

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: 375511	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Heritage Park		STREET ADDRESS, CITY, STATE, ZIP CODE 6912 Northwest 23rd Street Bethany, OK 73008	
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 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Based on interview and document review the facility's governing body failed to appoint a licensed administrator to be accountable and manage the facility since 05/07/2026. The deficient practice had the potential to affect all residents residing in the facility. Findings included: A letter from the Oklahoma State Department of Health (OSDH) to another facility, dated 06/18/2026, revealed this facility's Previous Administrator became the administrator of record of another facility beginning 05/07/2026. During an interview on 07/04/2026 at 11:00 AM, the Chief Financial Officer stated the last day the facility had a licensed administrator was on 05/07/2026, and the facility did not currently have a licensed administrator. He stated that he was not a licensed administrator and did not go into the building. On 07/08/2026 at 11:29 AM, the Director of Nursing (DON) stated that she expected that the facility would have a licensed nursing home administrator.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 375511	Facility ID: 375511 If continuation sheet Page 1 of 18

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and document review, the facility failed to ensure all staff were fit-tested for an N-95 respirator mask (protects residents and staff from the transfer of microorganisms that can cause infectious disease) per the Centers for Disease Control (CDC). This deficient practice had the potential to affect all 43 residents who resided in the facility. Findings included: A CDC document titled, National Institute for Occupational Safety and Health (NIOSH) Personal Protective Equipment, dated 02/03/2025, indicated, Before using a tight-fitting respirator in the workplace, The Occupational Safety and Health Administration (OSHA) requires users to pass a fit test to confirm proper fit and a tight seal against the user's face. A CDC document titled, Filtering our Confusion: Frequently Asked Questions about Respiratory Protection, Fit Testing, dated April 2018, indicated, The Occupational Safety and Health Administration (OSHA) (29 CFR [Code of Federal Regulations] 1910.134) requires an annual respirator fit test to confirm the fit of any respirator that forms a tight seal on the wearer's face before it is used in the workplace. The document further indicated, In addition to fit testing upon initially selecting a model of respirator, OSHA requires that fit testing be conducted annually, and repeated whenever an employee reports, or the employer or the physician or other licensed health care professional makes visual observations of changes in the employee's physical condition that could affect respirator fit (e.g. [exempli gratia, for example], facial scarring, dental changes, cosmetic surgery, or an obvious change in body weight). During an interview on 07/01/2026 at 12:01 PM, the Regional Nurse Consultant (RNC) stated the facility did not have a policy regarding N-95 fit testing. During an interview on 07/07/2026 at 2:15 PM, Certified Nurse Aide (CNA) #1, hired 06/16/2026, stated they had not been fit-tested for an N-95 mask. During an interview on 07/07/2026 at 4:23 PM, Certified Medication Aide (CMA) #2, hired 09/05/2024, stated they had not been fit-tested for an N-95 mask since they had been working at the facility. During an interview on 07/01/2026 at 11:32 AM, the Regional Nurse Consultant (RNC) stated that no recent N-95 fit testing had been completed at the facility. The RNC stated she did not know when the last fit testing was done. The RNC stated N-95 fit testing should be done annually and upon hire. The RNC stated that the Infection Preventionist (IP) was new to the IP role. During a follow-up interview on 07/01/2026 at 12:01 PM, the RNC stated the facility had no documented evidence that N-95 had been completed. During an interview on 07/08/2026 at 11:53 AM, the Director of Nursing (DON) stated she had been employed at the facility since 04/20/2026. The DON stated there had been no N-95 fit testing since she had been there, and she did not receive an N-95 fit test when she started. The DON stated she would expect to be fit-tested for an N-95 mask. During an interview on 07/06/2026 at 3:38 PM, the Previous Administrator stated they worked at the facility from March 2025 to May 2026 and was not involved in N-95 fit testing. The Previous Administrator stated they had been in the IP role for a time but was not trained to use the N-95 fit test kit. The Previous Administrator stated they were not tested while they worked at the facility and was not sure about the requirements for N-95 fit testing.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview, record review, facility document review, and facility policy review, the facility failed to protect the residents' right to be free from physical and verbal abuse perpetrated by a resident (Resident #33), which affected 4 (Residents #35, #39, #51, and #56) of 7 residents reviewed for abuse. Specifically, on 07/29/2025, Resident #33 pulled Resident #56 from a chair against their will, open-hand slapped Resident #51 on the face on 01/20/2026, caused Resident #39 to cry on 01/23/2026 when they snatched a bingo card from Resident #39 and called Resident #39 a vulgar slur, and hit Resident #35 on 06/04/2026. Findings included: A facility policy titled, Abuse Prevention Program, revised 12/2016, indicated, Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The policy revealed, As part of the resident abuse prevention, the administration will, which included 1. Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individuals; 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents; 4. Require staff training/ orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior; 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements; and 9. Establish and implement a QAPI [Quality Assurance and Performance Improvement] review and analysis of abuse incidents; and implement changes to prevent future occurrences of abuse. An admission Record revealed the facility admitted Resident #33 on 11/30/2022. According to the admission Record, the resident had a medical history that included diagnoses of severe major depressive disorder with psychotic symptoms and anxiety disorder. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/09/2025, revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. Resident #33's Care Plan Report included a focus area initiated 08/18/2023, that indicated the resident had poor impulse control in addition to controlling their anger in social settings and indicated that the resident was also known to slap other residents when angry. Interventions directed staff to immediately intervene for any aggressive behavior and report to charge nurse for additional interventions as needed (initiated 09/08/2023); monitor, document, and report any signs or symptoms of Resident #33 posing a danger to self and others (initiated 08/18/2023); and intervene before agitation escalates, guide the resident away from source of distress, engage the resident calmly in conversation, and if the resident's response was aggressive, walk calmly away and approach later (initiated 08/18/2023 and revised 09/19/2023). The Care Plan Report indicated that on 01/20/2026, Resident #33 slapped another resident on their face; on 01/23/2026, the resident slapped another resident and grabbed a playing card from the resident while cursing at them, and on 06/04/2026, the resident hit another resident on the shoulder after the other resident accidentally hit Resident #33's lower extremity when they were moving a chair. 1. An admission Record revealed the facility admitted Resident #56 on 01/08/2025 and discharged the resident on 01/05/2026. According to the admission Record, the resident had a medical history that included diagnoses of Alzheimer's, dementia, anxiety disorder and depression. A quarterly MDS, with an ARD of 10/26/2025, revealed Resident #56 had a BIMS score of 1, which (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated the resident had severe cognitive impairment. Resident #33's Progress Notes revealed a note, dated 07/29/2025 at 1:56 PM and electronically signed by Licensed Practical Nurse (LPN) #3, that indicated that Resident #33 was observed pulling on another resident in an attempt to get the other resident off a couch so that Resident #33 could sit down. During an interview on 07/08/2026 at 9:42 AM, LPN #3 stated that regarding the 07/29/2025 incident, she witnessed Resident #33 telling another resident to move from their seat in the facility's TV room. LPN#3 stated that when the other resident did not move, Resident #33 pulled the resident by the arm out of the seat, against their will. LPN#3 stated that she immediately separated the residents, made a progress note regarding the incident, and informed the Director of Nursing (DON) at the time (DON #4). Attempts to contact DON #4 were unsuccessful. Review of facility documents revealed no evidence the incident between Resident #33 and another resident on 07/29/2025 was investigated or reported to the state survey agency prior to the survey. An Oklahoma State Department of Health Incident Report Form that was submitted to the state survey agency on 07/05/2026, during the survey, indicated that on 07/29/2025, Resident #33 was observed pulling on another resident's arm to move them off a couch. The report identified the other resident as Resident #56. The previous Administrator (ADM), who was the ADM at the time of the incident was interviewed on 07/05/2026 at 11:53 AM. The ADM stated that the incident between Resident #33 and Resident #56 was not investigated or reported to the state survey agency and stated that she was unaware of the incident until that day (07/05/2026). The previous ADM further stated that the facility should have implemented interventions for Resident #33 related to the resident touching other residents and sent Resident #33 for a psychiatric review to ensure they were deemed safe to themselves and other residents. 2. An admission Record revealed the facility admitted Resident #51 on 12/10/2025 and discharged the resident on 02/03/2026. According to the admission Record, the resident had a medical history that included diagnoses of violent behavior, mood disorder, and bipolar disorder. An admission MDS, with an ARD of 12/17/2025, revealed Resident #51 had a BIMS score of 2, which indicated the resident had severe cognitive impairment. Resident #33's Progress Notes included a note, dated 01/20/2026 at 8:44 AM and electronically signed by the previous Administrator (ADM), who was the ADM at the time, that indicated that when Resident #33 approached another resident in the dining room pointing at the other resident's coffee, the other resident told Resident #33 to leave them alone. Per the note, Resident #33 then slapped at the other resident's face with an open hand and made contact slightly. Resident #51's Progress Notes included a note, dated 01/20/20256 and electronically signed by the previous ADM, that indicated that Resident #33 approached Resident #51 in the dining room and when Resident #51 told Resident #33 to leave them alone, Resident #33 slapped at Resident #51 with an open hand and made slight contact. An Oklahoma State Department of Health Incident Report Form for the incident that occurred on 01/20/2026, indicated that the facility reported an allegation of abuse/mistreatment to the state survey agency. The document indicated that Resident #33 open-handed slapped Resident #51 on 01/20/2026. The document indicated that Resident #33 was sent to the emergency room and returned with no new orders. Per the document, a psychiatric provider was notified and made medication changes and Resident #33 was educated to leave their hands to their self. During an interview on 07/01/2026 at 11:23 AM, Licensed Practical Nurse (LPN) #5 stated that Resident #33 asked Resident #51 if they wanted a cup of coffee. She stated that Resident #51 told Resident #33 to go away, and Resident #33 responded by slapping Resident #51 across the face. LPN #5 stated that she immediately separated the residents and while walking Resident #51 back to their room, she notified the ADM of the incident. The previous ADM, who was the ADM at the time of the incident, was interviewed on 07/05/2026 at 11:53 AM. In regard to the incident on 01/20/2026, the previous ADM (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that the facility did not implement any interventions following the incident to potentially prevent other incidents. 3. Resident #39's annual MDS, with an ARD of 04/08/2026, revealed the facility admitted Resident #39 on 03/31/2025. The MDS indicated that Resident #39 had a BIMS score of 3, which indicated the resident had severe cognitive impairment. Resident #33's Progress Notes included a note, dated 01/23/2026 at 3:30 PM and electronically signed by the Assistant Director of Nursing (ADON), that indicated that during a facility activity, Resident #33 snatched a card from another resident, called them a vulgar slur, and slapped their hand. An Oklahoma State Department of Health Incident Report Form for the incident that occurred on 01/23/2026 indicated that the facility completed a report an allegation of abuse/mistreatment to the state survey agency, but there was no indication that the report was submitted to the state survey agency. The document indicated that Resident #33 allegedly snatched a bingo card from Resident #39 and called Resident #39 name. The document indicated that it was thought that Resident #33 slapped Resident #39's hand, but Resident #39 said no contact was made. During an interview on 07/07/2026 at 5:04 PM, the Activity Director revealed that she witnessed the incident between Resident #33 and Resident #39. The Activity Director stated that during a facility activity, Resident #33 took a bingo card from Resident #39, which caused Resident #39 to cry. She stated that Resident #33 then called Resident #39 a crybaby then a vulgar slur and slapped their hand. She stated that she reported the incident to the Administrator when she and another staff member assisted Resident #33 to their room. 4. An admission Record revealed the facility admitted Resident #35 on 05/21/2026. According to the admission Record, the resident had a medical history that included diagnoses of schizophrenia, bipolar disorder, and anxiety. Resident #35's admission MDS assessment, with an ARD of 05/28/2026, revealed Resident #35 had a BIMS score of 15, which indicated the resident had intact cognition. Resident #33's Progress Notes included a note, dated 06/04/2026 at 6:01 PM, that indicated that Resident #35 moved a chair in the dining room and bumped into Resident #33's lower extremity. The note indicated that Resident #33 retaliated and hit Resident #35 on the shoulder. The note indicated that Resident #33 was sent to the hospital for evaluation and treatment. An Oklahoma State Department of Health Incident Report Form indicated that the facility reported an allegation of abuse/mistreatment to the state survey agency that occurred on 06/04/2026. The report indicated that Resident #35 bumped Resident #33 with a chair accidentally, then Resident #33 made contact smacking Resident #35's shoulder. During an interview on 07/07/2026 at 4:28 PM, Resident #11, who had a BIMS score of 15 indicating the resident had intact cognition, stated that they witnessed the incident between Resident #33 and Resident #35. Resident #11 stated that Resident #33 and Resident #35 were in the dining room around dinner time when Resident #33 told Resident #35 they were sitting in their chair. Resident #11 stated that Resident #35 got up and pushed the chair in Resident #33's direction but did not hit Resident #33 with it. Per Resident #11, Resident #33 retaliated by hitting Resident #35 on their shoulder. During an interview on 07/08/2026 at 12:16 PM, Director of Nursing (DON) stated the facility failed to conduct thorough investigations for the incidents on 07/29/2025, 01/20/2026, 01/23/2026, or 06/04/2026. She stated that if they had investigated thoroughly, they could have identified interventions that could have potentially prevented additional incidents of abuse from Resident #33.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure allegations of abuse were reported to the state survey agency within two hours after the allegation was made, which affected 4 (Residents #35, #39, #51, and #56) of 7 residents reviewed for abuse. Findings included: A facility policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised 04/2021, revealed, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. The policy revealed, 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The policy revealed, 3. 'Immediately' is defined as, which included a. within two hours of an allegation involving abuse or result in serious bodily injury; and or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. An admission Record revealed the facility admitted Resident #33 on 11/30/2022. According to the admission Record, the resident had a medical history that included diagnoses of severe major depressive disorder with psychotic symptoms and anxiety disorder. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/09/2025, revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. Resident #33's Care Plan Report included a focus area initiated 08/18/2023, that indicated the resident had poor impulse control in addition to controlling their anger in social settings and indicated that the resident was also known to slap other residents when angry. Interventions directed staff to immediately intervene for any aggressive behavior and report to charge nurse for additional interventions as needed (initiated 09/08/2023); monitor, document, and report any signs or symptoms of Resident #33 posing a danger to self and others (initiated 08/18/2023); and intervene before agitation escalates, guide the resident away from source of distress, engage the resident calmly in conversation, and if the resident's response was aggressive, walk calmly away and approach later (initiated 08/18/2023 and revised 09/19/2023). The Care Plan Report indicated that on 01/20/2026, Resident #33 slapped another resident on their face; on 01/23/2026, the resident slapped another resident and grabbed a playing card from the resident while cursing at them, and on 06/04/2026, the resident hit another resident on the shoulder after the other resident accidentally hit Resident #33's lower extremity when they were moving a chair. 1. An admission Record revealed the facility admitted Resident #56 on 01/08/2025 and discharged the resident on 01/05/2026. According to the admission Record, the resident had a medical history that included diagnoses of Alzheimer's, dementia, anxiety disorder and depression. A quarterly MDS, with an ARD of 10/26/2025, revealed Resident #56 had a BIMS score of 1, which indicated the resident had severe cognitive impairment. Resident #33's Progress Notes revealed a note, dated 07/29/2025 at 1:56 PM and electronically signed by Licensed Practical Nurse (LPN) #3, that indicated that Resident #33 was observed pulling on another resident in an attempt to get the other resident off a couch so that Resident #33 could sit down. During an interview on 07/08/2026 at 9:42 AM, LPN #3 stated that regarding the 07/29/2025 incident, she witnessed Resident #33 telling another resident to move from their seat in the facility's TV room. LPN#3 stated that when the other resident did not move, Resident #33 pulled the resident by the arm out of the seat, against their will. LPN#3 stated that she immediately separated the residents, made a progress note regarding the incident, and informed the (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Director of Nursing (DON) at the time (DON #4). Attempts to contact DON #4 were unsuccessful. Review of facility documents revealed no evidence the incident between Resident #33 and another resident on 07/29/2025 was reported to the state survey agency prior to the survey. An Oklahoma State Department of Health Incident Report Form that was submitted to the state survey agency on 07/05/2026, during the survey, indicated that on 07/29/2025, Resident #33 was observed pulling on another resident's arm to move them off of a couch. The report identified the other resident as Resident #56. The previous Administrator (ADM), who was the ADM at the time of the incident was interviewed on 07/05/2026 at 11:53 AM. The ADM stated that the incident between Resident #33 and Resident #56 was not reported to the state survey agency and stated that she was unaware of the incident until that day (07/05/2026). 2. An admission Record revealed the facility admitted Resident #51 on 12/10/2025 and discharged the resident on 02/03/2026. According to the admission Record, the resident had a medical history that included diagnoses of violent behavior, mood disorder, and bipolar disorder. An admission MDS, with an ARD of 12/17/2025, revealed Resident #51 had a BIMS score of 2, which indicated the resident had severe cognitive impairment. Resident #33's Progress Notes included a note, dated 01/20/2026 at 8:44 AM and electronically signed by the previous Administrator (ADM), who was the ADM at the time, that indicated that when Resident #33 approached another resident in the dining room pointing at the other resident's coffee, the other resident told Resident #33 to leave them alone. Per the note, Resident #33 then slapped at the other resident's face with an open hand and made contact slightly. Resident #51's Progress Notes included a note, dated 01/20/2026 and electronically signed by the previous ADM, that indicated that Resident #33 approached Resident #51 in the dining room and when Resident #51 told Resident #33 to leave them alone, Resident #33 slapped at Resident #51 with an open hand and made slight contact. An Oklahoma State Department of Health Incident Report Form for the incident that occurred on 01/20/2026, indicated that the facility reported an allegation of abuse/mistreatment to the state survey agency. The document indicated that after breakfast on 01/20/2026, Resident #33 open-handed slapped Resident #51 on 01/20/2026. The document indicated that Resident #33 was sent to the emergency room and returned with no new orders. Per the document, a psychiatric provider was notified and made medication changes and Resident #33 was educated to leave their hands to their self. The report indicated that it was submitted to the state survey agency as a Combined Initial and Final report. A facsimile receipt indicated that the facility submitted the report on 01/21/2026 at 12:24, which was over the two hour required timeframe. During an interview on 07/01/2026 at 11:23 AM, Licensed Practical Nurse (LPN) #5 stated that Resident #33 asked Resident #51 if they wanted a cup of coffee. She stated that Resident #51 told Resident #33 to go away, and Resident #33 responded by slapping Resident #51 across the face. LPN #5 stated that she immediately separated the residents and while walking Resident #51 back to their room, she notified the ADM of the incident. The previous ADM, who was the ADM at the time of the incident, was interviewed on 07/05/2026 at 11:53 AM. In regard to the incident on 01/20/2026, the previous ADM stated that she was not sure why she submitted the report as a combined initial and final report. She stated that it should have been reported to the state survey agency within two hours, and she did not have an excuse for why it was not. 3. Resident #39's annual MDS, with an ARD of 04/08/2026, revealed the facility admitted Resident #39 on 03/31/2025. The MDS indicated that Resident #39 had a BIMS score of 3, which indicated the resident had severe cognitive impairment. Resident #33's Progress Notes included a note, dated 01/23/2026 at 3:30 PM and electronically signed by the Assistant Director of Nursing (ADON), that indicated that during a facility activity, Resident #33 snatched a card from another resident, called them a vulgar slur, and slapped their hand. During an (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 07/07/2026 at 5:04 PM, the Activity Director revealed that she witnessed the incident between Resident #33 and Resident #39. The Activity Director stated that during a facility activity, Resident #33 took a bingo card from Resident #39, which caused Resident #39 to cry. She stated that Resident #33 then called Resident #39 a crybaby then a vulgar slur and slapped their hand. She stated that she reported the incident to the Administrator when she and another staff member assisted Resident #33 to their room. An Oklahoma State Department of Health Incident Report Form for the incident that occurred on 01/23/2026 indicated that the facility completed a report an allegation of abuse/mistreatment to the state survey agency, but there was no indication that the report was submitted to the state survey agency. The document indicated that Resident #33 allegedly snatched a bingo card from Resident #39 and called Resident #39 name. The document indicated that it was thought that Resident #33 slapped Resident #39's hand, but Resident #39 said no contact was made. The previous Administrator (ADM), who was the ADM at the time of the incident, was interviewed on 07/05/2026 at 11:53 AM. In regard to the incident that occurred on 01/23/2026, the previous ADM stated that she completed a report and thought she submitted it but was not sure when. She stated that she could not say that it was submitted timely. 4. An admission Record revealed the facility admitted Resident #35 on 05/21/2026. According to the admission Record, the resident had a medical history that included diagnoses of schizophrenia, bipolar disorder, and anxiety. Resident #35's admission MDS assessment, with an ARD of 05/28/2026, revealed Resident #35 had a BIMS score of 15, which indicated the resident had intact cognition. Resident #33's Progress Notes included a note, dated 06/04/2026 at 6:01 PM, that indicated that Resident #35 moved a chair in the dining room and bumped into Resident #33's lower extremity. The note indicated that Resident #33 retaliated and hit Resident #35 on the shoulder. The note indicated that Resident #33 was sent to the hospital for evaluation and treatment. During an interview on 07/07/2026 at 4:28 PM, Resident #11, who had a BIMS score of 15 indicating the resident had intact cognition, stated that they witnessed the incident between Resident #33 and Resident #35. Resident #11 stated that Resident #33 and Resident #35 were in the dining room around dinner time when Resident #33 told Resident #35 they were sitting in their chair. Resident #11 stated that Resident #35 got up and pushed the chair in Resident #33's direction but did not hit Resident #33 with it. Per Resident #11, Resident #33 retaliated by hitting Resident #35 on their shoulder. An Oklahoma State Department of Health Incident Report Form indicated that the facility reported an allegation of abuse/mistreatment to the state survey agency that occurred on 06/04/2026. The report indicated that Resident #35 bumped Resident #33 with a chair accidentally, then Resident #33 made contact smacking Resident #35's shoulder. A facsimile receipt indicated that the initial report was submitted to the state survey agency on 06/08/2026, four days later. During an interview on 07/08/2026 at 11:39 AM, the Assistant Director of Nursing (ADON) stated that all abuse allegations were to be reported immediately, and a report was to be submitted to the state survey agency within two hours. She stated that this did not happen for the incident on 06/04/2026. During an interview on 07/08/2026 at 12:16 PM, Director of Nursing (DON) stated that she was not aware of the incident between Resident #33 and Resident #35 when it occurred. She stated that she heard staff talking about the incident on 06/08/2026 and then she submitted the report. She stated that it was not reported within two hours During an interview on 7/04/2026 at 12:10 PM, the DON stated that she assumed the role of the facility's Abuse Coordinator the first week of May 2026. The DON stated that it was her responsibility to report allegations of abuse to the state survey agency within two hours and submit a final investigation within five days.		

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NAME OF PROVIDER OR SUPPLIER Heritage Park		STREET ADDRESS, CITY, STATE, ZIP CODE 6912 Northwest 23rd Street Bethany, OK 73008	
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on interview, record review, document review, and facility policy review, the facility failed to thoroughly investigate alleged incidents of verbal and physical abuse, which affected 5 (Residents #35, #36, #39, #51, and #56) of 7 residents reviewed for abuse. Specifically, alleged incidents of abuse perpetrated by Resident #33 occurred on 07/29/2025, 01/20/2026, 01/23/2026, 03/22/2026, and 06/04/2026 and were not thoroughly investigated. Findings included: A facility policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised 04/2021, revealed, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. The policy revealed, Investigating Allegations included 1. All allegations are thoroughly investigated. The administrator initiates investigations; 2. Investigations may be assigned to an individual trained in reviewing, investigating and reporting such allegations; and 7. The individual conducting the investigation as a minimum, which included a. reviews the documentation and evidence; b. reviews the residents medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; c. observes the alleged victim, including his or her interactions with staff and other residents; d. interviews the person(s) reporting the incident; e. interviews any witness to the incident; f. interviews the resident (as medically appropriate) or the resident's representative; g. interviews the resident's attending physician as needed to determine the resident's condition; h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; i. interviews the resident's roommate, family members and visitors; k. reviews all events leading up to the alleged incident; and l. documents the investigation completely and thoroughly. An admission Record revealed the facility admitted Resident #33 on 11/30/2022. According to the admission Record, the resident had a medical history that included diagnoses of severe major depressive disorder with psychotic symptoms and anxiety disorder. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/09/2025, revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. Resident #33's Care Plan Report included a focus area initiated 08/18/2023, that indicated the resident had poor impulse control in addition to controlling their anger in social settings and indicated that the resident was also known to slap other residents when angry. Interventions directed staff to immediately intervene for any aggressive behavior and report to charge nurse for additional interventions as needed (initiated 09/08/2023); monitor, document, and report any signs or symptoms of Resident #33 posing a danger to self and others (initiated 08/18/2023); and intervene before agitation escalates, guide the resident away from source of distress, engage the resident calmly in conversation, and if the resident's response was aggressive, walk calmly away and approach later (initiated 08/18/2023 and revised 09/19/2023). The Care Plan Report indicated that on 01/20/2026, Resident #33 slapped another resident on their face; on 01/23/2026, the resident slapped another resident and grabbed a playing card from the resident while cursing at them, and on 06/04/2026, the resident hit another resident on the shoulder after the other resident accidentally hit Resident #33's lower extremity when they were moving a chair. 1. An admission Record revealed the facility admitted Resident #56 on 01/08/2025 and discharged the resident on 01/05/2026. According to the admission Record, the resident had a medical history that included diagnoses of Alzheimer's, dementia, anxiety disorder and depression. A quarterly MDS, with an ARD of 10/26/2025, revealed Resident #56 had a BIMS score of 1, which indicated the resident had severe cognitive impairment. Resident #33's (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Progress Notes revealed a note, dated 07/29/2025 at 1:56 PM and electronically signed by Licensed Practical Nurse (LPN) #3, that indicated that Resident #33 was observed pulling on another resident in an attempt to get the other resident off a couch so that Resident #33 could sit down. During an interview on 07/08/2026 at 9:42 AM, LPN #3 stated that regarding the 07/29/2025 incident, she witnessed Resident #33 telling another resident to move from their seat in the facility's TV room. LPN#3 stated that when the other resident did not move, Resident #33 pulled the resident by the arm out of the seat, against their will. LPN#3 stated that she immediately separated the residents, made a progress note regarding the incident, and informed the Director of Nursing (DON) at the time (DON #4). Attempts to contact DON #4 were unsuccessful. Review of facility documents revealed no evidence the incident between Resident #33 and another resident on 07/29/2025 was investigated prior to the survey. An Oklahoma State Department of Health Incident Report Form that was submitted to the state survey agency on 07/05/2026, during the survey, indicated that on 07/29/2025, Resident #33 was observed pulling on another resident's arm to move them off of a couch. The report identified the other resident as Resident #56. The previous Administrator (ADM), who was the ADM at the time of the incident was interviewed on 07/05/2026 at 11:53 AM. The ADM stated that she was not aware of the incident between Resident #33 and Resident #56 until that day (07/05/2026). She stated that the incident should have been reviewed, but she did not know about it. 2. An admission Record revealed the facility admitted Resident #51 on 12/10/2025 and discharged the resident on 02/03/2026. According to the admission Record, the resident had a medical history that included diagnoses of violent behavior, mood disorder, and bipolar disorder. An admission MDS, with an ARD of 12/17/2025, revealed Resident #51 had a BIMS score of 2, which indicated the resident had severe cognitive impairment. Resident #33's Progress Notes included a note, dated 01/20/2026 at 8:44 AM and electronically signed by the previous Administrator (ADM), who was the ADM at the time, that indicated that when Resident #33 approached another resident in the dining room pointing at the other resident's coffee, the other resident told Resident #33 to leave them alone. Per the note, Resident #33 then slapped at the other resident's face with an open hand and made contact slightly. An Oklahoma State Department of Health Incident Report Form for the incident that occurred on 01/20/2026, indicated that the facility reported an allegation of abuse/mistreatment to the state survey agency. The document indicated that after breakfast on 01/20/2026, Resident #33 open-handed slapped Resident #51 on 01/20/2026. The document indicated that Resident #33 was sent to the emergency room and returned with no new orders. Per the document, a psychiatric provider was notified and made medication changes and Resident #33 was educated to leave their hands to their self. During an interview on 07/01/2026 at 11:23 AM, Licensed Practical Nurse (LPN) #5 stated that Resident #33 asked Resident #51 if they wanted a cup of coffee. She stated that Resident #51 told Resident #33 to go away, and Resident #33 responded by slapping Resident #51 across the face. LPN #5 stated that she immediately separated the residents and while walking Resident #51 back to their room, she notified the ADM of the incident. The facility's investigative documents revealed that it did not include witness statements to the incident or documentation of what the facility did to investigate the incident. The previous ADM, who was the ADM at the time of the incident, was interviewed on 07/05/2026 at 11:53 AM. In regard to the incident on 01/20/2026, the previous ADM stated that she thought reviewing camera footage of the incident was enough for an investigation. She stated that she now knew that she needed to obtain interviews with staff, victims, and witnesses, and make notifications. She stated that it was not a thorough investigation. 3. Resident #39's annual MDS, with an ARD of 04/08/2026, revealed the facility admitted Resident #39 on 03/31/2025. The MDS indicated that Resident #39 had a BIMS score of 3, which indicated the resident had severe cognitive (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	impairment. Resident #33's Progress Notes included a note, dated 01/23/2026 at 3:30 PM and electronically signed by the Assistant Director of Nursing (ADON), that indicated that during a facility activity, Resident #33 snatched a card from another resident, called them a vulgar slur, and slapped their hand. During an interview on 07/07/2026 at 5:04 PM, the Activity Director revealed that she witnessed the incident between Resident #33 and Resident #39. The Activity Director stated that during a facility activity, Resident #33 took a bingo card from Resident #39, which caused Resident #39 to cry. She stated that Resident #33 then called Resident #39 a crybaby then a vulgar slur and slapped their hand. She stated that she reported the incident to the Administrator (ADM) when she and another staff member assisted Resident #33 to their room. An Oklahoma State Department of Health Incident Report Form for the incident that occurred on 01/23/2026 indicated that the facility completed a report an allegation of abuse/mistreatment to the state survey agency, but there was no indication that the report was submitted to the state survey agency. The document indicated that Resident #33 allegedly snatched a bingo card from Resident #39 and called Resident #39 name. The document indicated that it was thought that Resident #33 slapped Resident #39's hand, but Resident #39 said no contact was made. The facility's investigative documents revealed that it did not include witness statements or documentation of what the facility did to investigate the incident. The previous ADM, who was the ADM at the time of the incident, was interviewed on 07/05/2026 at 11:53 AM. In regard to the incident on 01/23/2026, stated that she was not fully trained on the facility's abuse policy. The previous ADM stated she should have gotten statements from staff from all shifts related to the allegation, victims, and families. The previous ADM stated that the investigation was not thorough. 4. A quarterly MDS, with an ARD of 04/29/2026, revealed Resident #36 had a BIMS score of 3, which indicated the resident had severe cognitive impairment. An Oklahoma State Department of Health Incident Report Form indicated that the facility reported an allegation of abuse/mistreatment to the state survey agency that occurred on 03/22/2026. The document indicated that another resident, Resident #11, witnessed Resident #33 slapping Resident #36's hand. The report did not include the time of the alleged incident. A review of Resident #36's records and facility documents revealed no evidence of a progress note, incident report, witness statements, or any other documents that provided the time the incident occurred or other information regarding the incident or investigation. The previous Administrator (ADM), who was the ADM at the time of the incident, was interviewed on 07/05/2026 at 11:53 AM. In regard to the incident on 03/22/2026, the previous ADM stated that she had reviewed the video footage of the incident and did not see any physical contact between Resident #33 and Resident #36 and did not investigate the issue further. ADM further stated that she should have gotten statements from staff, the victim, and family and reviewed Resident #33's previous behavior to ensure a thorough investigation was completed. She stated that the investigation was incomplete and not thorough. 5. An admission Record revealed the facility admitted Resident #35 on 05/21/2026. According to the admission Record, the resident had a medical history that included diagnoses of schizophrenia, bipolar disorder, and anxiety. Resident #35's admission MDS assessment, with an ARD of 05/28/2026, revealed Resident #35 had a BIMS score of 15, which indicated the resident had intact cognition. Resident #33's Progress Notes included a note, dated 06/04/2026 at 6:01 PM, that indicated that Resident #35 moved a chair in the dining room and bumped into Resident #33's lower extremity. The note indicated that Resident #33 retaliated and hit Resident #35 on the shoulder. The note indicated that Resident #33 was sent to the hospital for evaluation and treatment. An Oklahoma State Department of Health Incident Report Form indicated that the facility reported an allegation of abuse/mistreatment to the state survey agency that occurred on 06/04/2026. The report indicated that Resident #35 bumped Resident #33 with a chair accidentally, (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	then Resident #33 made contact smacking Resident #35's shoulder. During an interview on 07/07/2026 at 4:28 PM, Resident #11, who had a BIMS score of 15 indicating the resident had intact cognition, stated that they witnessed the incident between Resident #33 and Resident #35. Resident #11 stated that Resident #33 and Resident #35 were in the dining room around dinner time when Resident #33 told Resident #35 they were sitting in their chair. Resident #11 stated that Resident #35 got up and pushed the chair in Resident #33's direction but did not hit Resident #33 with it. Per Resident #11, Resident #33 retaliated by hitting Resident #35 on their shoulder. The facility's investigative documents revealed that it did not include witness statements or documentation of what the facility did to investigate the incident. During an interview on 07/08/2026 at 11:39 AM, Assistant Director of Nursing (ADON) stated that she expected investigations to include statements from any witnesses. She stated that the incident on 06/04/2026 was not investigated thoroughly. The Director of Nursing (DON) was interviewed on 07/08/2026 at 12:16 PM. In regard to the incident on 06/04/2026, the DON stated that she was not aware on how in depth the investigation should have been. She stated that she did talk to nurses about what they knew about the incident and did interview the residents but did not believe she documented them. She stated that the incident was not thoroughly investigated. The DON stated the facility also failed to conduct thorough investigations for the incidents on 07/29/2025, 01/20/2026, 01/23/2026, or 03/22/2026. During an interview on 7/04/2026 at 12:10 PM, the DON stated that she assumed the role of the facility's Abuse Coordinator the first week of May 2026. The DON stated that she was responsible for conducting thorough investigation, which entailed interviewing residents, staff, notifying local law enforcement, and contacting families and the facilities' physician. The DON stated that she could also reach out to their corporate office to request access to video footage to assist with investigating an incident.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on facility policy review, interview, and record review, the facility failed to ensure medical records were complete and accurate related to documentation of the provision of activity of daily living (ADL) care for 3 (Residents #12, #13, and #29) of 4 residents reviewed for ADLs. Findings included: A facility policy titled, Charting and Documentation, revised 07/2017, indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. 1. An admission Record indicated the facility admitted Resident #13 on 01/23/2026. According to the admission Record, the resident had a medical history that included diagnoses of type 2 diabetes mellitus, severe protein-calorie malnutrition, and depression. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/30/2026, revealed Resident #13 had a Brief Interview for Mental Status (BIMS) of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated that the resident required substantial/maximal assistance with bathing. Resident #13's Care Plan Report included a focus area initiated 06/05/2026, that indicated the resident had an ADL self-care deficit. Interventions indicated that the resident required one-person assistance with bathing (initiated 06/05/2026). Resident #13's June 2026 ADL task record indicated the resident was to get a bath on 06/21/2026, 06/22/2026, 06/24/2026, 06/26/2026, 06/28/2026, and 06/29/2026. The record revealed staff did not document on those days to indicate if the bath had been offered or provided. During an interview on 07/08/2026 at 11:12 AM, Certified Nurse Aide (CNA) #1 stated that CNAs documented showers and stated that it was required for CNAs to document each shift. During an interview on 07/02/2026 at 2:18 PM, Licensed Practical Nurse (LPN) #8 stated that the provision of care should be documented. LPN #8 stated the certified nurse aides (CNAs) documented their charting electronically and should document whether the care was provided or refused. During an interview on 07/07/2026 at 5:06 PM, LPN #5 stated that the CNAs documented the provision of baths electronically. LPN #5 stated that the Assistant Director of Nursing (ADON) was responsible for monitoring the CNA documentation. During an interview on 07/08/2026 at 11:30 AM, the ADON stated she monitored the ADL documentation but did not monitor specific ADLs like bathing. The ADON stated if documentation of an ADL was missed, it would be flagged, and a list was generated from the flags, not from specific ADLs, and the report was turned in to the Director of Nursing (DON), then the DON sent the report to the corporate office. The ADON stated she expected the staff to document for bathing. During an interview on 07/02/2026 at 2:03 PM, Certified Medication Aide (CMA) #9 stated that some type of bath was provided every day. CMA #9 stated that if a resident refused, she reported it to the nurse and documented it. CMA #9 stated the bath should be documented in the electronic record whether provided or refused. She stated that she had not been able to document, and she had told someone the previous week and was able to currently. She stated that she did provide baths to Resident #13, but she had not been able to document it. During an interview on 07/08/2026 at 11:53 AM, the Director of Nursing (DON), upon review of Resident #13's bathing task form, stated there should be documentation for Resident #13 and there was not any documentation at the end of June for bathing. The DON stated she expected staff to document. She stated that if it was not documented, then they could not prove it was done. 2. An admission Record indicated the facility admitted Resident #12 on 06/24/2025. According to the admission Record, the resident had a medical history that included diagnoses of multiple sclerosis, adult failure to thrive, and schizoaffective disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Date (ARD) of 04/01/2026, revealed Resident #12 had a Brief Interview for Mental Status (BIMS) of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated that the resident was dependent on staff for the provision of bathing. Resident #12's Care Plan Report included a focus area initiated on 09/11/2025 that indicated the resident had an ADL self-care deficit. Interventions indicated that the resident required one-person assistance with bathing (initiated 09/11/2025). Resident #12's June 2026 Documentation Survey Report indicated that the resident was to get a bath on 06/01/2026, 06/03/2026, 06/05/2026, 06/08/2026, 06/10/2026, 06/12/2026, 06/15/2026, and 06/17/2026. The record revealed staff did not document on those days to indicate if the bath had been offered or provided. During an interview on 07/02/2026 at 2:03 PM, Certified Medication Aide (CMA) #9 stated that some type of bath was provided every day. CMA #9 stated that if the resident refused, she reported it to the nurse and documented it. CMA #9 stated the bath should be documented in the electronic record whether provided or refused. She stated that she had not been able to document it, and she had told someone the previous week and was able to currently. During an interview on 07/08/2026 at 11:12 AM, Certified Nurse Aide (CNA) #1 stated that CNAs documented showers and stated that it was required for CNAs to document each shift. During an interview on 07/02/2026 at 2:18 PM, Licensed Practical Nurse (LPN) #8 stated that the provision of care should be documented. LPN #8 stated the certified nurse aides (CNAs) documented their charting electronically and should document whether the care was provided or refused. During an interview on 07/07/2026 at 5:06 PM, LPN #5 stated that the CNAs documented the provision of baths electronically. LPN #5 stated that the Assistant Director of Nursing (ADON) was responsible for monitoring the CNA documentation. During an interview on 07/08/2026 at 11:30 AM, the ADON stated she monitored the ADL documentation but did not monitor specific ADLs like bathing. The ADON stated if documentation of an ADL was missed, it would be flagged, and a list was generated from the flags, not from specific ADLs, and the report was turned in to the Director of Nursing (DON), then the DON sent the report to the corporate office. The ADON stated she expected the staff to document for the provision of bathing. During an interview on 07/08/2026 at 11:53 AM, the Director of Nursing (DON), upon review of Resident #12's bathing task for June 2026, stated there was no documentation and there should have been. The DON stated she expected baths to be provided three days a week and expected baths to be documented, whether it was provided or refused.3. An admission Record revealed the facility admitted Resident #29 on 03/20/2026. According to the admission Record, the resident had a medical history that included diagnoses of incomplete paraplegia, chronic respiratory failure, and major depressive disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/14/2026, revealed Resident #29 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated that the resident was dependent on staff for toileting hygiene and personal hygiene and was always incontinent of bowel and bladder. Resident #29's Care Plan Report included a focus area revised 02/08/2026, that indicated the resident was incontinent of bowel and bladder. Interventions directed staff to provide incontinence care as needed (revised 02/08/2026). Resident #29's June 2026 ADL documentation for Bowel and Bladder Elimination revealed staff did not document any care being provided on 06/06/2026, 06/14/2026, 06/20/2026, 06/21/2026, 06/23/2026, 06/24/2026, 06/25/2026, 06/26/2026, 06/27/2026, or 06/28/2026. During an interview on 07/08/2026 at 9:30 AM, Certified Nurse Aide (CNA) #11 stated that incontinence care was documented in the electronic health record (EHR) for residents. She stated incontinence care was documented each shift under bowel and bladder elimination. She stated that refusals were also documented. She stated that she did work on the days in question but worked in a different hall. During an interview on 07/08/2026 at 9:58 AM, CNA #12 (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that all ADL care, including incontinence care, was required to be documented. She stated that if a resident refused incontinence care, the aide told the nurse and then documented in the EHR that the resident refused. She stated that there should not be any blanks on the CNA documentation. Per CNA #12, if there was no documentation, that was incomplete charting. She stated that she did work from 06/23/2026 to 06/26/2026, but stated that the resident often refused her, so it may have been an agency staff who worked with the resident. She stated that she would not have documented anything for Resident #29. During an interview on 07/08/2026 at 9:54 AM, CNA #13 stated she was agency staff and worked with Resident #29 and was familiar with them. She stated that Resident #29 needed incontinence care, which was charted in the EHR under bowel and bladder elimination. She stated aides charted once per shift, and one person for the hall documented. She stated she would not document again if someone else was already documenting. She stated aides were required to document, but sometimes there was missed communication and staff would say they would document but would get busy, or their partner thought they were doing it, but the partner was supposed to. She stated that she did work and provide incontinence care for Resident #29 on 06/20/2026, 06/21/2026, 06/27/2026, and 06/28/2026. She stated she did not recall if she documented on those days. She stated she did not know why there was no documentation but reiterated she did provide incontinence care. The Assistant Director of Nursing (ADON) was interviewed on 07/08/2026 at 11:08 AM. She stated that ADL documentation by the CNAs in the EHR was mandatory. She stated that documentation was reviewed Monday through Friday during a clinical meeting. She stated that they tracked all missed documentation on a form, submitted it to corporate staff, and then turned it in to the Director of Nursing (DON). The ADON stated that it was then posted at the nurses' station for aides to get it done within 24 hours, and the DON followed up from there. The DON was interviewed on 07/08/2026 at 11:29 AM. She stated that she expected documentation of ADL care, including incontinence care, to be completed in the EHR every shift by CNAs. She stated that she and the ADON were responsible for reviewing documentation for the previous shift each day, Tuesday through Friday, and on Monday, they review the previous three days. She stated the process was to have a clinical correction sheet filled out daily for any missing documentation. She stated that the sheet was sent to corporate daily, then she and the ADON followed up with the CNA the next day to let them know what they needed to make up. She stated she hung the clinical correction sheet at the nurses' station, which she then realized was not the best process.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375511	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Heritage Park		STREET ADDRESS, CITY, STATE, ZIP CODE 6912 Northwest 23rd Street Bethany, OK 73008	
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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview, record review, and facility policy review, the facility failed to ensure they had record of a resident/responsible party being informed of risks and benefits and receiving informed consent prior to administering psychotropic medications for 1 (Resident #3) of 5 residents whose medication regimen were reviewed. Findings included: An undated facility policy titled, Psychotropic Informed Consent, indicated, Responsible Party-Actions Required: Primary care physician, PA [Physician Assistant] or APN [Advanced Practice Nurse], which included 1. Orders for psychotropic medication only for the treatment of specific medical and/or psychiatric conditions or when the medication meets the needs of the resident to alleviate significant distress for the resident not met by the use of non-pharmacologic approaches; 2. Documents rational and diagnosis for use and identifies target symptoms; and 3. Documents or ensures documentation of discussion completed with the resident and/or responsible party regarding the risk versus benefit of the used of these medications included in the discussion and documentation must be the presence of any black box warning or off label use of the medication affecting the prescribing of the medication to the resident. The policy revealed, Nursing included 1. Informed consent will be obtained prior to first dose and every dosage change. An admission Record revealed the facility admitted Resident #3 on 01/19/2024. According to the admission Record, the resident had a medical history that included diagnoses of bipolar disorder, major depressive disorder, anxiety disorder, and other psychotic disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/26/2026, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. Resident #3's Care Plan Report included a focus area initiated 01/31/2024, that indicated the resident had behaviors and was resistive to care, including medications. Interventions initiated 01/31/2024 directed staff to allow Resident #3 to make decisions about treatment regime in order to provide a sense of control and to educate Resident #3/family/caregivers of the possible outcome(s) of not complying with treatment or care. Resident #3's Order Summary Report, dated 07/08/2026, contained the following active orders:- Aripiprazole (an antipsychotic) 2 milligrams (mg), one tablet by mouth one time a day for bipolar disorder, with a start date of 08/21/2024.- Citalopram hydrobromide (a selective serotonin reuptake inhibitor [SSRI]) 10 mg, one tablet by mouth one time a day for depression, with a start date of 09/13/2024.- Mirtazapine (an antidepressant) 7.5 mg, one tablet by mouth in the evening related to major depressive disorder, with a start date of 01/30/2025. During an interview on 07/02/2026 at 10:40 PM, the Regional Nurse Consultant (RNC) stated the facility did not have any informed consents for the psychotropic medications for Resident #3. During a follow-up interview on 07/03/2026 at 9:26 AM, the RNC stated that she had completed an audit in January 2026 for all informed consents and talked to the residents who did not have them. She stated that for those residents with lower BIMS scores, she reached out to family. She stated that she thought Resident #3 was one had left to do, and she did not have any documentation of reaching out to family. During an interview on 07/08/2026 at 10:39 AM, Licensed Practical Nurse (LPN) #8 stated that the facility was required to get informed consent for psychotropic medications. She stated that the consent was acquired by the Admissions Coordinator. She stated that if it was a new medication, the nurse talked to the resident or responsible party to inform them of the medication and get consent. She stated that staff needed to document the conversation with the responsible party obtaining informed consent for the medication and ensure it was scanned into the electronic health record. In regard to who would have gotten the informed consents for Resident #3, LPN #8 stated that she did not get the informed consents. The Assistant (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Heritage Park		STREET ADDRESS, CITY, STATE, ZIP CODE 6912 Northwest 23rd Street Bethany, OK 73008	
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (ADON) was interviewed on 07/08/2026 at 11:08 AM. The ADON stated that there was a form in the electronic health record that was completed at admission for informed consent for psychotropic medications. She stated that typically, she got consent from the responsible party as the ADON. She stated that if it was a new order, she or the charge nurse who received the order would get the informed consent. She stated that Resident #3 was at the facility prior to her employment at the facility, and she was not sure who was responsible for getting the informed consent prior to her employment. She stated that she did not know of an audit process to ensure informed consents were being completed. During an interview on 07/08/2026 at 11:29 AM, the Director of Nursing (DON) stated that she expected informed consent for all psychotropic medications being administered in the facility. She stated that the admitting nurse was responsible for getting consent prior to the administration of any doses. She stated that if a doctor prescribed a new psychotropic medication, it was the responsibility of the charge nurse to get consent and scan it into the electronic health record. She stated informed consent was to make sure the patient understood what they were being prescribed and that they were agreeable to it. The DON stated it did not meet her expectations for Resident #3 to have received those medications without any informed consent.		

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NAME OF PROVIDER OR SUPPLIER Heritage Park		STREET ADDRESS, CITY, STATE, ZIP CODE 6912 Northwest 23rd Street Bethany, OK 73008	
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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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview, record review, and facility document and policy review, the facility failed to follow physician orders for 1 (Resident #12) of 13 sampled residents. Specifically, on 10/29/2025, staff failed to administer Resident #12's medication per physician orders and in accordance with standards of practice. Findings included: A facility policy titled, Administering Medications, revised 04/2019, indicated, Medications are administered in a safe and timely manner, and as prescribed. The policy indicated, Medication errors are documented, reported, and reviewed by the QAPI [quality assurance and performance improvement] committee to inform process changes and or the need for additional staff training. An admission Record revealed the facility admitted Resident #12 on 06/24/2025. According to the admission Record, the resident had a medical history that included a diagnosis of multiple sclerosis. Resident #12's Order Summary Report included an order dated 04/22/2026 for oxycodone-acetaminophen 7.5 milligrams (mg)/325 mg, one tablet by mouth every four hours as needed for pain. Resident #12's Care Plan Report, revealed a focus area for miscellaneous information, which contained an intervention dated 10/29/2026, that indicated there was a medication error with no adverse reactions. A Medication Error incident report, dated 10/29/2025 at 5:30 PM, for Resident #12 indicated a Certified Medication Aide (CMA) notified the nurse that the resident had received the wrong medication (medication name not documented). The incident report indicated that the resident's physician, Director of Nursing (DON), and Administrator were notified of the medication error. Resident #12's nursing Progress Notes revealed an Incident Note, dated 10/29/2025 at 6:25 PM, that indicated a CMA notified the nurse that the resident received the wrong medication. Per the notes, the resident denied shortness of breath, nausea, or vomiting and was alert and oriented, with no signs or symptoms of distress. The note revealed that the Physician, DON, Administrator, and family were notified of the medication error. During an interview on 07/08/2026 at 11:53 AM, the DON stated that she had worked at the facility since 04/20/2026. The DON stated she expected residents to receive the right medication and the right dose of the medication. During an interview on 07/06/2026 at 3:38 PM, the Previous Administrator revealed a CMA made a medication error with Resident #12. The Previous Administrator stated that the CMA was not allowed to return to the facility to work.		