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	01/08/2026

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and interview, the facility failed to ensure RN coverage eight consecutive hours seven days per week.The administrator identified 84 residents resided in the facility. Findings:Time card reports for RN coverage were reviewed July 2025 through January 2026. There was no RN coverage for eight consecutive hours for the following days:a. 08/03/25,b. 08/17/25,c. 10/04/25, d. 10/18/25, e. 11/29/25,f. 12/27/25, andg. 01/04/26.On 01/07/26 at 4:05 p.m., the administrator stated they had an agency RN scheduled for the dates above, but nobody showed up, nor did anybody notify the administrator.

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and interview, the facility failed to complete an informed consent for the use of antipsychotic medication for 1 (#17) of 2 sampled residents reviewed for the use of antipsychotic medication. The administrator identified 29 residents received antipsychotic medication. Findings: An undated facility policy titled Psychotropic & Opioid Medication Therapy Informed Consent Policy, read in part, This form must be completed and signed before administering the first dose of any psychotropic or Opioid medication, except in emergency situations as defined by regulatory guidelines. An undated admission record showed Resident #17 had diagnoses which included atrial fibrillation, anxiety disorder, and recurrent depressive disorder. A care plan, dated 12/04/25, showed Resident #17 received psychotropic medication. The care plan showed the resident was to be/remain free of drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date. A physician order, dated 12/07/25, showed Resident #17 received Seroquel (an antipsychotic medication) 100mg by mouth at bedtime related to an anxiety disorder. An admission assessment, dated 12/10/25, showed Resident #17 was not impaired cognitively and had a BIMS of 14. The assessment showed the resident received antipsychotic medication, antidepressant medication, and anticoagulant medication. On 01/07/26 at 11:20 a.m., the DON reviewed the resident's clinical record and stated a consent for antipsychotic medication use was not completed. The DON stated a consent for the use of an antipsychotic medication should have been 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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure residents receiving antipsychotic medications had an appropriate diagnosis for 2 (#17 and #61) of 5 sampled residents reviewed for unnecessary medications.The administrator identified 29 residents received antipsychotic medication. Findings: 1. An undated facility policy titled Psychotropic & Opioid Medication Therapy Informed Consent Policy, read in part, This form must be completed and signed before administering the first dose of any psychotropic or Opioid medication, except in emergency situations as defined by regulatory guidelines. An undated admission record showed Resident #17 had diagnoses which included atrial fibrillation, anxiety disorder, and recurrent depressive disorder. A care plan, dated 12/04/25, showed Resident #17 received psychotropic medication. The care plan showed the resident was to be/remain free of drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date. A physician order, dated 12/07/25, showed Resident #17 received Seroquel (an antipsychotic medication) 100mg by mouth at bedtime related to an anxiety disorder. An admission assessment, dated 12/10/25, showed Resident #17 was not impaired cognitively and had a BIMS of 14. The assessment showed the resident received antipsychotic medication, antidepressant medication, and anticoagulant medication. On 01/07/26 at 10:15 a.m., the DON reviewed the resident's physician orders and stated the resident was receiving Seroquel for an anxiety disorder. The DON stated this was not an appropriate diagnosis for the use of an antipsychotic medication. On 01/07/26 at 10:41 a.m., the pharmacy consultant reviewed the resident's physician orders and stated the resident was receiving Seroquel for anxiety. They stated an anxiety diagnosis was not an acceptable diagnosis for the use of an antipsychotic medication. 2. A diagnosis report, dated 02/12/23, showed Resident #61 had a diagnosis of dementia without behavioral, psychotic, or mood disturbances. A physician order, dated 12/06/24, showed to administer Seroquel 400 mg daily at bedtime for dementia without behavioral, psychotic, or mood disturbances. An annual assessment, dated 02/19/25, showed Resident #61 was severely cognitively impaired with a BIMS score of 04. The assessment showed Resident #61 received antipsychotic medication. On 01/07/26 at 1:48 p.m., the DON stated dementia was not an appropriate diagnosis for the use of an antipsychotic medication.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure quarterly smoking assessments were completed for 1 (#5) of 1 sample resident reviewed for smoking.The DON identified eight residents smoked tobacco products.Findings:On 01/06/26 at 3:40 p.m., Resident #5 was observed outside smoking in designated area with monitoring by staff.An undated facility Smoking, Care of the resident policy, read in part, Complete a Supervised Smoking Assessment on all residents who smoke upon admission and quarterly thereafter.An initial smoking assessment dated [DATE], showed the evaluation would be utilized for the resident's smoking care plan on admission and as indicated.A care plan, dated 03/24/25, showed Resident #5 would always smoke in the designated smoking area. The care plan showed staff would assist resident to smoking areas and monitor as needed.An electronic admission Record, dated 01/06/26, showed Resident #5 was admitted to facility on 03/11/25 with a diagnosis of tobacco use.There was no additional documentation of quarterly smoking assessments completed for Resident #5.On 01/07/26 at 11:32 a.m., the DON was made aware of Resident #5 not having a quarterly smoking assessment during record review. The DON stated they thought smoking assessments were done annually. The DON was made aware of the facility's policy for quarterly smoking assessments. The DON stated they did not know why the smoking assessment was not completed quarterly for Resident #5.