STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375405	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrah Nursing Center	2400 Whites Meadow Drive Harrah, OK 73045

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure medical records were provided to a resident's representative and legal representative within 48 hours of request for 1 (#1) of 3 sampled residents reviewed for release of medical records.The director of nursing identified 68 residents resided in the facility. Findings: A Release of Information policy, dated 11/01/09, read in part, All information contained in the resident's medical record is confidential and may only be released by the written consent of the resident or his/her legal representative, consistent with state laws and regulations.A resident may obtain photocopies of his or her records by providing the facility with at least forty-eight hours' advance notice of such request.A discharge summary for Resident #1, dated 11/16/26, showed the resident admitted to the facility on [DATE] with diagnosis of deep vein thrombosis. The discharge summary showed the resident discharged from the facility on 11/10/25.A release of confidential information consent form for Resident #1, dated 12/19/25, showed the form was signed by the resident's representative.A copy of Resident #1's medical records, provided by family member #1, showed the records were printed on 12/29/25.A fax coversheet, dated 01/12/26, showed a records request from a lawyer's office.A written note provided by the administrator, dated 03/31/26 at 8:53 p.m., showed a call from a lawyer's office reporting they had made a second request for medical records on 02/03/26. A facility letter to the lawyer's office, dated 03/31/26, showed medical records for Resident #1 were sent on 03/31/26.On 04/29/26 at 4:35 p.m., family member #1 stated the family had issues with getting copies of Resident #1's medical records. Family member #1 stated family member #2 had requested Resident #1's medical records on 12/19/25 and did not receive the records until 01/02/26. Family member #1 stated the lawyer's office requested the resident's medical records from the facility on 01/12/26, 02/02/26, and 03/31/26. Family member #1 stated the lawyer's office did not receive the medical records until after the third request on 03/31/26.On 05/01/26 at 10:31 a.m., the administrator stated medical records should be released twenty-four to forty-eight hours after the release of information is signed. The administrator stated they did not know when the records were requested or released. The administrator stated they were told by the resident's representative it was no hurry in getting the records to them. The administrator stated the medical records were sent to the lawyer's office on 03/31/26, and they believed it was the second request from the lawyer's office.On 05/01/26 at 11:04 a.m., the administrator stated they found the records release signed by the resident's representative dated 12/19/25. The administrator stated there was no documentation of when the records were picked up by the resident's representative or when the lawyer's office had first requested the medical records.On 05/01/26 at 1:30 p.m., family member #2 reported they did not tell the facility it was no hurry on getting the medical records.

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