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	11/01/2024

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46387 Based on observation and interview, the facility failed to ensure residents were given the option to choose when to rise for the day for one (#19) of one sampled resident reviewed for choices. The DON identified 68 residents resided in the facility. Findings: Res #19 was admitted to the facility on [DATE] with diagnoses which included depression. On 10/28/24 at 10:24 a.m., Res #19 was observed seated in their recliner in their room. They stated they were not asked what time they liked to get up in the morning. They stated staff go them up at 4:00 a.m. and they can not go back to sleep. They stated they did not understand the reason they were being woken up at 4:00 a.m. just to sit there until breakfast. They stated they naturally wake up around 7:00 a.m. and would prefer to not be awoken by staff. On 10/31/24 at 11:05 a.m., the social services director stated the residents were not asked about what time they liked to get up in the morning.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43023 Based on observation, record review and interview, the facility failed to ensure comprehensive care plans were developed for two (#50 and #46) of 17 residents reviewed for care plans. The DON identified 68 residents resided in the facility. Findings: 1. Res #50 was admitted to facility with diagnoses which included COPD, acute and chronic respiratory failure with hypoxia, and malignant neoplasm of upper lobe. A review of the resident's care plan contained no documentation related to COPD On 10/31/24 at 11:49 a.m., MDS Coordinator #1 stated COPD should have been care planned. 33097 2. Res #46 had diagnoses which included acute respiratory failure with hypoxia, acute pulmonary edema, congestive heart failure, asthma, chronic obstructive pulmonary disease, dependence on supplemental oxygen, and obstructive sleep apnea. The care plan, dated 10/07/24, did not document the resident's use of oxygen. A physician order, dated 10/11/24, documented the resident was to receive oxygen at two liters per nasal cannula to keep oxygen saturation greater than 90 percent. An admission 5 day assessment, dated 10/13/24, documented the resident used continuous oxygen. On 10/28/24 at 1:34 p.m., the resident was sitting in a recliner watching television. The resident was receiving oxygen at two liters per nasal cannula. On 10/30/24 at 11:05 a.m., MDS Coordinator #1 reviewed the resident's care plan and stated the care plan should have document the use of oxygen for the resident.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43023 Based on observation and interview, the facility failed to ensure gait belts were used during transfers for one (#50) of four sampled residents reviewed for accident hazards. The DON identified 68 residents resided in the facility. Findings: An undated facility policy titled Moving a Resident, Bed to Chair/Chair to Bed, documented if moving a resident from the bed to a chair, if a resident can not stand alone, two persons should use a gait belt. Res #50 was admitted to the facility with diagnosis which included hemiplegia and hemiparesis following cerebral infarction affecting the left dominant side. On 10/28/24 at 1:10 p.m., CNA #1 was observed entering the resident's room to answer their call light. CNA #1 moved the resident's wheelchair close to the resident, then pulled a gait belt out of their pocket and placed it on the bed. The CNA then lifted the resident by holding them under under their arms from their recliner to their wheelchair. The resident remained in a bent knee position during the transfer. On 10/28/24 at 1:13 p.m., CNA #1 was asked what was the policy for using a gait belt. They stated they were supposed to use them getting residents up. On 10/31/24 at 10:41 a.m., the DON was made aware of the above observation and stated the gait belt should have been used.

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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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46387 On [DATE] an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to assess a resident with new onset respiratory changes for Res #72. Res #72 expired on [DATE]. A progress note, dated [DATE] at 6:44 a.m., documented Res #72 was having shortness of breath and wheezing. The note documented the physician was contacted and a breathing treatment was ordered. The note documented the Res #72 coughed up green sputum. The note did not document an assessment of the resident's lung sounds. A MAR, dated [DATE], documented the breathing treatment was administered as ordered at 6:46 a.m. The vital signs were documented as oxygen saturation 87%, heart rate 117, and irregular. There was no respiration rate documented. No oxygen saturation was documented after the administration. A progress note, dated [DATE] at 7:53 a.m., documented the breathing treatment was documented as effective. There were no vital signs or assessment of lungs documented. A progress note, dated [DATE] at 12:00 p.m., documented the breathing treatment was again documented as administered. The vital signs documented for the treatment were 89% oxygen saturation, and heart rate 104 and irregular. There was no respiration rate documented, and no post-treatment oxygen saturation documented. A progress note, dated [DATE] at 12:02 p.m., documented Res #72 vomited in the dining room and was taken to their room to clean up. The note documented the physician was notified and ordered a urinalysis and an anti-emetic (nausea medication). The note did not document vital signs or a respiratory assessment of the resident. A progress note, dated [DATE] at 1:00 p.m., documented the breathing treatment was documented as effective. There were no vital signs or respiratory assessment documented. A vital sign record, dated [DATE] at 8:50 p.m., documented Res 72's blood pressure was ,d+[DATE]. The CMA did not document any other vital signs. A progress note, dated [DATE] at 10:55 p.m., documented Res #72 was deceased . On [DATE] at 10:16 a.m., RN #1 (day shift RN) stated they had been informed Res #72 was ill upon arrival to their shift. They stated the resident had been sick all weekend prior. They stated Res #72 was kind of congested and had some wheezing. They stated Res #72's lungs sounded some better after the breathing treatment. They stated they did not document a respiratory assessment of the resident. They stated they passed the information along to the oncoming RN at the end of their shit. They stated there should be a focused assessment by a nurse on each shift if a resident has had a change. (continued on next page)

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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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:19 a.m., RN #2 (evening shift RN) stated they were informed right before the end of their shift Res #72 was having difficulty breathing, had congestion, and was asked by the aide if the resident had an order for breathing treatments. They stated they went to the computer to check for orders and notified the oncoming nurse (night shift RN) of the report from the aide. RN #2 denied assessing Res #72 on their shift or prior to clocking out. They stated as they were walking out the door the night shift RN came to them and stated they thought Res #72 had passed away. They stated they went with the night shift RN to Res #72's room and determined the resident had passed away. On [DATE] at 12:35 p.m., the DON stated they expected the nurses on shift to pass along changes in resident conditions at shift change. They stated shift report was given orally and there was no policy. They stated they would expect the staff to keep a close watch on residents experiencing new onset respiratory symptoms and for a respiratory assessment to be completed each shift. They stated there should have been a documented assessment of respiratory status for Res #72. A policy regarding respiratory assessment was requested. On [DATE] at 1:31 p.m., the DON stated the facility did not have a policy regarding respiratory assessment. They stated staff were expected to follow nursing 101 regarding nursing care. They stated a focused assessment should be done when a resident has changes. On [DATE] at 1:55 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On [DATE] at 2:05 p.m., the administrator was notified of the IJ situation. On [DATE] at 10:04 a.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The plan of removal documented: Plan for Removal of Immediate Jeopardy [name withheld] Date: [DATE] Time Started: 2:20 p.m. Time Completed: [DATE] 9:40 a.m. This plan is to show our compliance for the removal of the immediate jeopardy cited on [DATE]: 1. [DATE] at 2:30 pm the facility began in-service with the C.N.A. and C.M.A. regarding the importance of reporting any changes in condition in resident status including respiratory distress. (all c.n.a.'s and c.m.a.'s have been in-serviced. One unavailable staff will not be allowed to work until she has been in-serviced.) 2. [DATE] at 4:30 pm the facility began in-service with the licensed nursing staff addressing the importance of conducting a respiratory assessment on any resident who is exhibiting respiratory issues (see attached Change in Condition Monitoring Assessment). 3. The facility has conducted respiratory screening of all residents who have any type of respiratory diagnosis or exhibiting respiratory symptoms (see attached Respiratory Screener). (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. The facility has adopted a Change in Condition Policy addressing the importance of conducting a thorough and complete respiratory assessment on any resident exhibiting signs of respiratory distress (see attached policy). 5. All c.n.a.'s and c.m.a.'s have been in-serviced with the exception of one staff. [They] shall be in-serviced before [They] is allowed to return to work. The IJ was lifted effective [DATE] at 9:40 a.m. when all components of the plan of removal had been completed. The deficient practice remained at isolated with actual harm to the resident. Based on observation record review, and interview, the facility failed to: a. assess a resident with new onset respiratory changes for one (#72) of three sampled residents reviewed for closed records; b. change and date oxygen tubing for two (#36 and #46) of three sampled residents reviewed for respiratory care; and c. supervise the administration of a breathing treatment for one (#50) of three residents sampled for respiratory care. The DON identified 68 residents resided in the facility. Findings: A facility policy titled Specific Medication Administration Procedures, Oral Inhalation Administration for Nebulizer, dated [DATE], documented to remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer. An oxygen administration policy, dated [DATE], documented to change oxygen tubing and mask/cannula weekly and as needed. The policy had hand written changes documenting humidifier bottles were to be changed monthly on the first of the month on night shift. 1. Res #72 had diagnoses which included CHF and dementia. A progress note, dated [DATE] at 6:44 a.m., documented Res #72 was having shortness of breath and wheezing. The note documented the physician was contacted and a breathing treatment was ordered. The note documented the Res #72 coughed up green sputum. The note did not document an assessment of the resident's lung sounds. A physician order, dated [DATE], documented to administer albuterol sulfate nebulizer solution (a breathing treatment) 2.5 mg per 3 mL every six hours as needed for shortness of breath. The order documented to monitor pulse and oxygen saturation before and after treatment. A MAR, dated [DATE], documented the breathing treatment was administered as ordered at 6:46 a.m. The vital signs were documented as oxygen saturation 87%, heart rate 117, and irregular. There was no respiration rate documented. No oxygen saturation was documented after the administration. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note, dated [DATE] at 7:53 a.m., documented the breathing treatment was documented as effective. There were no vital signs or assessment of lungs documented. A progress note, dated [DATE] at 12:00 p.m., documented the breathing treatment was again documented as administered. The vital signs documented for the treatment were 89% oxygen saturation, and heart rate 104 and irregular. There was no respiration rate documented, and no post-treatment oxygen saturation documented. A progress note, dated [DATE] at 12:02 p.m., documented Res #72 vomited in the dining room and was taken to their room to clean up. The note documented the physician was notified and ordered a urinalysis and an anti-emetic (nausea medication). The note did not document vital signs or a respiratory assessment of the resident. A progress note, dated [DATE] at 1:00 p.m., documented the breathing treatment was documented as effective. There were no vital signs or respiratory assessment documented. A vital sign record, dated [DATE] at 8:50 p.m., documented Res 72's blood pressure was ,d+[DATE]. The CMA did not document any other vital signs. A progress note, dated [DATE] at 10:55 p.m., documented Res #72 was deceased . On [DATE] at 10:16 a.m., RN #1 (day shift RN) stated they had been informed Res #72 was ill upon arrival to their shift. They stated the resident had been sick all weekend prior. They stated Res #72 was kind of congested and had some wheezing. They stated Res #72's lungs sounded some better after the breathing treatment. They stated they did not document a respiratory assessment of the resident. They stated they passed the information along to the oncoming RN at the end of their shit. They stated there should be a focused assessment by a nurse on each shift if a resident has had a change. On [DATE] at 11:19 a.m., RN #2 (evening shift RN) stated they were informed right before the end of their shift Res #72 was having difficulty breathing, had congestion, and was asked by the aide if the resident had an order for breathing treatments. They stated they went to the computer to check for orders and notified the oncoming nurse (night shift RN) of the report from the aide. RN #2 denied assessing Res #72 on their shift or prior to clocking out. They stated as they were walking out the door the night shift RN came to them and stated they thought Res #72 had passed away. They stated they went with the night shift RN to Res #72's room and determined the resident had passed away. On [DATE] at 12:35 p.m., the DON stated they expected the nurses on shift to pass along changes in resident conditions at shift change. They stated shift report was given orally and there was no policy. They stated they would expect the staff to keep a close watch on residents experiencing new onset respiratory symptoms and for a respiratory assessment to be completed each shift. They stated there should have been a documented assessment of respiratory status for Res #72. A policy regarding respiratory assessment was requested. On [DATE] at 1:31 p.m., the DON stated the facility did not have a policy regarding respiratory assessment. They stated staff were expected to follow nursing 101 regarding nursing care. They stated a focused assessment should be done when a resident has changes. 2. Res #36 had diagnoses which included shortness of breath. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Physician orders, dated [DATE], documented to administer oxygen at two liters per minute via nasal cannula every shift; and change the oxygen bottle and nasal cannula tubing every month on the 1st. On [DATE] at 10:44 a.m., Res #36 was observed resting in their recliner with their eyes closed. The oxygen concentrator was observed between the bed and the recliner. The oxygen tubing was observed dated [DATE]. The bottle was observed dated [DATE]. On [DATE] at 2:15 p.m., RN #1 stated oxygen tubing was to be changed and dated monthly or PRN. 33097 3. Res #46 had diagnoses which included acute respiratory failure with hypoxia, acute pulmonary edema, congestive heart failure, asthma, chronic obstructive pulmonary disease, dependence on supplemental oxygen, and obstructive sleep apnea. The care plan, dated [DATE], did not document the resident's use of oxygen. A physician order, dated [DATE], documented the resident was to receive oxygen at two liters per nasal cannula to keep oxygen saturation greater than 90 percent. An admission 5 day assessment, dated [DATE], documented the resident used continuous oxygen. On [DATE] at 1:34 p.m., the resident was sitting in a recliner watching television. The resident was receiving oxygen at two liters per nasal cannula. The oxygen tubing and humidifier bottle were not dated. On [DATE] 9:44 a.m., the DON stated oxygen tubing should be changed monthly. The DON reviewed the facility policy for respiratory care and stated the policy documented oxygen tubing was to be changed weekly. The DON stated the policy needed the be corrected. 43023 4. Res #50 admitted to the facility with diagnoses which included COPD, acute and chronic respiratory failure with hypoxia, and malignant neoplasm of upper lobe. A physician order, dated [DATE], documented to administer ipratropium-albuterol inhalant solution 0XXX, d+[DATE].5 MG/ML, inhale 3 ml four times a day related to COPD with acute exacerbation. A quarertly assessment, dated [DATE], documented the resident's cognition was intact. On [DATE] at 2:31 p.m., Res #50 was observed holding their nebulizer. The nebulizer was approximately half full with clear liquid. The resident stated they could not remember the name of medication, and they administered their own breathing treatments. On [DATE] at 2:35 p.m., Res #50 started their nebulizer machine. The resident's record was reviewed and did not contain an assessment to self-administer breathing treatments. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 10:37 a.m., the DON was made aware of the above observation and stated the nurse should have stayed with the resident.

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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. 46387 Based on record review and interview, the facility failed to ensure residents receiving psychotropic medications were monitored for side effects for one (#19) of five sampled residents reviewed for unnecessary medications. The DON identified 68 residents resided in the facility. Findings: Res #19 had diagnoses which included depression. Physician orders, dated 08/17/24, documented to administer Sertraline (antidepressant medication) 150 mg daily for depression; and administer risperidone (antipsychotic medication) 2 mg at bedtime for depression. A chart review did not document side effect monitoring for the psychotropic medications. On 10/31/24 at 9:36 a.m., the DON stated there should have been side effect monitoring completed for the psychotropic medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43023 Based on observation and interview, the facility failed to ensure food was stored in accordance with the professional standards for food service safety. The DON identified 68 residents resided in the facility. Findings: On 10/28/24 at 8:22 a.m., during a tour of the kitchen there were 10 plastic cups covered with clear wrap. Three cups had yellow liquid, four had red liquid, one had pink liquid, one with white liquid, and one with dark brown liquid. There was no label or date. On 10/28/24 at 8:35 a.m, [NAME] #1 was asked what was the policy for labeling and dating food. They stated everything was supposed to be labeled and dated for the date you made it.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 33097 Based on observation and interview, the facility failed to ensure chemicals were locked away from residents and shower rooms were clean and safe. The administrator identified 38 residents who resided in the facility. Findings: On 10/28/24 at 8:36 a.m., the shower room on hall six was observed with plastic draping taped to two of three walls from approximately three feet down to floor and secured with duct tape. A grey, black, and white fuzzy substance was observed on the ceiling where the walls met and on inside of the door jamb and frame. On 10/28/24 at 2:29 p.m., an observation of the janitor closet on the Southwest resident hall was conducted. The door was without a lock on the knob to secure the closet. The closet contained multiple gallons of paint, a five gallon bucket of paint, a spray bottle of Windex cleaner, and a bottle labeled bleach without lid. There were multiple additional bottles of unlabeled liquids on the shelf. On 11/01/24 at 9:23 a.m, the administrator stated they were made aware the janitor closet door on the Southwest hall was unlocked. The administrator stated, It would not happen again. The administrator stated the housekeeping staff were responsible for cleaning the showers. The administrator stated the shower was to be cleaned every other day and as needed. The administrator stated there was no documented schedule for cleaning the shower rooms. The administrator stated there were only verbal instructions for cleaning the shower rooms.