

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375493	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Heartsworth Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 West Canadian Avenue Vinita, OK 74301	
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 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on record review and interview, the facility failed to ensure a volunteer with adverse actions was not allowed to volunteer at the facility for 1 (Volunteer #1) of 1 sampled volunteer reviewed for adverse actions. The ADON identified seven volunteers performed services in the facility. Findings: An undated facility policy titled Abuse, Neglect and Exploitation, read in part, Background, reference, and credentials' checks will be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. The facility will maintain documentation of proof that the screening occurred. An activity calendar, dated 07/2026, showed karaoke was to be held in the facility on 07/09/26, 07/16/26, 07/23/26, and 07/30/26 from 1:00 p.m. until 4:00 p.m. A review of the sex offender registry showed Volunteer #1 was convicted of lewd or indecent proposals/acts to a child on 09/01/04 and was a registered sex offender. On 07/08/26 at 9:50 a.m., the activities director stated Volunteer #1 had been performing karaoke on Thursday afternoons at the facility for at least two years. On 07/09/26 at 9:40 a.m., the ADON stated Volunteer #1 was on the sex offender registry and should not have been allowed to volunteer at the facility. The ADON stated they had not been screening volunteers, but they were going to start screening the volunteers. On 07/09/26 at 09:50 a.m., the DON stated Volunteer #1 was a registered sex offender and should not have been volunteering at the facility.		

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 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. Based on record review and interview, the facility failed to provide supervision to prevent elopement for 1 (#3) of 3 sampled residents reviewed for elopement. The ADON identified 11 residents at risk for elopement. Findings: An undated facility policy titled Elopements and Wandering Residents, read in part, This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. A quarterly assessment for Resident #3, dated 05/25/26, showed the resident had a brief interview for mental status score of 11, which indicated the resident was moderately impaired for daily decision making and could walk independently. A Wandering Risk Scale, dated 06/07/26, showed Resident #3 was a high risk to wander. An incident report form, dated 06/28/26, showed Resident #3 was returned to the facility at 3:27 p.m. after being located one block away from the facility. The report showed Resident #3 was assessed and no injuries were noted. The report showed the resident was off the property for 10-15 minutes. On 07/08/26 at 10:40 a.m., Certified Nurse Aide #1 stated Resident #3 wandered frequently but the staff kept an eye on them. On 07/08/26 at 11:15 a.m., Licensed Practical Nurse #2 stated they were not sure how Resident #3 got out of the building. They stated the doors were not locked, but they did have an alarm that was functioning properly. On 07/09/26 at 9:40 a.m., the ADON stated Resident #3 had not been adequately supervised when they eloped on 06/28/26. On 07/09/26 at 9:50 a.m., the DON stated they did not believe Resident #3 had been adequately supervised when they eloped from the facility on 06/28/26.		