

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER Heritage Skilled Nursing and Therapy		STREET ADDRESS, CITY, STATE, ZIP CODE 201 West Walnut Tecumseh, OK 74873	

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)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>49701</p> <p>Based on observation, record review, and interview, the facility failed to ensure protected health information was secure for 1 (#66) of 65 residents receiving care in the facility.</p> <p>The administrator identified 65 residents resided in the facility.</p> <p>Findings:</p> <p>On 03/26/25 at 12:24 p.m., a computer on a cart by the nurses station for the North and Northeast halls was observed to be open and showed protected health information for Resident #66. There were no residents or staff around at that time.</p> <p>A Resident's Records policy in the admission agreement, dated 10/14/19, read in part, Information included in the resident's medical records is confidential. Unauthorized persons shall not be allowed to review these records without the Resident's written consent except as required or permitted by law.</p> <p>On 03/26/25 at 12:27 p.m., the ADON returned to the cart and stated they were busy collecting a Vanco trough (antibiotic lab draw) and had just forgotten to close the screen out. They stated they knew it was a violation of Health Insurance Portability and Accountability Act (HIPPA).</p> <p>On 03/27/25 at 8:40 a.m., the administrator stated the ADON knew not to leave protected health information unsecured.</p>

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43023</p> <p>Based on record review and interview, the facility failed to develop comprehensive care plans for 2 (#24 and #38) of 19 resident care plans reviewed.</p> <p>The administrator identified 65 residents resided in the facility.</p> <p>Findings:</p> <p>1. Resident #24 was admitted to the facility on [DATE] with diagnosis of displaced fracture of upper end of left humerus.</p> <p>The admission (comprehensive) assessment was completed on 02/28/25. Care areas that were triggered (potential areas of concern) during the comprehensive assessment included: cognitive loss/dementia, ADL function, urinary incontinence, and psychoactive drug use.</p> <p>The care plan did not include cognitive loss, ADL function, urinary incontinence, or psychoactive drug use when reviewed on 03/25/25. The care plan should have been completed by 03/07/25.</p> <p>The Resident Assessment Instrument (RAI) guidelines state the comprehensive care plan should be completed by admission assessment completion plus seven days, and no later than the admitted plus 21 days.</p> <p>On 03/25/25 at 1:04 p.m., the MDS coordinator stated the comprehensive care plan was incomplete and should have addressed the triggered care areas. They stated it was their responsibility to make sure everything was in the care plan.</p> <p>2. Resident #38 was admitted to the facility with diagnosis of displaced intertrochanteric fracture of the left femur.</p> <p>An admission (comprehensive) assessment, dated 02/22/25, showed the resident required assist of one with all ADL's.</p> <p>A care plan, dated 03/03/25, did not contain ADL documentation. The care plan should have been completed by 03/01/25.</p> <p>On 03/27/25 at 7:51 a.m., the MDS coordinator reported ADL's should have been care planned.</p> <p>On 03/27/25 at 8:30 a.m., the administrator stated they were unaware comprehensive care plans were not being completed.</p> <p>49701</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49701</p> <p>Based on observation, record review, and interview, the facility failed to monitor and intervene for a PICC line that required care for 1 (#215) of 2 sampled residents with PICC lines.</p> <p>The administrator identified 65 residents resided in the facility and two residents had PICC lines.</p> <p>Findings:</p> <p>On 03/26/25 at 12:18 p.m., a PICC line to Resident #215's left shoulder was observed with a dressing that had a date of 03/16/25 on it. There was brown drainage noted under the clear dressing.</p> <p>Resident #215 was admitted on [DATE] with a diagnosis of encephalopathy and severe sepsis with septic shock.</p> <p>An IV [intravenous therapy] Nursing Policies and Procedures policy, dated 06/01/11, read in part, Sterile dressing changes will be performed every 7 days and immediately if the integrity of the dressing is compromised.</p> <p>On 03/26/25 at 12:27 p.m., the ADON stated they were trying to get orders to discontinue the PICC line. They stated the policy was to change the dressing within 24 hours after being placed and then every 72 hours. They stated the dressing had not been changed. They stated, There is no excuse for it to go this long in all honesty.</p> <p>On 03/27/25 at 8:31 a.m., the RN/administrator stated they were unaware the PICC line had not been taken care of. They stated they received the order to discontinue this morning and removed the PICC line.</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>43023</p> <p>Based on observation, record review, and interview, the facility failed to ensure bottles containing tube feeding were labeled and dated for 2 (#30 and #215) of 2 sampled residents observed for tube feeding.</p> <p>The administrator identified three residents required tube feedings.</p> <p>1. On 03/26/25 at 7:48 a.m., the tube feeding for Resident #30 was observed running at 60 ml/hr. The bottle was not labeled with the date or time opened, or who hung the bottle.</p> <p>A Tube Feeding policy, dated 06/24/10, read in part, Change and label (name of resident, date, and time) feeding set (tubing and appropriate syringe) every 24 hours.</p> <p>Resident #30 admitted to the facility with diagnoses which included dysphagia, diabetes mellitus, major depressive disorder, chronic pain, and cerebral infarction.</p> <p>A physician order, dated 10/14/24, read in part, one time a day Diabetisource AC 1250ml 60ml/hr x 21 hours flush at 35ml/hr over 21 hours AND one time a day turn feeding off at 9am on at noon AND every shift Diabetisource AC 60ml/hr x 21 hours document amount of formula only AND every shift flush 35ml/hr x 21 hours document amount of flush only.</p> <p>On 03/26/25 at 2:13 p.m., RN #1 was made aware of the observation this morning of the feeding tube bottle not having a date, time, or initials. RN #1 reported the bottle did not have any information on it.</p> <p>2. On 03/26/25 at 8:10 a.m., the ADON stopped the tube feeding that was running at 60 ml/hr so wound care could be completed. The tube feeding was observed to have no label or date.</p> <p>Resident #215 was admitted to the facility with a diagnosis of cachexia (significant weight loss and muscle wasting).</p> <p>A physician order, dated 03/21/25, showed enteral feed order: every shift Diabetisource AC 60 ml/hr x 24 hours.</p> <p>On 03/26/25 at 8:21 a.m., the corporate nurse stated the tube feeding bottle should be labeled with the date and time it was opened and hung and by whom, but it was not.</p> <p>On 03/27/25 at 7:35 a.m., the administrator was made aware of the above observations. The administrator stated the tube feeding bottles should have been dated, timed, and initialed per facility policy.</p> <p>49701</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Post nurse staffing information every day.</p> <p>43023</p> <p>Based on observation and interview, the facility failed to post nurse staffing in a prominent place accessible to residents and visitors.</p> <p>The administrator identified 65 residents who resided in the facility.</p> <p>Findings:</p> <p>On 03/25/25 at 8:00 a.m., no staffing board was observed in the facility.</p> <p>On 03/26/25 at 9:15 a.m., no staffing board was observed in the facility.</p> <p>On 03/26/25 at 10:58 a.m., the director of nursing pointed out a schedule on a cork board behind the nurses desk. Only half of the schedule was seen.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49701</p> <p>Based on observation, record review, and interview, the facility failed to ensure infection control practices were followed for glove usage.</p> <p>The administrator identified 65 residents resided at the facility.</p> <p>Findings:</p> <p>On 03/25/25 at 11:12 a.m., RN #1 was observed wearing gloves and getting a finger stick blood sugar of a resident. RN #1 then changed gloves and gave the resident their insulin. They did not sanitize their hands between glove changes.</p> <p>On 03/25/25 at 11:15 a.m., RN #1 was observed still wearing the same gloves out in the hall to get the sanitizing wipes from the nurses' cart. RN #1 cleaned the glucometer and then removed their gloves.</p> <p>A Personal Protective Equipment policy, dated 03/02/24, read in part, Gloves can protect both patients and healthcare personnel from exposure to infectious materials that may be carried on hands. During patient care, transmission of infectious organisms can be reduced by adhering to the principles of working from 'clean to dirty' and confining or limiting contamination to surfaces that are directly needed for patient care.</p> <p>On 03/25/25 at 11:18 a.m., RN #1 stated they should have sanitized their hands between glove changes, but they were unaware of the infection control issue when wearing gloves out in the hall after just giving insulin while wearing them.</p> <p>On 03/27/25 at 8:29 a.m., the administrator stated they do a lot of education on not wearing gloves in the halls.</p>		