STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375434	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heavener Nursing & Rehab	114 West 2nd Street Heavener, OK 74937

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident did not physically abuse another resident for 1 (#11) of 5 sampled residents reviewed for abuse. The DON identified 69 residents resided in the facility. Findings: An undated Abuse Policy and Procedure, read in part, We will endeavor to protect our occupants from maltreatment, which means any exploitation, neglect, physical abuse, sexual abuse, neglect, and the misappropriation of property. A nurse progress note, dated 12/22/25, showed Resident #11 tried to take a plate of food from another unnamed resident. The unnamed resident refused to release the tray. The note showed Resident #11 grabbed the unnamed resident's arm and clawed them. The altercation resulted in a skin tear to unnamed resident's right forearm with moderate bleeding. The note showed the two residents then tried to hit each other but were separated by CNAs and nurse. The note showed Resident #11 had been up all night wandering around taking things that were not theirs. A quarterly assessment, dated 04/27/26, showed Resident #11 was admitted on [DATE] and had a brief interview for mental status score of 1 indicating severe cognitive impairment. The assessment showed Resident #11 was diagnosed with Alzheimer's dementia. On 06/09/26 at 12:28 p.m., the DON stated Resident #11 had not hurt other residents, but Resident #11 was combative towards staff when they were trying to provide care. The DON stated Resident #11's medications had changed about two months ago during their last geriatric psychiatric hospitalization, and they had been pleasant since their return. On 06/10/26 at 12:54 p.m., LPN #1 stated At 1:30 p.m. every day, [Resident #11] would decide they were done with us. LPN #1 stated Resident #11 would then start to become more combative towards staff trying to provide care. LPN #1 stated Resident #11 had been to geriatric psychiatric facilities at least twice and had tried three different psychotropic medications. LPN #1 stated the hospital had prescribed lower potency drugs initially and then prescribed higher potency medications when the resident returned to the hospital. LPN #1 stated since Resident #11 came back from the hospital the second time, the medications had helped Resident #11 allow staff to provide care. On 06/11/26 at 2:36 p.m., the DON was provided the progress note written on 12/22/25. The DON stated they had not known about the incident, but it should have been reported.

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
	375434	A. Building B. Wing	06/11/2026

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Heavener Nursing & Rehab	114 West 2nd Street Heavener, OK 74937

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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 record review and interview, the facility failed to report an allegation of physical abuse for 1 (#11) of 1 sampled resident reviewed for abuse. The DON identified 69 residents resided in the facility. An undated Abuse Policy and Procedure, read in part, All allegations of resident maltreatment, including neglect, physical abuse .shall be promptly reported to Administrator and investigated by Facility management. Administrator will immediately report the allegation to the Oklahoma State Department of Health and the Local Police. An Acknowledgement of Resident Rights Training which includes Abuse, Neglect, Misappropriation of Property and Burnout, signed by RN #1 on 08/23/25, read in part, I understand the definition of abuse .I also understand when and to whom I am to report any violation of resident rights and what my participation is expected to be during any investigation of an allegation of such. Two actions to be taken immediately are stopping the abuse and reporting it to my supervisor/administrator immediately upon finding, I understand that any violation of resident rights can result in a variety of disciplinary actions up to termination of employment. A nurse progress note signed by RN #1, dated 12/22/25, showed Resident #11 tried to take a plate of food from another unnamed resident. The unnamed resident refused to release the tray and Resident #11 grabbed the unnamed resident's arm and clawed them. The note showed the altercation resulted in a skin tear to the unnamed resident's right forearm with moderate bleeding. The two residents then tried to hit each other but were separated by CNAs and a nurse. The note showed Resident #11 had been up all night wandering around taking things that were not theirs. A quarterly assessment, dated 04/27/26, showed Resident #11 was admitted on [DATE] and had a brief interview for mental status score of 1 indicating severe cognitive impairment. The assessment showed Resident #11 had a diagnosis of Alzheimer's dementia. On 06/09/26 at 12:28 p.m., the DON stated Resident #11 had not hurt other residents, but Resident #11 was combative towards staff when they were trying to provide care. The DON stated Resident #11's medications had changed about two months ago during their last geriatric psychiatric hospitalization, and they had been pleasant since their return. On 06/11/26 at 2:36 p.m., the DON was provided the progress note written on 12/22/25. The DON stated they had not known about the incident, but it should have been reported.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to ensure infection control was maintained during finger stick blood sugar checks and insulin injections for 7 (#12, 13, 14, 15, 16, 17, and #18) of 7 sampled residents observed for infection control. The regional consultant identified 19 residents required finger stick blood sugar checks. Findings: On 06/10/26 at 12:02 p.m., LPN #1 was observed obtaining Resident #12's FSBS. LPN #1 lanced Resident #12's finger and obtained a blood sample using a glucometer. LPN #1 was not observed to have cleaned the glucometer after the procedure. On 06/10/26 at 12:04 p.m., LPN #1 was observed obtaining Resident #13's FSBS. LPN #1 lanced Resident #13's finger and obtained a blood sample using a glucometer. LPN #1 was not observed to have cleaned the glucometer after the procedure. On 06/10/26 at 12:08 p.m., LPN #1 was observed administering an insulin injection to Resident #13. LPN #1 was not observed to have worn gloves during the insulin injection. On 06/10/26 at 12:10 p.m., LPN #1 was observed obtaining Resident #14's FSBS. LPN #1 lanced Resident #14's finger and obtained a blood sample using a glucometer. LPN #1 was not observed to have cleaned the glucometer after the procedure. On 06/10/26 at 12:13 p.m., LPN #1 was observed administering an insulin injection to Resident #14. LPN #1 was not observed to have worn gloves during the insulin injection. On 06/10/26 at 12:15 p.m., LPN #1 was observed obtaining Resident #15's FSBS. LPN #1 lanced Resident #15's finger and obtained a blood sample using a glucometer. LPN #1 was not observed to have cleaned the glucometer after the procedure. LPN #1 was not observed to wash or sanitize their hands after the procedure. On 06/10/26 at 12:21 p.m., LPN #1 was observed obtaining Resident #16's FSBS. LPN #1 lanced Resident #16's finger and obtained a blood sample using a glucometer. LPN #1 was not observed to have cleaned the glucometer after the procedure. LPN #1 was not observed to wash or sanitize their hands after the procedure. On 06/10/26 at 12:28 p.m., LPN #1 was observed obtaining Resident #17's FSBS. LPN #1 lanced Resident #17's finger and obtained a blood sample using a glucometer. LPN #1 was not observed to have cleaned the glucometer after the procedure. On 06/10/26 at 12:34 p.m., LPN #1 was observed obtaining Resident #18's FSBS. LPN #1 lanced Resident #18's finger and obtained a blood sample using a glucometer. LPN #1 was not observed to have cleaned the glucometer after the procedure and before placing the glucometer back into the medication cart. LPN #1 was not observed to wash or sanitize their hands after the procedure. On 06/10/26 at 12:39 p.m., LPN #1 stated the process to obtain a FSBS was to sanitize the skin and poke the side of the finger. LPN #1 stated they had two glucometers they would alternate use of to allow for sanitization, but one of the glucometers had been misplaced.On 06/11/26 at 2:35 p.m., the DON stated the glucometer should have been cleaned between each resident.