

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: 375207	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Mangum Skilled Nursing and Therapy		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure: a. mechanical lifts were free from dirt and debris for 3 of 4 observed, b. return air vents were free from dirt and debris for 2 of 2 observed, c. ceilings were in good repair and free from stains, and d. an air purifier was free from dirt and stains. The administrator identified 26 residents resided in the facility. Findings: On 07/28/26 at 12:30 p.m., the half wall to the entry inside the serving area for the dining room was observed to have many areas of a dried dark substance all across the top of the short wall and down the wall. The back wall where the entry to the serving area was, was observed to have large areas of dried yellow substance and a portable air purifier system, sitting in front of the wall, was observed to be covered in dirt along with a dried dark brown substance. The return air vents in the dining area were observed to be covered in dirt and dust. On 07/28/26 at 1:10 p.m., the drop-down ceilings down hall 100 were observed to have dark brown stains and the sheetrock ceiling in the common area was observed to have the tape separating from the seams with dark areas observed around the exposed sheetrock tape. On 07/28/26 at 1:16 p.m., a mechanical lift was observed in the room of Resident #26 The lift was observed to have a build-up of dirt on the base and up the shaft of the lift. On 07/31/26 at 9:22 a.m., the same observations were made of the dining area, hall 100 and the common area. On 07.31.25 at 11:30 a.m., the housekeeping supervisor was shown the lifts stored in room [ROOM NUMBER]. The housekeeping supervisor state they would clean the equipment if it needed it, but they had laundry to keep up with also and they were usually the only one there in the facility. They stated the lifts needed to be cleaned. On 07/31/26 at 11:35 a.m., the housekeeping supervisor was shown the observations in the dining area, and the air purifier. They stated no that was dietary's responsibility, they just swept and mopped the floors. On 07/31/26 at 11:48 a.m., the maintenance supervisor was shown the vents on hall 100 and the vents in the entry to the dining room. The maintenance supervisor was asked who was responsible for cleaning the vents. The maintenance supervisor stated they did not know who was responsible for cleaning them. They stated all the vents need to be cleaned, and they guessed they would do it. The maintenance supervisor was shown the ceilings. The maintenance supervisor stated they had started cleaning and painting the ceiling tiles. The maintenance supervisor was shown the areas of concern in the dining room. The maintenance supervisor stated it looked like they could use a good power washing. On 07/31/26 at 12:11 p.m., the DON stated they would get the air purifier on the cleaning schedule. The dietary manger stated they would be responsible for cleaning the dietary area. The dietary manager stated housekeeping used to be responsible, but when the new housekeeping supervisor started, they were informed cleaning was dietary's responsibility to keep that area clean.		

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 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 alleged mistreatment during the provision of grooming and hygiene of a resident was reported to the State Agency within two hours for 1 (#35) of 5 sampled residents reviewed for abuse. The administrator identified 26 residents resided in the facility. Findings: An undated admission Record, showed Resident #35 had a diagnoses of dementia and depression. A quarterly assessment for Resident #35, dated 10/31/25, showed the resident had a BIMS score of 3 which indicated the resident had severe cognitive impairment. The assessment showed Resident #35 was dependent on staff for grooming and hygiene. A Concern/Grievance Report for Resident #35, dated 11/19/25, read in part, Type of Issue: Mat removal. Description: Mat of hair to the back of head was removed but reddened area noted after it was removed. The grievance was signed by the administrator on 11/20/25. A nurse's progress note for Resident #35, dated 11/19/25 at 1:32 p.m., read in part, Residents scalp was red and irritated this morning, will monitor for discomfort. Resident did not want to get up today. A review the facility's investigations for abuse and mistreatment, dated 07/01/25 through 07/02/26, showed no documentation the facility had reported an allegation of mistreatment during the grooming of Resident #35's hair on 11/19/25. On 07/31/26 at 9:19 a.m., LPN #2 stated they had worked at the facility since February 2025. LPN #2 stated they have had one allegation of mistreatment alleged against them. LPN #2 stated it was alleged Resident #35 had been mistreated while they were having their matted hair brushed. LPN #2 stated the allegation was investigated and they were not suspended. On 07/31/26 at 9:42 a.m., the administrator was asked about the allegation of mistreatment while Resident #35 was having their matted hair brushed. The administrator stated they completed that allegation as a grievance. The administrator then stated it was caused by the matting of the hair and getting it out. The administrator then stated the facility wrote it up as a grievance due to Resident #35 refusing care and not having their hair brushed routinely. On 07/31/26 at 10:12 a.m., CNA #1 stated Resident #35 refused care a lot and had a matt in their hair. CNA #1 stated someone brushed it out and the next morning the resident was hollering out in pain. CNA #1 stated they reported it to staff other than the administrator. On 07/31/26 at 11:20 a.m., LPN #2 stated they knew it was an allegation of mistreatment because staff that were interviewed came and let them know what was asked. On 07/31/26 at 11:35 a.m., the administrator stated looking this should have been reported like an abuse allegation.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to ensure an alleged mistreatment during the provision of grooming and hygiene of a resident was thoroughly investigated for 1 (#35) of 5 sampled residents reviewed for abuse. The administrator identified 26 residents resided in the facility. Findings: An undated admission Record, showed Resident #35 had a diagnoses of dementia and depression. A quarterly assessment for Resident #35, dated 10/31/25, showed the resident had a BIMS score of 3 which indicated the resident had severe cognitive impairment. The assessment showed Resident #35 was dependent on staff for grooming and hygiene. A Concern/Grievance Report for Resident #35, dated 11/19/25, read in part, Type of Issue: Mat removal. Description: Mat of hair to the back of head was removed but reddened area noted after it was removed. The grievance was signed by the administrator on 11/20/2025. A nurse's progress note for Resident #35, dated 11/19/25 at 1:32 p.m., read in part, Residents scalp was red and irritated this morning, will monitor for discomfort. Resident did not want to get up today. A review the facility's investigations for abuse and mistreatment, dated 07/01/25 through 07/02/2026, showed no documentation the facility had investigated the allegation of mistreatment during the grooming of Resident #35 hair on 11/19/25. On 07/31/26 at 9:19 a.m., LPN #2 stated they had worked at the facility since February 2025. LPN #2 stated they have had one allegation of mistreatment alleged against them. LPN #2 stated it was alleged Resident #35 had been mistreated while they were having their matted hair brushed. LPN #2 stated the allegation was investigated. On 07/31/26 at 9:42 a.m., the administrator was asked about the allegation of mistreatment while Resident #35 was having their matted hair brushed. The administrator stated they completed that allegation as a grievance. The administrator then stated it was caused by the matting of the hair and getting it out. The administrator then stated the facility wrote it up as a grievance due to Resident #35 refusing care and not having their hair brushed routinely. On 07/31/26 at 10:12 a.m., CNA #1 stated Resident #35 refused care a lot and had a matt in their hair. CNA #1 stated someone brushed it out and the next morning the resident was hollering out in pain. CNA #1 stated they reported it to staff other than the administrator. On 07/31/26 at 11:20 a.m. LPN #2 stated they knew it was an allegation of mistreatment because staff that were interviewed came and let them know what was asked. On 07/31/26 at 11:35 a.m., the administrator stated looking this should have been investigated like an abuse allegation.		