STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375199	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Village Nursing Home	801 Hwy 48 North Holdenville, OK 74848

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, the facility failed to protect a resident from abuse for 1 (#8) of 3 sampled residents reviewed for abuse. The administrator identified four allegations of abuse in the past six months. Findings:An undated facility policy titled ABUSE, NEGLECT, EXPLOITATION, MISTREATMENT AND MISAPPROPRIATION OF RESIDENT PROPERTY, read in part, Abuse and neglect exist in many forms and to varying degrees. The following are the approved CMS [Centers for Medicare and Medicaid Services] definitions of abuse and neglect from the Draft State Operations Manual Appendix PP effective November 28, 2016.Neglect,' as defined at 483.5, means 'the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.An undated discharge/transfer report showed Resident #8 had diagnoses which included history of falls, muscle wasting and atrophy, and the need for assistance with personal care. An admission assessment, dated 08/03/25, showed Resident #8 had a brief interview for mental status of nine which indicated the resident was moderately impaired for daily decision making. The assessment showed the resident was continent of bowel/bladder and required partial/moderate assistance with toileting. An Oklahoma State Department of Health incident form, dated 10/28/25, showed the administrator was made aware by a charge nurse the family had noticed a bruise on Resident #8's right arm. The form showed Resident #8 was unaware of the bruise. The form showed Resident #8 stated a CNA last night was persistent the resident use a bedpan and not the bedside commode. The form showed Resident #8 stated they did not want the CNA to provide care for them again. The form showed an investigation was initiated. The form showed two CNAs were working the resident's hall at the time of the incident and both were suspended pending further investigation.On 10/28/25 the facility interviewed residents and statement reports were completed regarding abuse.A quality assurance document, dated 10/28/25, showed an investigation was initiated immediately for an allegation of abuse. The document showed an unidentified CNA forced Resident #8 to use the bedpan when they requested to use the bedside commode. The document showed the allegation of abuse was addressed, an investigation was initiated, and staff education regarding abuse was provided. The document showed after the investigation the CNA was identified, terminated, and staff was to receive ongoing education regarding abuse. An IN-SERVICE MEETING form, dated 10/29/25, showed 25 staff members received training related to abuse/mistreatment reporting.An Oklahoma State Department of Health incident form, date received 10/31/25, showed a final report regarding an allegation of physical abuse for Resident #8. The form showed CNA #4's employment was terminated due to evidence CNA #4 neglected to provide resident care per request and Resident #8 stated they were afraid of CNA #4. On 11/06/25 at 11:55 a.m., Resident #8 stated an unnamed staff member placed them on a bedpan and would not assist them to use the bedside commode. Resident #8 stated it made them mad and did not want the staff member to take care of them again.On 11/06/25 staff were interviewed regarding abuse. The staff stated they had received training regarding abuse. A typed statement, dated 11/06/25, showed CNA #4 and CNA #5 were suspended for regarding the allegation of abuse. The statement showed both CNAs worked to night shift and had worked the shift prior to the allegation of abuse. On 11/06/25 at 4:25 p.m., the administrator stated after the investigation had been completed it was determined CNA #4 placed Resident #8 on the bedpan. The administrator stated CNA #4 was terminated for failure to provide Resident #8's request for care.