STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375166	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks Healthcare Center	1501 Clayton Avenue Poteau, OK 74953

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. (continued on next page)

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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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, the facility failed to coordinate care with a facility contracted hospice service provider for 1 (#1) of 3 sampled residents reviewed for cardiac code status. The administrator identified 10 residents received hospice services.Findings:A care plan note, dated 05/07/25, showed Resident #1 and a family member reviewed the resident's cardiac code status as a full code and declined to make any changes to the resident's cardiac code status. A care plan note, dated 07/23/25, showed Resident #1 and a family member reviewed the resident's cardiac code status as a full code and declined to make any changes to the resident's cardiac code status. A physician's order, dated 07/30/25, showed Resident #1 was admitted to hospice services effective 07/29/25.A care plan note, dated 08/13/25, read in part, Care Plan Meeting held today with the IDT team and no answer for scheduled care plan meeting with [family member's name withheld] via phone. [Resident #1's name withheld] is currently in a LTC bed and weights are stable at this time. Currently a Full Code status and no code status changes at this time d/t family not in attendance and resident can't cognitively make the decision. No issues or concerns noted. Continue POC [plan of care]. A nurse's progress note, dated 08/24/25, showed Resident #1 was sluggish with audible secretions and the staff connected Resident #1 to 2 liters of oxygen. The note showed the facility arranged for the resident to be sent to the emergency room, contacted the contracted hospice provider, contacted the resident's primary care physician, and contacted the family member. The facility's Transfer and Referral Record, dated 08/24/25, showed Resident #1 was a Full Code and the reason for transfer to the hospital was shortness of breath and secretions. The hospital emergency room provider note, dated 08/24/25, showed Resident #1 was intubated, chemically sedated and paralyzed in route to the hospital by the emergency medical technicians. A nurse's progress note, dated 08/25/25, showed the facility staff contacted the physician and received an order to change the cardiac code status for Resident #1 from Full Code to Do Not Resuscitate [DNR]. The note showed the facility had a copy of the Do Not Resuscitate document signed by the guardian on 07/29/25. The note showed the facility added the signed Do Not Resuscitate document to the resident's electronic medical record. A code status audit, dated 08/26/25, showed an alphabetical list of all residents with their code status, confirmation of order for code status, and the resident's hospice provider, if applicable. An email correspondence, dated 08/26/25, showed the administrator summarized a meeting with the contracted hospice service provider for Resident #1. The email showed the meeting addressed four concerns: notification of new admits; DNR status; diagnoses for MDS update; and communication. The email showed the facility and hospice collaborated on a plan to prevent further issues. The plan included a nurse assigned to the facility to aid with consistency in communication; weekly meetings with hospice providers to review admissions, admission diagnoses for MDS; cardiac code status; and other resident concerns. The email showed the social service director made a central binder with each residents' cardiac code status and copies of their Do Not Resuscitate form and/or advanced directives. The email showed one hospice provider planned to provide access to hospice electronic medical records; all service providers were to provide new resident paperwork/orders/changes to the social service director; and the social service director communicated any new information / changes to the director of nursing and the medical director. On 09/11/25 at 4:40 p.m., the marketing representative for the contracted hospice service provider for Resident #1 stated they witnessed the cardiac code status change for Resident #1 from a Full Code status to a Do Not Resuscitate status and signed the document as one of two required witnesses to the document on 07/29/25. The marketing representative stated the document was signed by Resident #1's guardian at the guardian's home. The marketing representative stated they did not notify the facility of the change in Resident #1's code status and did not provide a copy of the signed Do Not Resuscitate document for Resident #1 to the facility. The marketing representative stated they were not sure how the hospice provider notified the facility of a change in a resident's code status but thought such documents were possibly faxed to the facility by the hospice provider's main office. On 09/11/25 at 4:22 p.m., MDS Coordinator #1 stated when a resident was admitted to hospice, the facility usually scheduled a new care plan meeting for the following Wednesday. MDS Coordinator #1 stated the floor nurses entered the order for hospice into the resident's clinical record. MDS Coordinator #1 stated if the terminal diagnosis was not entered as part of the hospice order, they contacted the contracted hospice provider to obtain the terminal diagnosis. MDS Coordinator #1 stated they did not ask about the resident's code status because it was usually placed in the resident's clinical record by the nursing staff and once there, MDS coordinator #1 updated the care plan. MDS Coordinator #1 stated