STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375390	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmbrook of Hugo	1200 West Finley 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45913 Based on record review and interview, the facility failed to ensure a resident was offered the choice to formulate an advanced directive for one (#1) of four sampled residents whose advance directive acknowledgements were reviewed. The administrator identified 55 residents who resided in the facility. Findings: An Advance Directives policy, revised on [DATE], read in part, The resident has the right to formulate an advance directive .1. Within 72 hours of admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives .3. Written information about the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive is provided .4. Written information includes a description of the facility's policies to implement advance directives and applicable state laws. An Emergency Procedure - Cardiopulmonary Resuscitation policy, revised February 2018, read in part, 7. Provide information on CPR/BLS and advance directives to each resident/representative upon admission. Res #1 was admitted on [DATE] and had diagnoses which included congestive heart failure and pneumonia. A physician's order, dated [DATE], documented Res #1 was a full code. A care plan focus, dated [DATE], documented in Res #1 was a full code. Res #1's medical record did not contain an advance directive acknowledgement. On [DATE] at 2:40 p.m., the DON reported they were unable to locate an advance directive acknowledgement for Res #1.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45913 Based on record review and interview, the facility failed to notify the physician of a resident's change in condition for one (#1) of four sampled residents who were reviewed for neglect. The administrator identified 55 residents who resided in the facility. Findings: The Guidelines for Notifying Physicians of Clinical Problems, revised [DATE], read in part, The charge nurse or supervisor should contact the attending physician if a clinical situation appears to require immediate discussion and management . Immediate Notification (Acute) Problems .Immediate implies that the physician should be notified as soon as possible .These situations include: .Rapid decline or continued instability .New onset of, or progression of usual, .dyspnea with a pulse oximetry below 90% or at least 3% below usual pulse oximetry range . Res #1 had diagnoses which included congestive heart failure, pneumonia and dyspnea. A physician's order, dated [DATE], documented to administer oxygen via nasal cannula at two liters per minute to maintain oxygen saturation above 90%. A physician's order, dated [DATE], documented Res #1 was a full code. A progress note, dated [DATE] at 2:17 a.m., documented LPN #1 observed Res #1's oxygen saturation was 55% on 3 liters of oxygen and their respiratory rate was 20. The note documented the nurse increased the resident's oxygen to four liters per minute and placed their nasal cannula into their mouth which raised their oxygen saturation to 82%. The note documented upon recheck of the resident's oxygen saturation it had dropped back down to 54%. The nurse documented they removed the supplemental oxygen and placed Res #1 on their CPaP machine which did not raise the resident's oxygen saturation beyond 55%. The note documented the resident remained with this oxygen saturation until 11:00 p.m. at which time LPN #1 reassessed Res #1's vital signs. The note documented the resident's oxygen saturation had dropped to 35%. The note did not document EMS or a physician was contacted at this time. The note documented LPN #1 continued to reassess the resident and the oxygen saturation did not rise beyond 34%. The note documented at 12:00 a.m., a CNA notified LPN #1 Res #1 was gone. The nurse documented upon their assessment of Res #1 no vital signs were detected and the provider was notified of their passing. The note documented the provider called a time of death of 12:15 a.m. The note did not document CPR was initiated, or emergency services were contacted. (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 0580 Level of Harm - Actual harm Residents Affected - Few	A written statement from CNA #1, dated [DATE], documented around 9:00 p.m. or 10:00 p.m. on the night of [DATE], LPN #1 noted Res #1's oxygen saturation was dropping and stated to CNA #1 it appeared the resident was going to die. CNA #1 documented they asked LPN #1 and LPN #2 what the resident's code status was more than one time and the response received was Res #1 was a DNR. The CNA documented they notified LPN #1 the resident was breathing but non-responsive during peri-care. CNA #1 documented when they returned to Res #1's room Res #1 was not breathing but was still warm. They documented they notified LPN #1 at which time the LPN went to the resident's room to assess the resident. The statement documented the LPN checked the resident for breath sounds and pulse, which were not observed. CNA #1 documented they observed LPN #1 calling LPN #2. The statement documented CNA #1 went to the other hall to provide care and upon their return LPN #1 stated the resident was a full code. CNA #1 documented they asked LPN #1 if CPR should be initiated to which the nurse stated its too late now. A documented facility interview, dated [DATE], documented LPN #1 did not notify the provider and had they known Res #1 was a full code they would have sent them to the hospital. On [DATE] at 4:40 p.m., RN #1 stated LPN #1 should have called Res #1's doctor when their condition changed.

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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	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** 45913 A past noncompliance Immediate Jeopardy (IJ) situation was determined to exist effective [DATE] related to the facility's failure to ensure cardio-pulmonary resuscitation was provided according to standards of care for Res #1 who was a full code status and implement all components of the facility's CPR policy On [DATE] at 4:20 p.m., the Oklahoma State Department of Health was notified and verified the existence of the past noncompliance IJ related to the facility's failure to implement their CPR policy and provide CPR to Res #1 who was a full code. The past noncompliance IJ was removed effective [DATE] after the facility put measure in place to prevent recurrence. On [DATE] staff were in-serviced on CPR status, DNR code status policy and procedures were reviewed, code status identification policy and procedures were included in all new hire packets, with in-person training upon hire. On [DATE] at 10:35 a.m., code status identification was observed at each room/name plates on the memory care unit. On [DATE] at 10:42 a.m., the Activity Director reported having been in-serviced regarding code status and CPR and reported knowledge of how to locate the code status of a resident and when CPR should be done. On [DATE] at 10:45 a.m., LPN #3 reported having been in-serviced regarding code status and CPR and reported examples of a change in condition for a resident, when to notify the physician, where a resident's code status is posted, when to do CPR. On [DATE] at 10:53 a.m., code status identification was observed at room/name plates in the long term care halls. On [DATE] at 10:55 a.m., RN #2 reported they were not able to attend the in-service, but did review the in-service documentation. RN #2 reported examples of a change in condition for a resident, when to notify the physician, where a resident's code status is posted and when to do CPR. Based on observation, record review, and interview, the facility failed to provide CPR to a resident who was full code status and implement their CPR policy for one (#1) of four sampled residents reviewed for code status. The DON identified 15 residents who were a full code status. The administrator identified 55 residents who resided in the facility. Findings: (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 Emergency Procedure - Cardiopulmonary Resuscitation policy, revised February 2018, read in part, Personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR) and basic life support (BLS), including defibrillation, for victims of sudden cardiac arrest .Preparation for Cardiopulmonary Resuscitation 1. Obtain and/or maintain American Red Cross or American Heart Association certification in Basic Life Support (BLS)/Cardiopulmonary Resuscitation (CPR) for key clinical staff members who will direct resuscitation efforts, including non-licensed personnel .7. Provide information on CPR/BLS and advance directives to each resident/representative upon admission. Res #1 had diagnoses which included congestive heart failure, pneumonia and dyspnea. A physician order, dated [DATE] documented Res #1 was a full code. A care plan focus, dated [DATE], documented Res #1 was full code status. There was no advance directive acknowledgement in Res #1's medical record. A progress note, dated [DATE] at 2:17 a.m., documented LPN #1 observed Res #1's oxygen saturation was 55% on 3 liters of oxygen and their respiratory rate was 20. The note documented the nurse increased the resident's oxygen to four liters per minute and placed their nasal cannula into their mouth which raised their oxygen saturation to 82%. The note documented upon recheck of the resident's oxygen saturation it had dropped back down to 54%. The nurse documented they removed the supplemental oxygen and placed Res #1 on their CPaP machine which did not raise the resident's oxygen saturation beyond 55%. The note documented the resident remained with this oxygen saturation until 11:00 p.m. at which time LPN #1 reassessed Res #1's vital signs. The note documented the resident's oxygen saturation had dropped to 35%. The note did not document EMS or a physician was contacted at this time. The note documented LPN #1 continued to reassess the resident and the oxygen saturation did not rise beyond 34%. The note documented at 12:00 a.m., a CNA notified LPN #1 Res #1 was gone. The nurse documented upon their assessment of Res #1 no vital signs were detected and the provider was notified of their passing. The note documented the provider called a time of death of 12:15 a.m. The note did not document CPR was initiated, or emergency services were contacted. A written statement from CNA #1, dated [DATE], documented around 9:00 p.m. or 10:00 p.m. on the night of [DATE], LPN #1 noted Res #1's oxygen saturation was dropping and stated to CNA #1 it appeared the resident was going to die. CNA #1 documented they asked LPN #1 and LPN #2 what the resident's code status was more than one time and the response received was Res #1 was a DNR. The CNA documented they notified LPN #1 the resident was breathing but non-responsive during peri-care. CNA #1 documented when they returned to Res #1's room Res #1 was not breathing but was still warm. They documented they notified LPN #1 at which time the LPN went to the resident's room to assess the resident. The statement documented the LPN checked the resident for breath sounds and pulse, which were not observed. CNA #1 documented they observed LPN #1 calling LPN #2. The statement documented CNA #1 went to the other hall to provide care and upon their return LPN #1 stated the resident was a full code. CNA #1 documented they asked LPN #1 if CPR should be initiated to which the nurse stated its too late now. (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	A facility interview with LPN #1, dated [DATE], documented the nurse was not aware of the process to check a resident's code status or the process to verify code status. The interview documented LPN #1 was told by another nurse during report Res #1 was a DNR and was not to be sent to the hospital but did not verify the resident's code status. The interview documented upon notification from the aide that Res #1 was gone, LPN #1 took about five minutes to determine Res #1 was full code status. The interview documented LPN #1 was unaware of the nursing standard requirement to start CPR on residents with unknown code status until EMS or a provider stopped CPR. A written statement from CNA #2, dated [DATE], documented at 10:30 p.m. on [DATE], CNA #2 was instructed by LPN #2 to go assist LPN #1 because Res #1's vital signs wasn't looking very great. CNA #2 observed LPN #1 obtaining vital signs. The CNA documented LPN #1 retrieved LPN #2 for assistance. The CNA documented they observed LPN #2 recheck[ed] what LPN #1 had done. The CNA documented they observed LPN #1 notify LPN #2 the resident had passed. They documented they discovered the resident was a full code while attempting to find contact information for the resident's family. The CNA documented they were upset because they were told the resident was a DNR and felt they could have done CPR. An undated written statement from CNA #3, documented LPN #1 notified them around 11:00 p.m. Res #1 had passed. They documented while waiting for instruction from the nurse they were informed by LPN #2 the resident was a DNR. They documented the nurses discovered the resident was a full code while attempting to contact the resident's spouse. An employee disciplinary action form for LPN #2, dated [DATE], documented LPN #2 had received disciplinary action due to failure to provide life saving measures. The form documented LPN #2 declined to give a written statement of events. An employee termination form, dated [DATE], documented LPN #1 was terminated due to the failure to provide life saving measures for Res #1 on [DATE]. On [DATE] at 2:40 p.m., the DON reported they were unable to locate an advance directive acknowledgement for Res #1. On [DATE] at 4:40 p.m., RN #1 reported LPN #1 should have provided CPR to Res #1.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45913 Based on record review and interview, the facility failed to: a. follow physician's orders for a resident with oxygen, b. obtain orders for a CPAP, and c. ensure a CPAP was in working order for one (#1) of four sampled residents who were reviewed for neglect. The administrator identified 55 residents who resided in the facility. Findings: An Oxygen Administration policy, revised [DATE], read in part, The purpose of this procedure is to provide guidelines for safe oxygen administration .1. Verify that there is a physician's order for this procedure. Review the physician's orders for oxygen administration. 2. Review the resident's care plan .1. Oxygen therapy is administered by way of .nasal cannula .b. The nasal cannula is a tube that is place approximately one-half inch into the resident's nose. A CPAP/BiPAP Support policy, revised [DATE], read in part, 1. Only a qualified and properly trained nurse or respiratory therapist should administer oxygen through a CPAP mask .3. Review the physician's order to determine the oxygen concentration and flow, and the PEEP pressure for the machine. Res #1 had diagnoses which included congestive heart failure, pneumonia, and sleep apnea. A physician's order, dated [DATE], documented to administer oxygen via nasal cannula at a rate of two liters per minute to maintain oxygen saturation above 90%. Res #1 did not have a physician's order for use of a CPAP. A care plan, dated [DATE], documented Res #1 required a BiPap due to sleep apnea. The goals listed the resident will breathe at an optimal level and settings would be applied as ordered by the physician. The care plan documented to monitor the resident for shortness of breath or episodes of apnea. A progress note, dated [DATE] at 2:21 p.m., documented Res #1 was receiving oxygen via nasal cannula at 3.5 liters per minute. A progress note, dated [DATE] at 2:06 p.m., documented Res #1 was receiving oxygen via nasal cannula at three liters per minute. A progress note, dated [DATE] at 10:38 p.m., documented Res #1 was receiving oxygen via nasal cannula at three liters per minute and required a CPAP at night, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated [DATE] at 2:09 p.m., documented Res #1 was receiving oxygen via nasal cannula at 3.5 liters per minute and required a CPAP at night. A progress note, dated [DATE] at 11:25 p.m., documented Res #1 was receiving oxygen via nasal cannula at three liters per minute. A progress note, dated [DATE] at 3:55 p.m., documented Res #1 was receiving oxygen via nasal cannula at three liters per minute. A progress note, dated [DATE] at 2:10 a.m., documented Res #1 had a CPAP on their dresser that was prepped and ready for use at bedtime. A progress note, dated [DATE] at 2:17 a.m., documented LPN #1 observed Res #1's oxygen saturation was 55% on 3 liters of oxygen and their respiratory rate was 20. The note documented the nurse increased the resident's oxygen to four liters per minute and placed their nasal cannula into their mouth which raised their oxygen saturation to 82%. The note documented upon recheck of the resident's oxygen saturation it had dropped back down to 54%. The nurse documented they removed the supplemental oxygen and placed Res #1 on their CPaP machine which did not raise the resident's oxygen saturation beyond 55%. The note documented the resident remained with this oxygen saturation until 11:00 p.m. at which time LPN #1 reassessed Res #1's vital signs. The note documented the resident's oxygen saturation had dropped to 35%. The note did not document EMS or a physician was contacted at this time. The note documented LPN #1 continued to reassess the resident and the oxygen saturation did not rise beyond 34%. The note documented at 12:00 a.m., a CNA notified LPN #1 Res #1 was gone. The nurse documented upon their assessment of Res #1 no vital signs were detected and the provider was notified of their passing. The note documented the provider called a time of death of 12:15 a.m. The note did not document CPR was initiated, or emergency services were contacted. A facility interview with LPN #1, dated [DATE], documented the nurse was not aware of the process to check a resident's code status or the process to verify code status. The interview documented LPN #1 was told by another nurse during report Res #1 was a DNR and was not to be sent to the hospital but did not verify the resident's code status. The interview documented upon notification from the aide that Res #1 was gone, LPN #1 took about five minutes to determine Res #1 was full code status. The interview documented LPN #1 was unaware of the nursing standard requirement to start CPR on residents with unknown code status until EMS or a provider stopped CPR. The interview documented LPN #1 placed the CPAP machine on Res #1 without a physician order and with knowledge it was non-functional. The interview documented LPN #1 was aware the CPAP would not help Res #1 who was struggling to breathe. On [DATE] at 3:30 p.m., the DON stated the order for Res #1's CPAP was missed. They stated they were not aware the CPAP was nonfunctional and the nurses should have followed the physician orders for oxygen administration.