STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375107	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand at Bethany Skilled Nursing and Therapy	7000 Northwest 32nd Street Bethany, OK 73008

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 49701 Based on record review and interview, the facility failed to ensure residents were free from abuse for two (#5 and #6) of four sampled residents reviewed for abuse. The administrator identified 106 residents resided in the facility. Findings: An undated Resident Abuse, Neglect, and Misappropriation of Property policy, read in part, The resident has the right to be free from verbal, sexual, physical, and mental abuse. The policy also read, If the alleged perpetrator is facility staff, removal of the alleged perpetrator's access to the alleged victim and other residents and assurance that ongoing safety and protection is provided for the alleged victim and other residents. 1. Resident #5 had diagnoses which included atrial fibrillation and anxiety. 2. Resident #5's significant change assessment, dated 08/26/24, documented the resident was severely cognitively impaired and was dependent with most ADLs. Resident #6 had diagnoses which included hemiplegia, bipolar, depression, anxiety, and spinal stenosis. Resident #6's significant change assessment, dated 08/17/24, documented the resident was cognitively intact, but was dependent with most ADLs. A Final State Reportable Incident form, dated 09/13/24, documented an allegation of abuse/mistreatment. It was documented on 09/13/24 at 3:40 p.m., the police department was notified of an allegation of abuse made by Resident #5 and Resident #6. It was documented CNA #1 had abused/handled them roughly. It was documented the physician and family were notified. It was documented involved staff and residents were interviewed, and focused assessments were performed on the residents. It was documented there were evaluations of their medications, medical and incident history. It was documented the facility updated the residents' care plans. It was documented CNA #1 was terminated the day of completion of the investigation. It was documented the facility provided in-service on abuse to staff. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Notification of Nurse Aide/Nontechnical Service Worker form, dated 09/13/24, documented that CNA #1 was terminated on 09/13/24. On 09/13/24, an in-service on abuse was conducted. The facility form titled Compliance Rounds documented compliance rounds were made on 09/13/24, 09/17/24, 09/23/24, 09/24/24, and 10/01/24. On 10/07/24 at 2:35 p.m., Resident #6 stated CNA #1 had been wiping them roughly and the CNA did not adjust when they complained to them it was painful. They stated they felt it was abusive and told the social worker about it. They stated the next thing they knew the police were at their door. On 10/07/24 at 2:55 p.m., an interview was attempted with Resident #5. They asked for a tissue and was instructed to push the call light. By the time the resident was able to push the call light, they had already forgotten what they needed. On 10/07/24 at 3:22 p.m., the administrator stated they did their investigation, substantiated the findings, terminated the employee, and began the process of in-servicing on abuse. They stated they also completed compliance rounds and made a performance improvement plan. They stated they QAPI committee had not had a meeting since the incident, but it was on the agenda for the next meeting.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49701 Based on record review, and interview, the facility failed to ensure staff followed proper transfer technique to prevent accidents for one (#2) of three sampled residents reviewed for falls. The failure resulted in a fractured femur for Resident #2. The administrator identified 106 residents resided in the facility. Findings: A Fall Program policy, revised 05/2024, read in part, develop care plan using appropriate interventions. Resident #2 had diagnoses which incldued intracerebral hemorrhage, speech deficit, and convulsions. A care plan intervention, initiated 06/25/20, documented the resident needed the assistance of two staff for transfers. A progress note, dated 09/21/24 at 6:18 p.m., documented the resident was lowered to the floor during a transfer. It was documented the resident stated, Broke and pointed to their leg. It was documented a fracture was identified and the resident requested to be sent to the hospital. A progress note, dated 09/25/24 at 2:27 p.m., documented the resident returned from the hospital with 15 staples to their right hip and a dignosis of fracture of neck of right femur. On 10/07/24 at 3:00 p.m., an interview was attempted with Resident #2. When asked about ADL care they stated, You know, 1234567 yeah. Attempts were made to interview emergency contacts, but was unsuccessful in contacting emergency contact #1 and #2. On 10/08/24 at 12:23 p.m., CNA #2 was called, but the phone number was restricted. On 10/08/24 at 12:24 p.m., LPN #1 stated they questioned whether the break happened while being lowered to the floor. They stated they could not remember if there was enough staff on the hall to help the CNA with the transfer, but LPN #1 was not asked to help with the transfer. LPN #1 stated the staff have been in-serviced about falls and being lowered to the floor would be considered a fall. On 10/08/24 at 12:43 p.m., the administrator stated CNA #2 was transferred from a sister facility recently and had been through training on transfer procedures in June of 2024 at the sister facility. They stated CNA #2 did not look at the care plan to see how Resident #2 should have been transferred.