:On 05/05/26 at 12:40 p.m., CNA #1 and CNA #2 were observed providing incontinent care for Resident #1. A sign posted at Resident #1's door read, enhanced barrier precautions, staff must wear gown and gloves for bathing, changing linen, and providing hygiene for the resident. CNA #1 and CNA #2 did not wear a gown when providing care. CNA #1 did not wash or sanitize their hands when changing their gloves and moving from a dirty area to a clean area. On 05/05/26 at 2:25 p.m., LPN #1 was observed to change the wound vac dressing for Resident #1. LPN #1 was not wearing a gown. LPN #1 stated they did not know the resident was on enhanced barrier precautions. LPN #1 placed a new wound vac dressing, removed their gloves, and did not wash or sanitize their hands after removing their gloves. On 05/06/26 at 10:27 a.m., the ADON was observed to complete wound care for Resident #1. The ADON cleaned the pressure ulcer wounds to the gluteal folds and wearing the same pair of gloves applied a clean dressing. A facility policy titled Enhanced Barrier Precautions, dated 04/01/24, read in part, An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices .Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room.A facility policy titled Hand Hygiene, dated 06/13/24, read in part, All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.On 05/05/26 at 12:42 p.m., CNA #2 stated they did not wear a gown when incontinent care was provided for Resident #1. CNA #2 stated they should have worn a gown to provide care. On 05/05/26 at 12:43 p.m., CNA #1 stated they were in a hurry and forgot the put a gown on to provide care for Resident #1. CNA #1 stated they should have worn a gown when care was provided for Resident #1.On 05/06/26 at 10:29 a.m., the DON stated the ADON should have changed their gloves and washed their hands between dirty and clean surfaces. The DON stated staff was to wear a gown and gloves per enhanced barrier precautions when providing contact resident care for Resident #1.