STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375317	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Hills Living & Rehabilitation Center	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 - 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. 46582 Based on observation, record review, and interview, the facility failed to ensure residents were free from abuse for two (#33 and #59) of three sampled residents reviewed for abuse. The administrator identified 58 residents who resided in the facility. Findings: An Investigation of Abuse, Neglect and Exploitation policy, undated, read in parts, .The facility prohibits mistreatment, neglect or abuse of residents. The resident has the right to be free from verbal, sexual, physical, or mental abuse .Physical abuse includes hitting, slapping, pinching, and kicking .In the event there is an allegation or incidents involving resident to resident abuse, the individuals involved in the abuse should be immediately separated by staff .Once safety is established, the Administrator and Director of Nursing should be notified immediately. Put the resident on 1:1 when needed and document .An investigation into what triggered the abuse shall be conducted by the DON with referrals made accordingly .The facility shall prevent the occurrence of abuse by reviewing past specific incidents for lessons learned and policy amendments .The facility shall ensure that any substantiated incidents of abuse are reported and analyzed, and that appropriate corrective remedial or disciplinary actions occurs in accordance with local, state or federal law . 1. Res #33 had diagnoses which included major depressive disorder, suicidal ideations, and persistent mood disorder. A nurse note, dated 04/13/2024 at 7:41 p.m., documented Res #33 ran into another resident in the hallway. The note documented Res #33 cursed the other resident. A nurse note, dated 04/17/24 at 10:09 a.m., documented Res #33 was yelling and cursing at staff. A nurse note, dated 05/17/24 at 9:20 a.m., documented Res #33 was yelling and verbally threatening staff. A nurse note, dated 06/03/24 at 4:39 p.m., documented Res #33 was yelling and verbally threatening staff. The note documented physical behaviors of knocking items off the nurses' station and hitting a CNA in the face with a metal drinking tumbler. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375317	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Hills Living & Rehabilitation Center	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 - Actual harm Residents Affected - Few	A quarterly assessment, dated 06/07/24, documented Res #33 was cognitively intact, had minimal depression, and had exhibited physical and verbal behaviors towards others. A nurse note, dated 08/07/24 at 12:02 p.m., documented Res #33 was yelling and threatening another resident for not getting out of their way. A facility observation detail report, dated 08/07/24 at 12:02 p.m., documented Res #33 had aggressive behavior towards a peer and was yelling and cursing staff. The report documented continue plan of care as action taken to care plan. There was no documentation of verbal/physical behaviors on Res #33's care plan. 2. Res #59 had diagnoses which included Alzheimer's disease and insomnia. An admission assessment, dated 08/07/24, documented Res #59 was severely cognitively impaired, had no symptoms of depression, and had exhibited delusions. A nurse note, dated 08/07/24 at 4:22 p.m., documented Res #33 pushed Res #59 in the hallway resulting in a laceration to Res #59's head. The note documented Res #59 was transferred to the hospital for medical evaluation and treatment. A facility observation detail report, dated 08/07/24 at 4:35 p.m., documented Res #59 had been pushed by another resident resulting in a fall with head injury. An OSDH initial incident report form, dated 08/07/24, read in part, .At approx 3:45 pm was in office, heard a loud commotion then a crash in hallway. [Res #59] was noted laying on back with blood on floor. Laceration on upper back of head. Pressure applied and EMS notified. [Res #33] stated I told that [curse word] to stay away from my room. Unnamed resident was in hallway and stated [Res #59] wasn't even in [Res #33] room, [Res #59] was in the hallway when [Res #33] pushed them hard and was cussing at them. [Res #59] was sent to the hospital for evaluation and treatment. [Res #33] was placed on 1 on 1 . The report documented the physician, resident representative, law enforcement, and APS was notified of the incident. Hospital discharge instructions, dated 08/07/24 at 5:54 p.m., documented Res #59 had diagnoses which included skin tear and head injury/concussion. An OSDH final incident report form, dated 08/13/24, documented actual physical aggression by Res #33 against Res #59 witnessed by another unnamed resident. The report documented Res #33 had shoved Res #59 resulting in Res #59 falling to the floor and hitting their head. The unnamed resident witness stated the aggression was unprovoked. The report documented Res #33 had no further aggression noted and had no aggression against any resident witnessed or reported inside this facility prior to this incident. The report documented Res #59 did not return to the facility after discharge from the hospital. There was no documentation of an investigation related to the incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375317	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Hills Living & Rehabilitation Center	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 - Actual harm Residents Affected - Few	On 10/31/24 at 8:35 a.m., Res #33 was observed sitting in their room. Res #33 stated Res #59 had attempted to come into their room and they had the right to defend their property. Res #33 stated they had pushed Res #59 out of their room. Res #33 stated they were not aware of any injuries Res #59 had received and did not care. On 10/31/24 at 8:30 a.m., CNA #1 stated they were present in the facility, but had not witnessed the incident between Res #33 and Res #59. They stated Res #33 was calm some of the time and angry at other times. CNA #1 stated they were not instructed to provide one-on-one supervision of Res #33 after the incident. They stated they had not been instructed on any interventions to prevent the occurrence of abuse regarding Res #33 prior to or after the incident. On 10/31/24 at 8:40 a.m., LPN #1 stated they were present in the facility, but had not witnessed the incident between Res #33 and Res #59. LPN #1 stated after the incident, Res #33 was instructed to stay in their room, but one-on-one staff supervision had not occurred. They stated Res #33 had a history of verbal/physical aggression, but no interventions had been implemented to prevent abuse. On 10/31/24 at 9:10 a.m., the DON stated the Res #33 had exhibited verbal aggression earlier in the day prior to the incident. They stated CNA #2 had been assigned to provide one-on-one supervision of Res #33. The DON stated CNA #2 had left Res #33 for a few minutes to answer a call light when the incident occurred with Res #59. They stated CNA #2 continued one-and-one supervision of Res #33 after the incident occurred. The DON stated one-on- one supervision of Res #33 continued for 72 hours and no additional verbal/physical behaviors were observed. They stated the one-on-one supervision would have been documented in the medical record. The DON stated they had not completed the incident report or investigation of the abuse. They stated the IP nurse or ADON usually completed those tasks. The DON stated there were not aware that Res #33's verbal/physical behaviors had not been documented in the care plan. On 10/31/24 9:50 a.m., CNA #2 stated they were present in the facility, but had not witnessed the incident between Res #33 and Res #59. CNA #2 stated they had not been instructed to provide one-on-one supervision of Res #33 prior to or after the incident of abuse. CNA #2 stated no interventions had been implemented for Res #33 before or after the incident to prevent verbal/physical abuse. On 10/31/24 at 9:40 a.m., the administrator was asked how the facility ensured residents were free from abuse. The administrator stated they were not sure other than rounding frequently. They stated Res #33's history of physical/aggressive behaviors should have been documented in their plan of care prior to the incident of abuse with Res #59. On 10/31/24 at 10:12 a.m., the IP stated they were not present in the facility when the incident occurred. The IP stated they completed the final incident report upon return to the facility. They stated they had interviewed staff and residents as part of the abuse investigation, but could not locate the documentation. The IP stated Res #33's history of verbal/physical behaviors should have been documented in the care plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375317	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Hills Living & Rehabilitation Center	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 - Actual harm Residents Affected - Few	On 10/31/24 at 10:24 a.m., the ADON stated they were present in the facility, but had not witnessed the incident between Res #33 and Res #59. They stated they had completed the initial incident report of abuse. The ADON stated a nurse aide had been assigned to provide one-on-one supervision of Res #33 after the incident, but could not remember which one. The ADON stated they had not personally completed any interviews or documentation regarding the abuse investigation. The ADON stated documentation of the 72 hour supervision of Res #33 and staff/resident interviews should have been completed by the nursing staff, but none of the documentation could be located at this time. They stated Res #33's history of verbal/physical aggressive behaviors should have been documented in the plan of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375317	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Hills Living & Rehabilitation Center	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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 46582 Based on observation, record review, and interview, the facility failed to conduct a thorough investigation into an incident of abuse for two (#33 and #59) of three sampled residents reviewed for abuse. The administrator identified 58 residents who resided in the facility. Findings: An Investigation of Abuse, Neglect and Exploitation policy, undated, read in parts, .The facility prohibits mistreatment, neglect or abuse of residents. The resident has the right to be free from verbal, sexual, physical, or mental abuse .Physical abuse includes hitting, slapping, pinching, and kicking .In the event there is an allegation or incidents involving resident to resident abuse, the individuals involved in the abuse should be immediately separated by staff .Once safety is established, the Administrator and Director of Nursing should be notified immediately. Put the resident on 1:1 when needed and document .An investigation into what triggered the abuse shall be conducted by the DON with referrals made accordingly .The facility shall prevent the occurrence of abuse by reviewing past specific incidents for lessons learned and policy amendments .The facility shall ensure that any substantiated incidents of abuse are reported and analyzed, and that appropriate corrective remedial or disciplinary actions occurs in accordance with local, state or federal law . 1. Res #33 had diagnoses which included major depressive disorder, suicidal ideations, and persistent mood disorder. A quarterly assessment, dated 06/07/24, documented Res #33 was cognitively intact, had minimal depression, and had exhibited physical and verbal behaviors towards others. 2. Res #59 had diagnoses which included Alzheimer's disease and insomnia. An admission assessment, dated 08/07/24, documented Res #59 was severely cognitively impaired, had no symptoms of depression, and had exhibited delusions. An OSDH initial incident report form, dated 08/07/24, read in part, .At approx 3:45 pm was in office, heard a loud commotion then a crash in hallway. [Res #59] was noted laying on back with blood on floor. Laceration on upper back of head. Pressure applied and EMS notified. [Res #33] stated I told that [curse word] to stay away from my room. Unnamed resident was in hallway and stated [Res #59] wasn't even in [Res #33] room, [Res #59] was in the hallway when [Res #33] pushed them hard and was cussing at them. [Res #59] was sent to the hospital for evaluation and treatment. [Res #33] was placed on 1 on 1 . The report documented the physician, resident representative, law enforcement, and APS was notified of the incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375317	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Hills Living & Rehabilitation Center	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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An OSDH final incident report form, dated 08/13/24, documented actual physical aggression by Res #33 against Res #59 witnessed by another unnamed resident. The report documented Res #33 had shoved Res #59 resulting in Res #59 falling to the floor and hitting their head. The unnamed resident witness stated the aggression was unprovoked. The report documented Res #33 had no further aggression noted and had no aggression against any resident witnessed or reported inside this facility prior to this incident. The report documented Res #59 did not return to the facility after discharge from the hospital. There was no documentation of an investigation related to the incident. On 10/31/24 at 8:35 a.m., Res #33 was observed sitting in their room. Res #33 stated Res #59 had attempted to come into their room and they had the right to defend their property. Res #33 stated they had pushed Res #59 out of their room. Res #33 stated they were not aware of any injuries Res #59 had received and did not care. On 10/31/24 at 8:30 a.m., CNA #1 stated they were present in the facility, but had not witnessed the incident between Res #33 and Res #59. They stated Res #33 was calm some of the time and angry at other times. CNA #1 stated they were not instructed to provide one-on-one supervision of Res #33 after the incident. They stated they had not been instructed on any interventions to prevent the occurrence of abuse regarding Res #33 after the incident. On 10/31/24 at 8:40 a.m., LPN #1 stated they were present in the facility, but had not witnessed the incident between Res #33 and Res #59. LPN #1 stated after the incident, Res #33 was instructed to stay in their room, but one-on-one staff supervision had not occurred. They stated Res #33 had a history of verbal/physical aggression, but no interventions had been implemented to prevent abuse. On 10/31/24 at 9:10 a.m., the DON stated the Res #33 had exhibited verbal aggression earlier in the day prior to the incident. They stated CNA #2 had been assigned to provide one-on-one supervision of Res #33. The DON stated CNA #2 had left Res #33 for a few minutes to answer a call light when the incident occurred with Res #59. They stated CNA #2 continued one-on-one supervision of Res #33 after the incident occurred. The DON stated one-on-one supervision of Res #33 continued for 72 hours and no additional verbal/physical behaviors were observed. They stated the one-on-one supervision would have been documented in the medical record. The DON stated they had not completed the incident report or investigation of the abuse. They stated the IP nurse or ADON usually completed those tasks. On 10/31/24 at 9:40 a.m., the administrator was made aware of the absence of abuse investigation documentation regarding Res #33 and Res #59. The administrator stated, That is not good. They stated an investigation should have been documented by the nursing staff. On 10/31/24 9:50 a.m., CNA #2 stated they were present in the facility, but had not witnessed the incident between Res #33 and Res #59. CNA #2 stated they had not been instructed to provide one-on-one supervision of Res #33 prior to or after the incident of abuse. CNA #2 stated no interventions had been implemented for Res #33 before or after the incident to prevent verbal/physical abuse. On 10/31/24 at 10:12 a.m., the IP stated they were not present in the facility when the incident occurred. The IP stated they completed the final incident report upon return to the facility. They stated they had interviewed staff and residents as part of the abuse investigation, but could not locate the documentation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375317	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Hills Living & Rehabilitation Center	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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24 at 10:24 a.m., the ADON stated they were present in the facility, but had not witnessed the incident between Res #33 and Res #59. They stated they had completed the initial incident report of abuse. The ADON stated a nurse aide had been assigned to provide one-on-one supervision of Res #33 after the incident, but could not remember which one. The ADON stated they had not personally completed any interviews or documentation regarding the abuse investigation. The ADON stated documentation of the 72-hour supervision of Res #33 and staff/resident interviews should have been completed by the nursing staff, but none of the documentation could be located at this time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375317	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Hills Living & Rehabilitation Center	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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 45913 Based on record review and interview, the facility failed to ensure resident assessments were accurate for two (#30 and #41) of 15 sampled residents whose resident assessments were reviewed for accuracy. The administrator identified 58 residents who resided in the facility. 1. Res #30 had diagnoses which included depression, anxiety, mood disorder, and intermittent explosive disorder. An annual resident assessment, dated 08/31/24, documented a diagnosis of psychotic disorder. 2. Res #41 had diagnoses which included impulse disorder. A quarterly resident assessment, dated 11/24/21, documented a diagnosis of psychotic disorder. On 10/29/24 at 1:05 p.m., the IP reported no resident had a diagnosis of psychotic disorder in the facility. They were unsure as to why resident assessments would document the diagnosis of psychotic disorder. On 10/31/24 at 11:41 a.m., the MDS coordinator reported they started their position in December, and documented the diagnosis, psychotic disorder, on Res #30 and #41 because the diagnosis was documented on their previous resident assessments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375317	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Hills Living & Rehabilitation Center	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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 46582 Based on record review and interview, the facility failed to notify the OHCA of a new possible serious mental disorder diagnosis for two (#37 and #20) of six sampled residents reviewed for PASARR assessments. The administrator identified 58 residents who resided in the facility. Findings: 1. A Level I PASARR, dated 07/19/21, documented Res #37 did not have a serious mental illness. On 10/06/21, Res #37 received a new diagnoses of specified persistent mood disorder. There was no documentation the OHCA had been contacted to see if a Level II PASARR was required. On 10/30/24 at 12:10 p.m., the administrator stated OHCA must not have been contacted because the notification information was not documented at the bottom of the Level I PASSAR that was reviewed. 42171 2. Resident #20 had diagnoses which included diabetes mellitus and adjustment disorder with depressed mood. A Level I PASARR screen, dated 11/29/22, documented no serious mental illness. On 01/06/23, the resident was diagnosed with delusional disorder. On 10/31/24 at 11:41 am, the administrator stated the OHCA should have been contacted regarding Resident #20's new diagnosis and it should have been documented in the nurse's notes. A review of Resident #20 medical record did not document the OHCA had been contacted regarding the diagnosis of delusional disorder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375317	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Hills Living & Rehabilitation Center	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 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. 46582 Based on observation, record review, and interview, the facility failed to ensure: a. vaping of tobacco did not occur inside the facility, and smoking assessments were completed quarterly for one (#35) of two sampled residents reviewed for smoking; and b. oxygen tanks were stored properly for one (#12) of five sampled residents reviewed for oxygen. The DON identified 23 residents who smoked/vaped tobacco products and 13 residents who received oxygen therapy. Findings: A smoking policy, dated 01/09/22, documented smoking/vaping is only allowed in designated areas. The policy documented the courtyard is the only designated area for residents to smoke. 1. Res #35 had a diagnosis of nicotine dependence. A care plan, dated 09/10/20, documented the resident was an unsupervised smoker. The care plan documented the resident would follow facility policy related to smoking areas. An annual assessment, dated 08/12/23, documented the resident was cognitively intact. A quarterly smoking assessment, dated 11/07/23, documented the resident had a minimal problem of smoking in unauthorized areas and had no problem with the ability to understand the facility's safe smoking policy. There was no additional documentation of quarterly smoking assessments found in record review. On 10/28/24 at 8:51 a.m., Res #35 was observed lying in bed. Res #35 was observed utilizing a battery-powered tobacco vape device. Res #35 stated it was acceptable to vape in their room as long as their roommate did not object. On 10/29/24 at 9:30 a.m., the DON was made aware of the observation. The DON stated residents were not allowed to vape tobacco inside the facility per policy. On 10/29/24 at 9:57 a.m., the DON stated a smoking assessment should have been completed quarterly for Res #35. 42171 2. Res #12 had diagnoses which included COPD and respiratory failure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375317	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Hills Living & Rehabilitation Center	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order, dated 06/15/23, documented Res #12 was to receive oxygen at three liters per minute via a nasal cannula. On 10/28/24 at 10:00 a.m., an oxygen tank was observed standing upright next to the wall in Res #12's room. The tank was not secured or in any type of holder. On 10/31/24 at 9:34 a.m., the DON stated oxygen tanks should be locked in the nurse's closet and not left in resident rooms unsecured.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375317	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Hills Living & Rehabilitation Center	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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 46582 Based on observation, record review, and interview, the facility failed to change and label oxygen tubing according to physician orders for four (#17, 28, 31, and #50) of four sampled residents reviewed for respiratory treatments. The DON identified 13 residents who received oxygen therapy. Findings: A Respiratory Care/Oxygen Therapy policy, dated 09/07/22, read in part, .Change tubing weekly. Label tubing with date and initials . 1. Res #17 had diagnoses which included COPD and chronic respiratory failure with hypercapnia. An admission assessment, dated 01/17/22, documented the resident was cognitively intact and received oxygen therapy. A physician order, dated 09/27/22, documented to change oxygen tubing weekly on Thursdays. The order documented to date and initial the tubing. On 10/28/24 at 9:56 a.m., Res #17 was observed lying in bed. The resident was observed wearing oxygen delivered by nasal cannula at three liters per minute. The oxygen tubing was observed with a tape label dated 10/17/24. Res #17 stated the staff changed the tubing, but was not sure how often. 2. Res #28 had diagnoses which included COPD and chronic respiratory failure with hypercapnia. A physician order, dated 12/11/22, documented to change oxygen tubing weekly on Thursdays. The order documented to date and initial the tubing. An annual assessment, dated 12/12/23, documented the resident was cognitively intact and received oxygen therapy. On 10/28/24 at 10:11 a.m., Res #28 was observed sitting in a wheelchair. The resident was observed wearing oxygen delivered by nasal cannula at three liters per minute. The oxygen tubing was observed with a tape label dated 10/17/24. Res #28 stated they did not know when the tubing had been changed last. 3. Res #31 had diagnoses which included shortness of breath. A physician's order, dated 10/21/22, documented to change oxygen tubing weekly on Thursdays. On 10/28/24 at 2:05 p.m., Res #31 was laying in bed with oxygen infusing by nasal cannula at two liters per minute. The oxygen tubing was observed with tape labeled/dated 10/17/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375317	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Hills Living & Rehabilitation Center	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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Res #50 had diagnoses which included shortness of breath, chronic respiratory failure with hypercapnia and hypoxia, obstructive sleep apnea, congestive heart failure and COPD. A physician's order, dated 04/19/24, documented to change oxygen tubing weekly on Thursdays. On 10/28/24 at 2:06 p.m., Res #50 was laying in bed with oxygen infusing by nasal cannula at three liters per minute. The oxygen tubing was observed with tape labeled/dated 10/17/24. On 10/29/24 at 2:00 p.m., the DON was made aware of the oxygen tubing observations. The DON stated all oxygen tubing should have been changed weekly. They stated the tubing had not been changed on 10/24/24 per physician orders. 45913

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375317	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Hills Living & Rehabilitation Center	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42171 Based on observation and interview, the facility failed to maintain the physical environment of the kitchen and ensure employees with facial hair wore a beard guard in the kitchen. The administrator identified 58 residents who resided in the facility. Findings: On 10/28/24 at 8:30 a.m., the kitchen was observed to have: a. a broken paper towel dispenser at the handwashing sink, b. missing trim on the exterior door, c. a broken cover on a fluorescent light fixture, d. build up of brown sticky substance on the walls around the grill area, and e. rusted air vents on the ceiling. On 10/28/24 at 12:15 p.m., a male employee with a partial beard was observed in the kitchen not wearing a beard guard. On 10/29/24 at 12:00 p.m., a male employee with a partial beard was observed in the kitchen not wearing a beard guard. On 10/30/24 at 8:41 a.m., the CDM stated they had made maintenance aware of the physical environment. They stated they would ensure staff wore beard guards when needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375317	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Hills Living & Rehabilitation Center	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 46582 Based on record review and interview, the facility failed to implement a water management program to prevent the growth of Legionella and other opportunistic waterborne pathogens in the building water system. The administrator identified 58 residents who resided in the facility. Findings: CMS memo 17-30, revised date 06/09/17, documented CMS expects long term care facilities to have water management policies and procedures to reduce the risk of growth and the spread of Legionella and other opportunistic pathogens in the facility water system. No documentation of water management policies and procedures were found from record review. On 10/29/24 at 1:00 p.m., the maintenance supervisor was asked to provide documentation of water management policies and procedures. The maintenance supervisor stated they had never heard of a water management program to reduce the risk and growth of Legionella. They stated the facility did not need a water management program because they never had any standing water. On 10/29/24 at 1:22 p.m., the IP stated the facility did not have policies and procedures to reduce the risk of growth and spread of Legionella.