

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375530	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER Corn Heritage Village and Rehab of Weatherford		STREET ADDRESS, CITY, STATE, ZIP CODE 801 North Washington Weatherford, OK 73096	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702</p> <p>Based on record review and interview, the facility failed to ensure a family representative and physician were notified of an abuse allegation for one (#1) of three sampled residents reviewed for notifications.</p> <p>The administrator identified 66 residents resided in the facility.</p> <p>Findings:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses which included cognitive communication deficit and major depressive disorder.</p> <p>A comprehensive assessment, dated 09/05/24, documented Resident #1's cognition was significantly impaired.</p> <p>The facility's Incident Report Form, dated 08/18/24, documented Resident #1 alleged allegations of abuse/mistreatment by an unidentified direct care staff.</p> <p>The facility's electronic health record did not document the family representative or physician was notified of the abuse/mistreatment allegation on 08/18/24.</p> <p>On 10/10/24 at 11:30 a.m., a family representative was asked if they were notified of the abuse allegation on 08/18/24. The family representative stated they were not notified of the allegation of abuse.</p> <p>On 10/10/24 at 12:00 p.m., the DON was asked what the policy and procedure was for notifications after an abuse allegation. They stated the family representative and physician should be notified and documented in the progress notes. The DON was asked to provide documentation to show when the family representative and physician was notified. The DON stated there was no documentation in the electronic health record the family representative and physician were notified. The DON was asked to provide a copy of the policy regarding required notifications. The DON stated they did not have a policy regarding notifications of family and physicians after an abuse allegation.</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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