STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375360	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Nursing Center	1100 Oak Ridge Drive Durant, OK 74701

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. (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A past noncompliance Immediate Jeopardy (IJ) situation was determined to exist effective [DATE], related to the facility's failure to ensure:a. CPR was not stopped for a resident who was a full code, b. staff members could definitively identify a resident's code status, andc. effective cardiopulmonary resuscitation was provided by the use of a backboard and providing rescue breaths. A progress note, dated [DATE] at 4:07 a.m., showed a code had been called for Res #1 and CPR had been started. Staff interviews showed CPR on Res #1 had been halted when they could not determine the resident's code status and the CPR provided did not make use of a backboard or provide rescue breaths via an Ambu bag or use of a face shield thus excluding two valuable tools for providing effective CPR.The past noncompliance IJ was removed effective [DATE] after the facility put measures in place to prevent recurrence:a. On [DATE] all staff were in-serviced on code status, crash carts, code leader, CPR, and mock codes.b. On [DATE] a system to identify staff trained in CPR was put in place.c. On [DATE] staff training on how to identify a resident's code status was completed.d. On [DATE] members of the QAPI team met via TEAMS regarding CPR, mock codes drills, code status accuracy, verification with hospice providers, system review, post code briefings, and investigation completion.On [DATE] facility staff members were interviewed, and facility documentation was reviewed which showed and confirmed steps required for the facility to become compliant had occurred and were place.Based on record review and interview, the facility failed to ensure:a. a backboard was used when chest compressions were used for a resident that was laying on a mattress,b. CPR was not withheld for a resident that wanted CPR because staff could not identify the resident's correct code status; andc. rescue breaths were used during CPR according to the standards of practice and the facility's CPR policy for 1 (#1) of 5 sampled resident reviewed for code status.The administrator identified 56 residents resided in the facility.Findings:A facility policy titled Emergency Procedure - Cardiopulmonary Resuscitation, read in part, Policy Statement. Personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR) and basic life support (BLS), including defibrillation, for victims of sudden cardiac arrest. If the first responder is not CPR certified, that person will call 911 and follow the 911 operator's instruction until a CPR certified-staff member arrives. 5. Breathing: after 30 chest compressions provide 2 breaths via Ambu bag or manually (with CPR shield). 6. All rescuers, trained or not, should provide chest compressions to victims of cardiac arrest. All rescuers should also provide ventilations with a compression-ventilation ratio of 30:2.A face sheet located in the Res #1's EMR, dated [DATE], showed the resident's code status was full code (the resident chose to have CPR performed if required).A facility document titled Acknowledgment of Advance Directive, dated [DATE], showed Res #1 had declined to initiate DNR status. (This indicated the resident chose to have CPR performed if required). The document was signed by the resident and witnessed by the resident's legal representative. A physician's order, dated [DATE], showed Res #1's code status was a full code.A CPR certificate of completion, dated [DATE], showed TNA #1 had been trained in CPR for professional rescuers.A care plan for Res #1, revised date [DATE], showed on page one next to the resident's name the resident was a full code.A facility document titled Crash Cart Checklist, dated [DATE] through [DATE], showed the facility crash carts did contain Ambu bag's each date of that month including the date Res #1 had coded, [DATE].A quarterly assessment, dated [DATE], showed in Section C Res #1 had a BIMS score of 15 (this score on the BIMS showed the resident's cognition was intact for decision making).A progress note for Res #1, dated [DATE] at 4:07 a.m., showed the resident had been found unresponsive and a code was called. The note showed an ambulance was called and CPR was started and continued until the ambulance arrived. The note showed the ambulance staff documented the time of death as 4:39 a.m. The note was authored by LPN #2. An initial incident report form (ODH Form 283), incident date [DATE], showed the DON had submitted the form regarding Res #1. The report showed an unidentified CNA had reported information about a code (a staff response to a life-threatening condition) had been performed on Res #1. The form further showed after interviewing staff involved in the code, conflicting accounts had been given, and an investigation was begun. A final incident report form (ODH Form 283), incident date [DATE], showed the DON had submitted the form regarding Res #1. The form showed the facility leadership could not determine if neglect occurred because of conflicting statements and emotions surrounding the event. The report showed facility leadership was unable to determine what staff had provided CPR at any specific time due to staff members entering and exiting the residents' room during the incident. The report showed the nurses on duty adamantly stated CPR