STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375409	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corn Heritage Village and Rehab	106 West Adams Corn, OK 73024

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the physician was notified of a change in condition for 1 (#3) of 3 sampled residents reviewed for change in condition.The administrator identified 54 residents resided in the facility. Findings:A policy titled Neurological Observation, updated 10/12/17, read in part, A resident that receives any type of head wound or trauma involving the head, a neurologic assessment will be performed for the period of 72 hours. The physician will be notified immediately and with any changes in neurological status.A policy titled Notification of Changes, dated 10/24/24, read in part, All pertinent information will be made available to the provider by the health care team. Team members are educated to identify changes in a resident's status and define changes that require notification .of the resident's physician, to ensure best outcomes of care for the resident. Requirements for notification of .physician: A significant change in the resident's physical, mental, or psychosocial status. A significant change includes deterioration in health, a need to alter treatment significantly.A Medication Administration Record, dated June 2025, showed Resident #3 was taking Xarelto (a blood thinner) 20mg one tablet at bedtime every day. The medication administration record showed the Xarelto was given 06/01/25 through 06/24/25 and never held. An Incident Note, dated 06/23/25 at 7:00 a.m., read in part, Late entry: Resident was getting up out of [their] recliner and fell forward to the floor, hitting [their] head and causing a large goose egg. Bruising is noted to area. Resident wasn't sure what happened or why [they] fell. Was found in a sitting position by CNA. Resident also has bruising to upper left arm as well as an abrasion to left hand. Neuros WNL. Systolic BP elevated. Resident does report pain at the site of the knot on [their] head.A Neurological Flow Sheet, dated 06/23/25 at 10:30 a.m., showed Resident #3's blood pressure was 127/49.An Incident Note, dated 06/23/25 at 7:00 p.m., read in part, Focus charting on IR of unwitnessed fall in room on 6/23/25 with neuro checks. Resident awake and verbal with [family member] to visit. Resident with hematoma and discoloration to left side of forehead, bruising to left arm, and middle finger to left hand. Voiced of slight pain per generalized areas. Meds and tx per order, staff to monitor for changes. 132/53 97.1 84 18 92%.An Incident Note, dated 06/24/25 at 1:57 a.m., read in part, Focus charting on IR of unwitnessed fall in room on 6/23/25 with neuro checks. Resident awake and verbal with [family] to visit. Resident with hematoma and discoloration to left side of forehead, bruising to left arm, and middle finger to left hand. Voiced of slight pain per generalized areas. Meds and tx per order, staff to monitor for changes. 111/49 96.2 74 18 87%.An Incident Note, dated 06/24/25 at 8:00 a.m., read in part, Focused evaluation related to unwitnessed fall on 06/22/2025. New injury noted. Resident now has 2 black eyes that didn't show up yesterday. Resident also has bruised, tender left foot. Resident is able to move foot up and down. VS are as follows: 125/53,97.9, 76, 18, 90%.A Neurological Flow Sheet, dated 06/24/25 at 11:30 a.m., showed Resident #3's blood pressure was 103/43.A Nurse Progress Note, dated 06/24/25 at 7:47 p.m., read in part, Staff reported resident requiring more assistance with ambulating. Possibly needing walker to steady self.A Transfer to Hospital Summary Note, dated 06/25/25 at 7:45 p.m., read in part, Resident continues on neuro check. This nurse entered resident room. Resident's [family member] at bedside. Resident noted to have a change in neuro status. Pupils pinpoint and resident confused and slow to respond. Reported to [physician name withheld]. New order received to send resident to ER via ambulance.A Discharge summary, dated [DATE], read in part, admission diagnosis acute subdural hematoma. Bruising on entire face. Past medical history of atrial fibrillation on Xarelto, admitted to neuro ICU on 06/25/25 for traumatic left subdural hematoma after a fall at [their] nursing home. Patient's anticoagulation was reversed.An MDS Assessment, dated 10/08/25, showed Resident #3 was admitted to the facility on [DATE] with diagnoses to include atrial fibrillation and heart failure.On 10/27/25 at 2:45 p.m., the DON stated Resident #3 should have been sent to the hospital immediately after the fall on 06/23/25 due to being on a blood thinner. On 11/10/25 at 10:50 a.m., Resident #3's physician's office was contacted. The physician's nurse stated the charge nurse (LPN #2) had reported Resident #3's fall on 06/23/25, but was told Resident #3 was not on a blood thinner. The physician's nurse stated no other information regarding Resident #3 was reported to the physician.On 11/10/25 at 12:17 p.m., LPN #2 stated they did not notify the physician Resident #3 was on a blood thinner when they reported their fall on 06/23/25. When LPN #2 was asked to verify the indication for Xarelto, they stated, It's a blood thinner and I overlooked it. LPN #2 stated Resident #3 should have been sent out immediately after the fall on 06/23/25 due to hitting their head and taking blood thinners. LPN #2 stated the physician should also have been notified of Resident #3's two black

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure allegations of abuse were reported to the OSDH no later than 24 hours of the alleged abuse for 2 (#1 and #2) of 2 sampled residents reviewed for abuse.The administrator identified 54 residents resided in the facility.Findings:Findings:On 10/22/25 at 2:45 p. m., during facility tour, Resident #1 was observed to have 1:1 supervision with staff.An undated facility policy titled Reporting Resident Neglect, Mistreatment, Exploitation, Abuse or Misappropriation of a Resident's Property read in part, It is the responsibility of Corn Heritage Village to accept reports of incidents or suspected incidents .from any source. Any alleged violations involving abuse must be reported immediately to the administrator and Director of Nursing. This notification shall apply to any time of day or night. The Administrator or Director of Nursing is responsible for reporting any allegations of abuse to officials in accordance with state law.An initial report made to the OSDH, dated 10/21/25, showed alleged abuse occurred on 10/19/25. The report showed staff heard Resident #1 stated, Give it to me to Resident #2. The report showed as staff approached the two residents who were sitting in the common area, they observed Resident #1 placed Resident #2's hands in Resident #1's groin area over their clothes. The report showed the two were immediately separated. 1. Resident #1's annual MDS, dated [DATE], showed a BIMS score of 9, which indicated moderate cognitive impairment, was alert to self only, and required assistance with most ADL's including transfers, but was independent with wheelchair mobility.A comprehensive care plan, dated 08/15/25, showed Resident #1 had history of sexual inappropriate statements and placed their hands in their own pants in public areas.Resident #1's October 2025 physician orders showed diagnoses which included dementia, hypertension, restless leg syndrome, and diabetes mellitus. 2. An admission MDS for Resident #2, dated 09/15/25, showed a BIMs score of 3, which indicated severe cognitive impairment and the resident was alert to self only. The assessment showed Resident #2 required assistance with most ADL's including transfers and was dependent with wheelchair mobility. Resident #2's October 2025 physician orders showed Resident #2 was admitted on [DATE] with diagnoses which included intellectual disabilities and hypertension. On 10/22/25 at 4:05 p.m., Resident #2 stated everyone was nice and denied being approached by a resident of the opposite sex.On 10/27/25 at 2:45 p.m., the DON verified the allegation of resident-to-resident sexual abuse should have been reported to OSDH within 24 hours.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/10/25 at 2:33 p.m., the OSDH was notified and verified the existence of an immediate jeopardy situation related to the facility's failure to ensure monitoring and intervention for Resident #3 who was on a routine long-term anticoagulant. This resulted in the resident being admitted to the ICU with an acute subdural hemorrhage after a fall.On 11/10/25 at 3:34 p.m., the administrator and interim executive director were notified of the immediate jeopardy and was provided the immediate jeopardy template. On 11/13/25 at 12:39 p.m., an acceptable plan of removal was approved by the OSDH.The plan of removal read in part,Staff will identify residents on anticoagulants at shift change by notifying oncoming staff at shift change of all residents on anticoagulants starting 11/14/2025 7:00 am at shift change and going to continue for 4 weeks and then reevaluate at that time.Administration will post a roster in the medication room of all residents on anticoagulants.Administration will post a roster in the medication room of all anticoagulant medications.Will adjust EHR resident dashboard to indicate the use of anticoagulant medicationImmediate In-Service Education of medication management with a focus on high-risk drugs like anticoagulants for nursing staff and CMAs.Competency assessments will be completed by nursing administration including demonstrations of skills, med-administration, side effects and monitoring requirements.All residents were reassessed for changes in condition and care plans were updated for discrepancies.Nursing staff were educated on monitoring residents through routine assessments (Every shift for 72 hours), ongoing observation, and documentation. This includes checking vital signs, evaluating physical and mental status, and noting any changes in behavior, appearance, or function. Staff are now trained to recognize both subtle and obvious changes in residents' health, such as increased confusion, changes in mobility, altered appetite, new or worsening pain, or unusual sleep patterns.Nursing Staff were educated on promptly notifying the physician whenever there is a significant change in the condition of a nursing home resident on anti-coagulants. This includes any acute medical events, substantial changes in physical or mental status, or any situation that may require a change in treatment or intervention. Notification should occur as soon as reasonably possible after the change has been identified by nursing staff, in accordance with regulatory guidelines and the facility's policies. Nursing home nursing staff will receive dedicated training focused on the indications for commonly used medications, with special emphasis on blood thinners. The training will cover: Overview of blood thinners: indications, expected outcomes, and common side effects. Recognizing signs and symptoms of adverse reactions or complications (e.g., bleeding, bruising, changes in mental status, or unexplained pain). Monitoring protocols for residents on blood thinners, including vital signs, laboratory values, and physical assessments. Documentation requirements and communication procedures for reporting changes in resident conditions. Emergency response procedures for suspected medication-related complications. The training will be delivered by the facility's Director of Nursing, in collaboration with the facility pharmacist consultant and CHV nurse consultant. These professionals have specialized knowledge in pharmacology, geriatric care, and clinical practice, ensuring nursing staff receive accurate and practical information.The IJ was lifted, effective 11/14/25 at 11:59 p.m., when all components of the plan of removal had been verified as completed. Records of staff training showed all staff, including administration, had received training in intervening when there were changes in residents' condition as well as completed an annual competency skill checklist. Records of nurse competency skill checks and nurse tests regarding new training were verified to be complete. Review of a current resident assessment log showed residents who were identified to receive high risk drugs such as anticoagulants were reassessed by the DON and ADON and care plans were updated. Interviews conducted with staff showed they had received training in falls, medications, and changes in condition. The deficiency remained at an isolated level with the potential for more than minimal harm.Based on observation, record review and interview, the facility failed to ensure monitoring and intervention was implemented for a change in condition for 1 (#3) of 1 sampled resident reviewed for monitoring and intervention.The administrator identified 54 residents resided in the facility.Findings:On 10/23/25 at 11:50 a.m., Resident #3 was observed to be lying in bed. The resident was pleasant and smiling. A facility policy titled Neurologic Observation dated 10/12/17, read in part, a resident that receives any type of head wound or trauma involving the head, a neurologic assessment will be performed for the period of 72 hours. The physician will be notified immediately and with any changes in neurological status.An initial incident report made to OSDH, dated 06/28/25, showed Resident #3 had an unwitnessed fall from the recliner in their room, which occurred on 06/23/25. The report read in part, per nurses notes resident was

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 11/10/25 at 2:33 p.m., the OSDH was notified and verified the existence of an immediate jeopardy situation related to the facility's failure to ensure nursing staff were competent to effectively assess, monitor, and intervene for Resident #3 who was on a routine blood thinner and sustained a fall with injury causing an acute subdural hemorrhage resulting in being admitted to ICU.On 11/10/25 at 3:34 p.m., the administrator and interim executive director were notified of the immediate jeopardy and was provided the immediate jeopardy template. On 11/13/25 at 12:39 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part,Plan of removal: 11/14/25 11:59 p.m.All nursing staff have completed Skills Competency proficiency of change of condition with a focus on high-risk drugs like anticoagulants for nursing staff.DON and ADON have been In-service on training and completing nursing skills competency education for nursing staff by administrator.All residents were reassessed for changes in condition and care plans were updated for discrepancies.DON and ADON have been educated on auditing nursing staff annual skills competency educationDON and ADON have been educated on auditing nursing staff new hire skills competency educationNursing staff will complete testing regarding changes in condition, medication drug class identification, and recognizing vital signs.Nursing staff are educated on what constitutes a significant change in condition that requires reporting by Corn Heritage Village Nurse Consultant. These changes include, but are not limited to: Sudden onset of symptoms (chest pain, shortness of breath, acute confusion)Significant changes in vital signs (high fever, low blood pressure, rapid heart rate)New or worsening painChanges in mobility, such as inability to walk or standAltered level of consciousness or responsivenessSigns of infection (redness, swelling, discharge)Unexplained weight loss or gainChanges in skin integrity, such as new wounds or pressure sores.The IJ was lifted, effective 11/14/25 at 11:59 p.m., when all components of the plan of removal had been verified as completed. Records of staff training showed all staff, including administration, had received training in intervening when there were changes in residents' condition as well as completed an annual competency skill checklist. Review of a current resident assessment log showed residents who were identified to receive high risk drugs such as anticoagulants were reassessed by the DON and ADON and care plans were updated. Interviews conducted with staff showed they had received training in falls and changes in condition. The deficiency remained at an isolated level with the potential for more than minimal harm.Based on record review and interview, the facility failed to ensure staff were competent to effectively assess, monitor, and intervene for residents with a change in condition for 1 (#3) of 1 sampled resident reviewed for monitoring and intervening.The administrator identified 54 residents resided in the facility. Findings: A policy titled Neurological Observation, updated 10/12/17, read in part, A resident that receives any type of head wound or trauma involving the head, a neurologic assessment will be performed for the period of 72 hours. 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Resident with hematoma and discoloration to left side of forehead, bruising to left arm, and middle finger to left hand. Voiced of slight pain per generalized areas. Meds and tx per order, staff to monitor for