

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER Heritage Hills Living & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 411 North West Street McAlester, OK 74502	

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review and interview, the facility failed to maintain an abuse free environment for 1 (Resident #1) of 4 sampled residents reviewed for allegations of abuse. The facility DON identified 50 residents resided in the facility. Findings: On 10/21/25 at 6:00 p.m., Resident #1 was observed in bed receiving oxygen via a nasal cannula. The resident was covered with blankets from their chin down. The resident appeared tired with dark circles under their eyes and congested with a hoarseness to their voice. On 10/22/25 at 11:20 a.m., Resident #1 was observed in bed receiving oxygen via a nasal cannula. The resident was covered with a blanket from their upper chest down. The resident spoke in a calm and animated voice without signs of fear or hesitation. Resident #1's incident statement, dated 10/02/25, read in part, [Resident #1] states was out smoking [and] did not realize [they] had BM on [their] way out to smoke. Nurse came out told [them] to come inside and clean up d/t [they] had soiled [themselves]. Resident states nurse grabbed chair, pushed forward, and [Resident #1] slid to [the] ground on [their] butt then nurse went inside, got a pitcher of water, and threw it on [Resident #1]. Resident #5's incident statement, dated 10/02/25, read in part, [Resident #5] was outside smoking with [Resident #1]. Nurse came out telling [Resident #1] to come in and get cleaned up [and] resident said no. Nurse grabbed chair and the next thing [they] knew [Resident #1] was on ground. Nurse went in and came back out with a piture [sic] of water and threw it on [Resident #1]. A nurse's progress note, dated 10/02/25, read in part, Resident observed ambulating down hallway, incontinent of stool on floor, then proceeded outside during nonsmoking hours. Resident is a supervised smoker and refused to return indoors when directed by staff. While outside, resident became incontinent of urine, saturating clothing and ground. Resident stood, became incontinent of stool on concrete, stepped in the middle of stool, slipped on stool and wet surface, and fell onto edge of chair. This nurse grabbed chair to keep it from tipping over backwards, resident slid out of chair unto butt. No injuries observed upon assessment. Denies pain. Resident assisted to safe position, stool cleaned off concrete, resident assisted with mechanical lift to seated position. Resident able to stand with walker and ambulated with staff assistance to shower. Resident cleaned, fresh clothing provided, and comfort maintained. Safety precautions reinforced. PCP notified. EC notified. CNA #4's incident statement, dated 10/02/25, read in part, [LPN #1] came into facility telling me and [CNA #2] that [Resident #1] was on the ground outside and [they] had poop all over themselves. When we got outside [Resident #1] was laying on the ground [with a] puddle of fluid all around [them]. I asked [Resident #1] what it is. [Resident #1] said [LPN #1] threw water on [Resident #1] and [LPN #1] said no, I poured some water on your foot to get the shit off it. [Resident #1] was covered from head to toe in water. We got [Resident #1] off the ground. [LPN #1] then showed a picture of the poop in the floor to another resident and was making fun of [Resident #1] for the accident. CMA #2's incident statement, dated 10/02/25, read in part, I heard [LPN #1] tell [Resident #1] shit in the hallway on [their] way outside to smoke so I went outside to get [Resident #1] to come back in to change. I informed [Resident #1 they were] on supervised smoking and it wasn't time yet then I asked [them] to come in and change. [Resident #1] responded, 'I want to finish my cig.' So, I told [LPN #1] [they] wanted to finish smoking, [they] didn't want to come in right that second. [LPN #1] went outside with a med cup full of water from my med cart. I got [Resident #38] BP turned around and my pitcher was gone then [LPN #1] come from outside with it and refilled it and [unable to read] informed me [Resident #1] was on the ground. All the aides and [LPN #1] went and got [Resident #1] from outside. [Resident #1] was soaking wet and tracking BM through the whole building then [CNA #2] gave [Resident #1] a shower and got [Resident #1] cleaned up. When I move [sic] to west hall to finish my med pass, [LPN #1] was showing picture of [Resident #1's] BM on the floor to [Resident #7] and laughing and making fun of it. When I gave [Resident #7 their medication they were] talking about it with [Resident #39]. CNA #3's incident statement, dated 10/02/25, read in part, I was sitting at nurses' station on west and east hall when I witnessed [LPN #1] ask [Resident #1] if [they] just shit in the floor. [Resident #1] stated no. I witnessed [LPN #1] take a picture of the poop on [their] phone. A hour later, I witnessed [LPN #1] showing the pic to [Resident #40]. Resident #6 came out of [their] room about 8:45 p.m. and offered to take [Resident #1] to smoke since [Resident #1] is supervised. [LPN #1] told [Resident #6], only if [Resident #6] took a bio bag with [them] and clean [sic] up after [Resident #1.] if [Resident #6] was going to be responsible for [Resident #1]. [LPN #1] said, 'Kinda like when you have to pick up after your pet. 'CNA #1's incident statement, dated 10/02/25, read in part, I was sitting at nursing station while the nurse was showing pictures of [Resident #1's] poop. CNA #2's incident statement dated 10/02/25 showed CNA #2</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, record review, and interview, the facility failed to secure chemicals which had the potential to harm residents if the chemicals were touched, inhaled, or ingested. The DON identified 50 residents resided in the facility. Findings: On 10/22/25 at 11: 00 a.m., there were no wandering residents observed on the East hall. At the end of the East hall was an unsecured resident room which was used for storage. There was no way to lock the storage room door and located behind the door was six 1-gallon sized bottles of unsecured chemicals. The chemicals included three 1-gallon bottles of ZEP Wet Look Floor Polish, two 1-gallon bottles of Floor Front Floor Finish, and a gallon bottle of Betco Advanced Alcohol Gel Sanitizer. Each of the 6 bottles of chemicals had a warning label which read to keep out of reach of children. On 10/22/25 at 11:07 a.m., the DON observed the unsecured chemicals in the storage room. An undated and unnamed facility policy showed all chemicals must be secured with locks and accessible to only housekeeping and maintenance. The MSDS for Floor Front Floor Finish, dated 05/15/19, showed the chemical may be harmful if swallowed, may cause skin irritation, may cause eye irritation, and inhalation of vapors or mist may cause respiratory irritation. The MSDS for Zep Wet Look Floor Polish, dated 05/24/19 showed the vapors may cause irritation to the eyes respiratory system and the skin. The MSDS showed to avoid contact with skin and eyes; smoking, eating and drinking should be prohibited in the application area; and to dispose of rinse water according to local and national regulations. The MSDS for Advanced Alcohol Gel Sanitizer, dated 06/08/22, showed the chemical was dangerous; was a highly flammable liquid and vapor; and caused serious eye irritation. On 10/22/25 at 11:07 a.m., the DON stated all chemicals were to be locked up and only accessible to housekeeping and maintenance. The DON stated the staff knew better than to store chemicals in an unsecured room.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on observation and interview, the facility failed to securely store protected health information. The DON identified 50 residents resided in the facility. Findings:On 10/22/25 at 11: 00 a.m., at the end of the East hall was an unsecured resident room with three 4-drawer tall file cabinets and one 5-drawer tall file cabinet. On top of one file cabinet were loose papers and files with residents' protected health information, including name, birthdate, social security numbers, insurance information, labs, and physician's progress notes. None of the file cabinet drawers were locked and two of the 4-drawer file cabinets held more resident clinical records. On 10/22/25 at 11:07 a.m., the DON observed the unsecured storage room and resident records. An undated and unnamed facility policy showed all resident records were to be behind locked doors at all times with keys kept in the administrator's office.On 10/22/25 at 11:07 a.m., the DON stated all resident records should be secured with a lock and with limited staff access.</p>		