STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375123	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Heights Nursing Center	1305 Southeast Adams Idabel, OK 74745

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 33097 Based on record review and interview, the facility failed to implement their abuse policy for three (#1, 2, and #4) of four sampled residents reviewed for abuse. The administrator identified 83 residents who resided in the facility. Findings: A policy titled Allegations of Abuse, Neglect, Exploitation or Mistreatment, read in parts All alleged violations involving abuse, neglect, exploitation or mistreatment, .are reported immediately, but not later than 2 hours after the allegation is made .to the Administrator of this facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures .All alleged violations, whether oral or in writing, must be immediately reported to the Administrator of this facility .The results of all investigations are reported to the Administrator or his/her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident .Documentation that an alleged violation was thoroughly investigated will be recorded and maintained .Definitions: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. 1. Resident #1 had diagnoses which included anxiety and major depressive disorder. A facility incident report, dated 12/14/24, documented a housekeeping staff member alerted the nurse another resident had slapped the right side of Resident #1's face. The report documented the physician and the local police were notified. The report did not document the administrator of the facility was notified. No state agency incident report/investigative findings to the state agency were provided. 2. Resident #2 had diagnoses which included major depressive disorder, absence of left foot, and nicotine dependence. (continued on next page)

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility incident report, dated 12/14/24, documented a housekeeping staff member reported the resident slapped another resident on the face while in the smoking area. The report documented the resident stated the other resident slapped them first. The report documented the physician, DON, CCO, and administrator were made aware of the incident. No state agency incident report/investigative findings provided to the state agency were provided. A police incident report, dated 12/14/24, documented the police were called to the facility for an assault complaint regarding Resident #1 and Resident #2. Investigative documentation provided by the facility, dated 12/14/24, documented two nursing staff statements regarding notification of the incident. There were no resident statements or resident/staff witnessed statements provided. 3. Resident #4 had diagnoses which included chronic kidney disease, carcinoma of the skin to the scalp and neck area, and encephalopathy. A facility incident report, dated 11/26/24, documented the staff was alerted to the dining area for an altercation between residents. The report documented during a verbal altercation another resident pushed Resident #3 causing them to fall and sustain an abrasion to the left side of their head. The report documented the family, administrator, and physician were notified of the incident. No state agency incident report/ investigative findings reported to the state agency were provided. On 01/22/25 at 12:16 p.m., the administrator stated they were responsible for allegations of abuse. The administrator reviewed the facility incident reports for Resident #1 and Resident #2 and stated they did not feel it was abuse. The administrator reviewed the facility policy definition for abuse and stated per the policy definition the incident should have been reported within two hours and a thorough investigation completed. On 01/22/25 at 3:44 p.m., the administrator reviewed the facility incident report for Resident #4. The administrator stated per the facility abuse policy and the incident report documentation, an abuse incident report should have been submitted to the state agency within two hours and an investigation completed.

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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. 33097 Based on record review and interview, the facility failed to ensure all allegations of abuse were reported immediately to the state agency, but no later than two hours after the allegation was made for three (#1, 2, and #4) of four sampled residents reviewed for abuse. The administrator identified 83 residents who resided in the facility. Findings: A policy titled Allegations of Abuse, Neglect, Exploitation or Mistreatment, read in parts All alleged violations involving abuse, neglect, exploitation or mistreatment, .are reported immediately, but not later than 2 hours after the allegation is made .to the Administrator of this facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures .All alleged violations, whether oral or in writing, must be immediately reported to the Administrator of this facility .Definitions: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. 1. Resident #1 had diagnoses which included anxiety and major depressive disorder. A facility incident report, dated 12/14/24, documented a housekeeping staff member alerted the nurse another resident had slapped the right side of Resident #1's face. The report documented the physician and the local police were notified. The report did not document the administrator of the facility was notified. No state agency incident report/investigative findings to the state agency were provided. 2. Resident #2 had diagnoses which included major depressive disorder, absence of left foot, and nicotine dependence. A facility incident report, dated 12/14/24, documented a housekeeping staff member reported the resident slapped another resident on the face while in the smoking area. The report documented the resident stated the other resident slapped them first. The report documented the physician, DON, CCO, and administrator was made aware of the incident. No state agency incident report/investigative findings provided to the state agency were provided. A police incident report, dated 12/14/24, documented the police were called to the facility for an assault complaint regarding Resident #1 and Resident #2. Investigative documentation provided by the facility, dated 12/14/24, documented two nursing staff statements regarding notification of the incident. There were no resident statements or resident/staff witnessed statements provided. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #4 had diagnoses which included chronic kidney disease, carcinoma of the skin to the scalp and neck area, and encephalopathy. A facility incident report, dated 11/26/24, documented the staff was alerted to the dining area for an altercation between residents. The report documented during a verbal altercation another resident pushed Resident #3 causing them to fall and sustain an abrasion to the left side of their head. The report documented the family, administrator, and physician were notified of the incident. No state agency incident report/ investigative findings reported to the state agency were provided. On 01/22/25 at 12:16 p.m., the administrator stated they were responsible for allegations of abuse. The administrator reviewed the facility incident reports for Resident #1 and Resident #2 and stated they did not feel it was abuse. The administrator reviewed the facility policy definition for abuse and stated per the policy definition the incident should have been reported within two hours and a thorough investigation completed. On 01/22/25 at 3:44 p.m., the administrator reviewed the facility incident report for Resident #4. The administrator stated per the facility abuse policy and the incident report documentation, an abuse incident report should have been submitted to the state agency within two hours and an investigation completed.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 33097 Based on record review and interview, the facility failed to thoroughly investigate allegations of abuse for three (#1, 2, and #4) of four sampled residents reviewed for abuse. The administrator identified 83 residents who resided in the facility. Findings: A policy titled Allegations of Abuse, Neglect, Exploitation or Mistreatment, read in parts All alleged violations involving abuse, neglect, exploitation or mistreatment, .All alleged violations, whether oral or in writing, must be immediately reported to the Administrator of this facility .The results of all investigations are reported to the Administrator or his/her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident .Documentation that an alleged violation was thoroughly investigated will be recorded and maintained .Definitions: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. 1. Resident #1 had diagnoses which included anxiety and major depressive disorder. A facility incident report, dated 12/14/24, documented a housekeeping staff member alerted the nurse another resident had slapped the right side of Resident #1's face. The report documented the physician and the local police were notified. The report did not document the administrator of the facility was notified. No state agency incident report/investigative findings to the state agency were provided. 2. Resident #2 had diagnoses which included major depressive disorder, absence of left foot, and nicotine dependence. A facility incident report, dated 12/14/24, documented a housekeeping staff member reported the resident slapped another resident on the face while in the smoking area. The report documented the resident stated the other resident slapped them first. The report documented the physician, DON, CCO, and administrator was made aware of the incident. No state agency incident report/investigative findings provided to the state agency were provided. A police incident report, dated 12/14/24, documented the police were called to the facility for a assault complaint regarding Resident #1 and Resident #2. Investigative documentation provided by the facility, dated 12/14/24, documented two nursing staff statements regarding notification of the incident. There were no resident statements or resident/staff witnessed statements provided. 3. Resident #4 had diagnoses which included chronic kidney disease, carcinoma of the skin to the scalp and neck area, and encephalopathy. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility incident report, dated 11/26/24, documented the staff was alerted to the dining area for an altercation between residents. The report documented during a verbal altercation another resident pushed Resident #3 causing them to fall and sustain an abrasion to the left side of their head. The report documented the family, administrator, and physician were notified of the incident. No state agency incident report/ investigative findings reported to the state agency were provided. On 01/22/25 at 12:16 p.m., the administrator stated they were responsible for allegations of abuse. The administrator reviewed the facility incident reports for Resident #1 and Resident #2 and stated they did not feel it was abuse. The administrator reviewed the facility policy definition for abuse and stated per policy definition the incident should have been reported within two hours and a thorough investigation completed. On 01/22/25 at 3:44 p.m., the administrator reviewed the facility incident report for Resident #4. The administrator stated per the facility abuse policy and the incident report documentation, an abuse incident report should have been submitted to the state agency within two hours and an investigation completed.