STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375493	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartsworth Center for Nursing & Rehabilitation	1200 West Canadian Avenue Vinita, OK 74301

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** On [DATE], an IJ was determined to exist related to the facility's failure to ensure a resident who had chosen to have a full code status was provided CPR after a life threating medical emergency was discovered. On [DATE] CNA #1 found Res #3 in their room and unresponsive. CNA #1 reported the situation to LPN #1 who checked the blood pressure of the resident then told CNA #1 the resident was dead and to clean them up. CNA #1 stated no code had been called for Res #3 and no CPR had been attempted.On [DATE] at 12:02 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation.On [DATE] at 12:20 p.m., the DON was notified of the IJ situation and provided the IJ template.On [DATE] at 4:09 p.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health.The facility plan of removal, dated [DATE] at 4:09 p.m., read in part, On [DATE], the facility QAPI members met to discuss this event, root cause, immediate implementation of interventions and auditing/compliance tools.There are DNR Binders located at each nurse's station in the instance PCC is down for any reason. The ADON is responsible to update the binder for new admissions.The DON immediately conducted chart audits regarding code status to ensure accuracy.The Nurse was suspended pending further investigation and later terminated. The Root Cause Analysis identified was that the charge nurse assumed that since the resident was on Hospice, that [gender withheld] had a DNR in place.The failure was due to the charge nurse failing to check and verify code status and follow proper policy and procedure for a resident being unresponsive/not breathing with a full code status.Monitoring will be accomplished by the DON and/or [gender withheld] designee will audit Code status weekly for 90 days to ensure compliance.In addition, any resident death that occur in the facility will be reviewed to be sure code status was followed correctly.The date of substantial compliance: [DATE].On [DATE], after interviews with staff, review of in-service training, review of audits of resident code status, review of code binders, and review of staff competencies, the IJ was lifted [DATE] at 12:12 p.m. when all components of the plan of removal had been confirmed to have been completed. The deficiency remained at an isolated level with the potential for than minimal harm.Based on record review and interview, the facility failed to ensure a resident that chose to be a full code was provided cardiopulmonary resuscitation when the resident experienced a life-threatening medical emergency for 1 (#3) of 5 sampled residents reviewed for code status.The ADON reported 72 residents resided in the facility.Findings:A facility policy and procedure titled Emergency Procedure - Cardiopulmonary Resuscitation, dated February 2018, read in part, If an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR: a. Instruct a staff member to activate the emergency response system (code) and all 911. b. Instruct a staff member to retrieve the automatic external defibrillator. c. Verify or instruct a staff member to verify the DNR or code status of the individual. d. Initiate the base life support (BLS) sequence of events.An MDS quarterly assessment for Res #3, dated [DATE], showed in Section C the resident had a BIMS score of 15 which indicated their cognition was intact for decision making.A physician's order, dated [DATE], showed Res #3 was a full code.On [DATE] at 9:36 a.m., CNA #1 was asked to describe their involvement in the care of Res #3 that occurred on [DATE]. CNA #1 stated they were working on a different hall than the one Res #3 had resided. They stated CNA #2 had come to them and stated Res #3 had died and they had never done the aftercare before. CNA #1 stated they asked CNA #2 if the resident was a DNR or full code because the aftercare was different. They stated CNA #2 had replied they had not done CPR so they assumed there was a DNR and they would clean the resident up accordingly. CNA #1 stated they went to the hall where Res #3 was and cleaned the body. CNA #1 was asked what Res #3's body looked like. They stated the upper body clothing was covered in a foul-smelling vomit and when they rolled the body to the sides during cleaning, more of the substance exited the resident's mouth. They stated the skin looked normal except the veins looked bluer than a living person. CNA #1 was asked if there was any blue areas of the skin or any stiffness observed. They stated the skin did not have any blue areas and the body was limp.On [DATE] at 9:49 a.m., CNA #2 was asked to describe their involvement in the care of Res #3 that occurred on [DATE]. CNA #2 stated they had gone into Res #3's room for their routine check and the resident did not respond when they spoke with them and did not appear to be breathing. CNA #2 stated they went to LPN #1 and gave them that information. They stated LPN #1 entered the room and put a blood pressure measuring device on the resident's arm and checked Res #3's blood pressure. They stated LPN #1 stated, She's dead. CNA #2 stated they asked LPN #1 what they should do to which the LPN