STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375207	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mangum Skilled Nursing and Therapy	320 Carey Street Mangum, OK 73554

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34333 On [DATE] an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure a resident received CPR, per the physician's order and the resident's plan of care, when the resident was found unresponsive and without vital signs. The resident was pronounced deceased by EMS without ever receiving CPR. On [DATE] at 7:08 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation. On [DATE] at 7:11 p.m., the administrator and regional manager were notified and provided the IJ template. Sufficient evidence of correction was provided to determine past non-compliance, with a compliance date of [DATE], when all staff members had been in-serviced, CPR training provided, new processes implemented to prevent lapses in certification and/or licensure, and compliance rounds and code drills implemented with ongoing auditing. Based on observation, record review and interview, the facility failed to initiate CPR, to an unresponsive resident with a full code status for 1 (#1) of 1 sampled resident reviewed for emergency basic life support to include CPR. The administrator reported 2 residents had expired in the facility in the past 90 days. Findings: On [DATE] at 11:00 a.m., a tour of the facility was conducted. Color-coded name strips/tags were observed by each residents door. The name tags were observed to be either green or red. Resident charts at the nurse's station were observed to have green or red tags and observed to match the name tags at the residents doors. A DNR, Advance Directives and End of Life Decisions policy, dated [DATE], read in part, It is the policy of this Facility to comply with a Resident's Advanced Directive and Do Not Resuscitate Consent .In the absence of a DNR Consent Facility staff will routinely initiate cardiopulmonary resuscitation (CPR) in accordance with their training for Residents who suffer cardiac or pulmonary arrest within the Facility and pursuant to the Facility's Emergency Resuscitation Policy. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 had diagnoses which included dementia, cardiac pacemaker, atherosclerosis, schizoaffective disorder, type 2 diabetes, insomnia, depression, Bipolar disease, anxiety, and chronic pain. A care plan for Resident #1, dated [DATE], showed the resident to be a full code. The care plan showed the resident wished to be resuscitated, their wish would be honored, and the resident would receive all available emergency services and aggressive treatment. The care plan showed if Resident #1 was found in cardiac or respiratory arrest, to start CPR immediately. The care plan showed the green nameplate outside the resident's door indicates full code status. A discharge MDS assessment, return anticipated, for Resident #1, dated [DATE], showed the resident was independent with cognitive skills. The assessment showed the resident required moderate assistance with activities of daily living. A physician order, dated [DATE], showed Resident #1 as full code/CPR status. A progress note for Resident #1, dated [DATE] at 6:23 a.m., showed LPN #1 was called to the resident's room by CNA #1. The note showed the resident was noted to be pale and without respirations or pulse. The note showed 911 was called and emergency personnel confirmed no vital signs and asystole rhythm. There was no documentation to show any other intervention was provided when the resident was found or while waiting for emergency personnel. A CPR/Full Code Response In-service form, dated [DATE], showed RN #1 provided in-service training by lecture to LPN #1. The in-service, read in part, The CPR/Full Code response can be initiated by any staff member that approaches a resident that is non responsive .Review code drill/policy. The form was signed by LPN #1 and RN #1. A typed note, dated [DATE], showed the administrator suspended LPN #1 from [DATE] to [DATE]. A nursing staff schedule was reviewed and showed the LPN had been scheduled to work, but was removed from the schedule while suspended. An In-Service Educational Program form, dated [DATE], showed a code blue class was provided to all staff. The facility's policy for DNR, Advance Directives and End of Life Decisions was used for this training. The in-service sign-in sheets showed some staff members were contacted by phone for training. Copies of Code Drill Guideline forms, dated [DATE] through [DATE], were provided and showed code drills were conducted on each shift. The forms included sign-in for staff members who participated. The code drill guideline included eight steps for conducting the code drill and showed the drills would be conducted each shift monthly. The guideline gave instructions for employees to sign in online to show participation in code drills. An In-Service Educational Program form, dated [DATE], showed a CPR class was provided to nursing staff and activities/social services staff. (continued on next page)

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An email provided by the facility's regional manager, dated [DATE], showed the company was working on CPR certification compliance and instructed facility staff to enter CPR certification expiration dates for all licensed nurses by end of day on [DATE]. The email gave instructions regarding where to enter the data in the system spreadsheet, and how to run a CPR License Expire report to see who was missing an entry or had an expired certification. An In-Service Educational Program form, dated [DATE], showed a CPR class was provided to additional staff members, including a certified nurse aide. Copies of Compliance Rounds forms were provided for [DATE], [DATE], and [DATE]. These were conducted on the day, evening, and night shifts. The compliance rounds included questions to staff regarding how to respond to a code situation, how to know when a resident was a full code or a DNR, and who could participate in a full code situation. A Quality Tip Report, dated [DATE], showed problem identified: CPR response and certification. The report showed plan of correction: code drills every shift for five days, CPR class to be held [DATE] and [DATE]; compliance rounds twice weekly for one month then monthly for six months. The report showed all staff were in-serviced on the CPR/DNR policy. The report showed QA would meet again upon completion of compliance rounds. The report showed date problem identified: [DATE]; date range for compliance rounds: [DATE] through [DATE] then monthly for six months. The report showed date problem reported to QA committee: [DATE]. The report was signed by RN #1. On [DATE] at 11:05 a.m., CNA #2 reported the facility's process for identifying a resident's code status was to use a red name strip if the resident was a DNR and a green name strip if the resident was a full code. The CNA reported the color-coded name strips were at each resident's door, as well as on the resident's hard chart at the nurse's station. The CNA reported this identification process was not new and had been in place for a while. On [DATE] at 11:25 a.m., LPN #2 reported they were not aware of any issues with identifying a resident's code status. The LPN reported the facility's process was to use green for a full code and red for a DNR, and this could be found at the resident's door, on the hard chart, and in the electronic medical record. On [DATE] at 11:30 a.m., LPN #3 reported the facility had CPR training the previous week for all staff who were not already certified or needed to be re-certified. The LPN reported this training was related to a resident being found unresponsive and staff did not initiate CPR. On [DATE] at 12:40 p.m., LPN #1 was interviewed by phone. The LPN reported it was during their last round of the night that CNA #1 called for their help with Resident #1. The LPN reported they checked the resident and grabbed the vital sign machine to see if their suspicion was correct. The LPN reported they were unable to get vital signs on the resident and attempted to call the DON to see what the protocol was in this situation. The LPN reported they were unable to reach the DON so then called 911. The LPN reported they knew the resident was a full code, but since the resident appeared to be deceased and had no vital signs, they were uncertain about starting CPR. The LPN reported EMTs arrived, placed an EKG machine on the resident, and confirmed there was no pulse and pronounced the resident. (continued on next page)

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:55 p.m., CNA #1 was interviewed by phone. The CNA reported it was probably 5:00 or 5:30 a.m., while making rounds, when they found Resident #1 unresponsive in their room. The CNA reported they thought it was probably about 3:00 a.m. when they had last looked in on the resident and heard the resident snoring. The CNA reported they were aware the resident was a full code and immediately called for the nurse who took over from there. The CNA reported in most situations if they thought the nurse was not going to do CPR, they would do it, but in this case the CNA thought the nurse felt it wouldn't help the resident. On [DATE] at 1:30 p.m., RN #1 reported two staff members could not be reached for the code blue in-service on [DATE], but would be in-serviced prior to their next shifts. RN #1 provided a resident roster which listed each resident and their code status. The RN reported in addition to the [DATE] in-service, they checked door tags, advanced directive acknowledgements, and DNR status with each resident's chart to ensure all were correct and identified correctly on the resident's door/name tags. The RN reported they found no discrepancies. On [DATE] at 1:35 p.m., the regional manager reported the new process for tracking CPR certification and licenses would allow the facility to prevent lapses in licensure and certification and had already been initiated as of [DATE]. On [DATE] at 5:10 p.m., the DON reported they told LPN #1 they should always do CPR if the resident was a full code, regardless of the circumstances. The LPN told the DON they did not feel performing CPR on the resident was the right thing to do when they believed the resident was already gone, and was not sure what the protocol was in this situation. On [DATE] at 5:15 p.m., RN #1 reported they told LPN #1 during their 1:1 in-service/lecture that it was not their place to make the decision on whether to perform CPR or not, as the resident was a full code status. The RN reported the LPN and all other staff had been in-serviced.

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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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34333 On [DATE] an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure staff were trained and competent to respond to a resident's needs when the resident was found unresponsive and without vital signs. The resident was pronounced deceased by EMS without ever receiving CPR. On [DATE] at 7:08 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation. On [DATE] at 7:11 p.m., the administrator and regional manager were notified and provided the IJ template. Sufficient evidence of correction was provided to determine past non-compliance, with a compliance date of [DATE], when all staff members had been in-serviced, CPR training provided, new processes implemented to prevent lapses in certification and/or licensure, and compliance rounds and code drills implemented with ongoing auditing. Based on observation, record review, and interview, the facility failed to ensure staff were trained and competent to respond to a resident's needs for 1 (#1) of 2 sampled residents reviewed for competency of staff. The administrator reported two residents had expired in the facility in the past 90 days. Findings: On [DATE] at 11:00 a.m., a tour of the facility was conducted. Color-coded name strips/tags were observed by each resident's door. The name tags were observed to be either green or red. Resident charts at the nurse's station were observed to have green or red tags and observed to match the name tags at the resident's doors. A DNR, Advance Directives and End of Life Decisions policy, dated [DATE], read in part, It is the policy of this Facility to comply with a Resident's Advanced Directive and Do Not Resuscitate Consent .In the absence of a DNR Consent Facility staff will routinely initiate cardiopulmonary resuscitation (CPR) in accordance with their training for Residents who suffer cardiac or pulmonary arrest within the Facility and pursuant to the Facility's Emergency Resuscitation Policy. Resident #1 had diagnoses which included dementia, cardiac pacemaker, atherosclerosis, Schizoaffective disorder, type 2 diabetes, insomnia, depression, Bipolar disease, anxiety, and chronic pain. A care plan for Resident #1, dated [DATE], showed the resident to be a full code. The care plan showed the resident wished to be resuscitated, their wish would be honored, and the resident would receive all available emergency services and aggressive treatment. The care plan showed if Resident #1 was found in cardiac or respiratory arrest, to start CPR immediately. The care plan showed the green nameplate outside the resident's door indicates full code status. (continued on next page)

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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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A discharge MDS assessment, return anticipated, for Resident #1, dated [DATE], showed the resident was independent with cognitive skills. The assessment showed the resident required moderate assistance with activities of daily living. A physician order, dated [DATE], showed Resident #1 as full code/CPR status. A progress note for Resident #1, dated [DATE] at 6:23 a.m., showed LPN #1 was called to the resident's room by CNA #1. The note showed the resident was noted to be pale and without respirations or pulse. The note showed 911 was called and emergency personnel confirmed no vital signs and asystole rhythm. There was no documentation to show any other intervention was provided when the resident was found or while waiting for emergency personnel. A CPR/Full Code Response In-service form, dated [DATE], showed RN #1 provided in-service training by lecture to LPN #1. The in-service read in part, The CPR/Full Code response can be initiated by any staff member that approaches a resident that is non responsive .Review code drill/policy. The form was signed by LPN #1 and RN #1. A typed note, dated [DATE], showed the administrator suspended LPN #1 from [DATE] to [DATE]. A nursing staff schedule was reviewed and showed the LPN had been scheduled to work, but was removed from the schedule while suspended. An In-Service Educational Program form, dated [DATE], showed a code blue class was provided to all staff. The facility's policy for DNR, Advance Directives and End of Life Decisions was used for this training. The in-service sign-in sheets showed some staff members were contacted by phone for training. Copies of Code Drill Guideline forms, dated [DATE] through [DATE], were provided and showed code drills were conducted on each shift. The forms included sign-in for staff members who participated. The code drill guideline included eight steps for conducting the code drill and showed the drills would be conducted each shift monthly. The guideline gave instructions for employees to sign in online to show participation in code drills. An In-Service Educational Program form, dated [DATE], showed a CPR class was provided to nursing staff and activities/social services staff. An email provided by the facility's regional manager, dated [DATE], showed the company was working on CPR certification compliance and instructed facility staff to enter CPR certification expiration dates for all licensed nurses by end of day on [DATE]. The email gave instructions regarding where to enter the data in the system spreadsheet, and how to run a CPR License Expire report to see who was missing an entry or has an expired certification. An In-Service Educational Program form, dated [DATE], showed a CPR class was provided to additional staff members, including a certified nurse aide. Copies of Compliance Rounds forms were provided for [DATE], [DATE], and [DATE]. These were conducted on the day, evening, and night shifts. The compliance rounds included questions to staff regarding how to respond to a code situation, how to know when a resident is a full code or a DNR, and who can participate in a full code situation. (continued on next page)

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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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Quality Tip Report, dated [DATE], showed problem identified: CPR response and certification. The report showed plan of correction: code drills every shift for five days, CPR class to be held [DATE] and [DATE]; compliance rounds twice weekly for one month then monthly for six months. The report showed all staff were in-serviced on the CPR/DNR policy. The report showed QA would meet again upon completion of compliance rounds. The report showed date problem identified: [DATE]; date range for compliance rounds: [DATE] through [DATE] then monthly for six months. The report showed date problem reported to QA committee: [DATE]. The report was signed by RN #1. On [DATE] at 11:05 a.m., CNA #2 reported the facility's process for identifying a resident's code status was to use a red name strip if the resident was a DNR and a green name strip if the resident was a full code. The CNA reported the color-coded name strips were at each resident's door, as well as on the resident's hard chart at the nurse's station. The CNA reported this identification process was not new and has been in place for a while. On [DATE] at 11:25 a.m., LPN #2 reported they were not aware of any issues with identifying a resident's code status. The LPN reported the facility's process was to use green for a full code and red for a DNR, and this could be found at the resident's door, on the hard chart, and in the electronic medical record. On [DATE] at 11:30 a.m., LPN #3 reported the facility had CPR training the previous week for all staff who were not already certified or needed to be re-certified. The LPN reported this training was related to a resident being found unresponsive and staff did not initiate CPR. On [DATE] at 12:40 p.m., LPN #1 was interviewed by phone. The LPN reported it was during their last round of the night that CNA #1 called for their help with Resident #1. The LPN reported they checked the resident and grabbed the vital sign machine to see if their suspicion was correct. The LPN reported they were unable to get vital signs on the resident and attempted to call the DON to see what the protocol was in this situation. The LPN reported they were unable to reach the DON so then called 911. The LPN reported they knew the resident was a full code but since the resident appeared to be deceased and had no vital signs, they were uncertain about starting CPR. The LPN reported EMTs arrived, placed an EKG machine on the resident, and confirmed there was no pulse and pronounced the resident. On [DATE] at 12:55 p.m., CNA #1 was interviewed by phone. The CNA reported it was probably 5:00 or 5:30 a.m., while making rounds, when they found Resident #1 unresponsive in their room. The CNA reported they thought it was probably about 3:00 a.m. when they had last looked in on the resident and heard the resident snoring. The CNA reported they were aware the resident was a full code and immediately called for the nurse who took over from there. The CNA reported in most situations if they thought the nurse was not going to do CPR, they would do it, but in this case the CNA thought the nurse felt it would not help the resident. On [DATE] at 1:30 p.m., RN #1 reported two staff members could not be reached for the code blue in-service on [DATE], but would be in-serviced prior to their next shifts. RN #1 provided a resident roster which listed each resident and their code status. The RN reported in addition to the [DATE] in-service, they checked door tags, advanced directive acknowledgements, and DNR status with each resident's chart to ensure all were correct and identified correctly on the resident's door/name tags. The RN reported they found no discrepancies. (continued on next page)

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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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:35 p.m., the regional manager reported the new process for tracking CPR certification and licenses would allow the facility to prevent lapses in licensure and certification and has already been initiated as of [DATE]. On [DATE] at 5:10 p.m., the DON reported they told LPN #1 they should always do CPR if the resident was a full code, regardless of the circumstances. The LPN told the DON they did not feel performing CPR on the resident was the right thing to do when they believed the resident was already gone, and was not sure what the protocol was in this situation. On [DATE] at 5:15 p.m., RN #1 reported they told LPN #1 during their 1:1 in-service/lecture that it was not their place to make the decision on whether to perform CPR or not, as the resident was a full code status. The RN reported the LPN and all other staff had been in-serviced.