

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375502	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Heritage Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 3804 North Barr Oklahoma City, OK 73122	

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>48344</p> <p>Based on observation, record review, and interview, the facility failed to ensure a privacy curtain was utilized during personal care for one (#9) of three sampled residents observed receiving incontinent care.</p> <p>The AIT identified 44 residents resided in the facility.</p> <p>Findings:</p> <p>An undated PERI CARE policy, read in part, Provide privacy, ensure door is closed, privacy curtain is pulled to provide full visual privacy and window blinds are closed.</p> <p>Resident #9 had diagnoses which included generalized muscle weakness and cerebral infarction.</p> <p>Resident #9's annual resident assessment, dated 09/17/24, documented they had severe cognitive impairment.</p> <p>Resident #9's care plan for ADL deficit, revised 10/10/24, documented they required total assist with toileting.</p> <p>On 10/22/24 at 2:59 p.m., CNA #1 entered Resident #9's room to provide incontinent care. CNA #1 closed the door. The resident's roommate was in the room in their wheelchair.</p> <p>On 10/22/24 at 3:00 p.m., CNA #1 told the resident they would be providing care. CNA #1 provided incontinent care to the resident. The privacy curtain was not utilized during the provision of care.</p> <p>On 10/22/24 at 3:11 p.m., CNA #1 stated the policy was to pull the privacy curtain during care. They stated they did not pull the privacy curtain during the provision of peri care.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>48344</p> <p>Based on observation, record review, and interview, the facility failed to ensure thorough incontinent care was provided for one (#9) of three sampled residents observed receiving incontinent care.</p> <p>The AIT identified 44 residents resided in the facility.</p> <p>Findings:</p> <p>Resident #9 had diagnoses which included generalized muscle weakness and cerebral infarction.</p> <p>Resident #9's annual resident assessment, dated 09/17/24, documented they had severe cognitive impairment.</p> <p>Resident #9's care plan for ADL deficit, revised 10/10/24, documented they required total assist with toileting.</p> <p>On 10/22/24 at 2:59 p.m., CNA #1 entered Resident #9's room to provide incontinent care. They closed the door.</p> <p>On 10/22/24 at 3:00 p.m., CNA #1 told Resident #9 they would be providing care. CNA #1 had on gloves. They partly removed the resident's soiled brief, turned the resident on their side, and cleansed their buttocks. Fecal matter was observed during cleaning. CNA #1 removed the soiled brief and put it in a trash bag. They put the soiled pad on the floor mat. CNA #1 put a new brief on the resident and adjusted the resident in bed. Fecal matter was observed on Resident #9's labia. CNA #1 did not clean the resident's front peri-area.</p> <p>On 10/22/24 at 3:02 p.m., CNA #1 was asked to observe Resident #9's front peri-area. They stated they did not see the fecal matter in the peri-area. The new brief was observed to have fecal matter. CNA #1 stated they were supposed to clean the resident's front peri-area.</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>48344</p> <p>Based on observation, record review, and interview, the facility failed to maintain infection control during the provision of incontinent care for one (#9) of three sampled residents observed receiving incontinent care.</p> <p>The AIT identified 44 residents resided in the facility.</p> <p>Findings:</p> <p>Resident #9 had diagnoses which included generalized muscle weakness and cerebral infarction.</p> <p>Resident #9's annual resident assessment, dated 09/17/24, documented they had severe cognitive impairment.</p> <p>Resident #9's care plan for ADL deficit, revised 10/10/24, documented they required total assist with toileting.</p> <p>On 10/22/24 at 2:59 p.m., CNA #1 entered Resident #9's room to provide incontinent care. They closed the door.</p> <p>On 10/22/24 at 3:00 p.m., CNA #1 told Resident #9 they would be providing care. CNA #1 had on gloves. They partly removed the resident's soiled brief, turned the resident on their side, and cleansed their buttocks. Fecal matter was observed during cleaning. CNA #1 removed the soiled brief and put it in a trash bag. They put the soiled pad on the floor mat. They put a new brief on the resident and adjusted the resident in bed. CNA #1 did not change their gloves.</p> <p>On 10/22/24 at 3:02 p.m., CNA #1 was asked to observe Resident #9's front peri-area. They stated they did not see the fecal matter in the peri-area. The new brief was observed to have fecal matter.</p> <p>On 10/22/24 at 3:03 p.m., CNA #1, with the same gloves they had on at the start of the incontinent care, opened Resident #9's drawers looking for wipes and a brief. They removed their gloves to go out of the room to locate wipes and a brief.</p> <p>On 10/22/24 at 3:06 p.m., CNA #1 came back with wipes. They donned gloves and cleansed the resident's peri-area. Another staff brought CNA #1 a brief. CNA #1 put the new brief on the resident and adjusted them in bed. CNA #1 did not change their gloves.</p> <p>On 10/22/24 at 3:08 p.m., CNA #1 with the same gloves, pinned the call light to the bed, and propped the resident with pillows. CNA #1 removed their gloves, took the trash out, and washed their hands.</p> <p>On 10/22/24 at 3:12 p.m., CNA #1 stated they were supposed to put the dirty pad in a plastic bag. They stated lately they were not provided with plastic bags.</p> <p>(continued on next page)</p>		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/24 at 3:13 p.m., CNA #1 stated they were supposed to change their gloves three times, but changed them twice during the incontinent care.		