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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375492	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead of Hugo	1001 Heritage Way Hugo, OK 74743

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to ensure an allegation of abuse, neglect, exploitation, or mistreatment was reported immediately to the OSDH, but no later than two hours after the allegation for 1 (#4) of 3 sampled residents reviewed for abuse. The administrator identified five allegations of abuse from 06/01/25 through 12/01/25.Findings:A facility policy titled Abuse-Reportable Events, revised 01/2018, read in part, Abuse- 2 Hour Limit- As defined in 42 CFR 483.5- The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. An undated face-sheet showed Resident #4 had diagnoses which included major depressive disorder, psychotic features, dementia, and behavioral disturbances.A discharge return anticipated assessment, dated 09/18/25, showed Resident #4 was severely impaired for daily decision making and required substantial assistance with activities of daily living.An OSDH incident report, dated 09/17/25, showed an allegation of abuse. The report showed an allegation of financial abuse by a family member. A fax transmittal report showed the allegation of abuse was reported to the OSDH on 09/23/25.On 12/01/25 at 3:35 p.m., the administrator reviewed the incident report regarding the allegation of abuse for Resident #4 on 09/27/25. The administrator stated all allegations of abuse should be reported to the OSDH within two hours. The administrator stated they did not know why the allegation of abuse regarding Resident #4 was not reported within the two hour required time frame.

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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NAME OF PROVIDER OR SUPPLIER Homestead of Hugo		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 Heritage Way Hugo, OK 74743	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. On 11/24/25 an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure hazardous chemicals were secured away from wandering residents located in the memory care unit.Upon observation of the memory care unit there were three rooms found to be unlocked/unsecured with hazardous chemicals. A clean linen closet, a soiled linen closet, and a whirlpool/shower room with a cabinet in the unlocked whirlpool/shower room: with three unsecured bottles of cleaner, degreaser, and bleach products, unsecured personal products as shaving cream, disinfectant cleaner, and other personal care items. On 11/24/25 at 4:14 p.m., the OSDH verified the existence of the IJ situation.On 11/24/25 at 4:27 p.m., the administrator was notified of the IJ situation and the IJ template was read in full to the administrator.On 11/25/25 at 12:40 p.m., an acceptable plan of removal was submitted to the OSDH. The plan of removal read in part, Immediate Jeopardy ResponseNovember 25, 2025, Time sent at 12:34 p.m.Homestead Of HugoIJ Plan of Removal for Chemical StorageCompletion Date November 25, 2025, 12:32 p.m.The locks on the clean linen room and dirty room have been locked. The padlock on the shower cabinet has been replaced. The entire facility has been checked for chemicals. The keys to these rooms will be on a separate key chain locked in the Medication Cart. In person and telephone in-services were begun on all employees about chemical storage. Monitoring will be conducted daily for 2 months, weekly for 2 months then move to random checks during compliance rounds.On 11/25/25 at 1:12 p.m., the survey team completed a tour of the facility, and both linen doors were locked and the cabinet in the shower room was locked. The keys to the linen closets were locked up in the med cart.On 11/25/25 at 2:16 p.m., in-service records were reviewed, interviews with staff were conducted, and observation of locked linen doors and cabinet doors were all locked.On 11/25/25 at 2:31 p.m., the administrator was notified that the immediacy had been lifted after all components of the plan of removal were verified effective 11/25/25. The deficient practice remained isolated with no actual harm.Based on observation, record review, and interview, the facility failed to ensure resident environments remained free of hazardous chemicals for 10 of 26 wandering residents in the memory care unit.The administrator identified 12 rooms in the facility that stored hazardous chemicals and 10 residents who wandered on the memory care unit.Findings:On 11/24/25 at 11:38 a.m., an unlocked soiled linen closet was observed with a bottle of Room Sense Disinfectant Cleaner (disinfectant), an unsecured bottle of all-purpose cleaner Fabuloso all-purpose cleaner and degreaser, and an unsecured bleach bottle Novel Wash Bleach labeled keep out of reach of children. On 11/24/25 at 11:45 a.m., an unlocked clean linen closet was observed with bottles of 1/2 gallon of DermaCen Peri Wash (a no rinse spray cleanser), shaving cream, a 4 oz bottle of mouthwash, and two (4 oz) bottles of hand sanitizer labeled keep out of reach of children. Resident #1 was observed wandering and opened the clean linen closet door.A significant change assessment, dated 10/10/25, showed Resident #1 was severely impaired in cognition.A resident face sheet, dated 11/2/5/25, showed Resident #1 had a diagnosis of dementia.On 11/24/25 at 11:45 a.m., LPN #1, assigned to the memory care unit, stated the doors were supposed to be locked, but they had a female resident that would grab the key that was hanging up by the door, and they can't find the keys. LPN#1 stated there were at least four residents that wandered independently.On 11/24/25 at 11:56 a.m., CNA #1 stated the linen doors were usually locked and they did not remember if they were locked overnight. On 11/24/25 at 12:05 p.m., an unlocked whirlpool/shower room was observed with two cans of shaving cream, a plastic bottle of disinfectant cleaner (Room Sense 200) labeled Do not drink and keep out of reach of children in the unlocked cabinet in the shower room.On 11/24/25 at 12:05 p.m., an unlocked whirlpool/shower room on the memory care unit was observed with cans of shaving cream, a plastic bottle of Room Sense (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	200 (disinfectant cleaner) and other personal care items which read in part, Do not drink and keep out of reach of children. The cabinet in the shower room was observed unlocked with the keys hanging up on the side of the cabinet. The keys observed hanging up on the side of the cabinet were to unlock the cabinet where the unsecured hazardous chemicals were observed.On 11/24/25 at 12:12 p.m., CNA #1 stated the items in the shower room were supposed to be locked up in the cabinet in the shower room. CNA #1 stated the cabinet in the shower room had not been locked in approximately one month.On 11/24/25 at 1:15 p.m., the administrator was notified of the unlocked clean, soiled linen closets, and shower room containing the hazardous chemicals.On 11/24/25 at 1:16 p.m., the administrator stated they did not have a policy. The administrator stated they just thought it was a given the doors should be locked.