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	02/27/2025

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 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** 36191 On [DATE] an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure staff could identify a resident's code status in an emergency. Resident #1 became unresponsive while in the whirlpool tub and CPR was initiated before the resident's code status was confirmed. The resident had a DNR in place. On [DATE] at 5:56 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation. On [DATE] at 6:09 p.m., the administrator and regional RN were notified of the IJ situation and provided the IJ template. On [DATE] at 5:29 p.m., the administrator was notified of an amended IJ template related to Resident #1's code status via telephone. On [DATE] at 5:49 p.m., an amended IJ template was provided to the administrator and the regional RN via email. On [DATE] at 11:03 a.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The facility's plan of removal, dated [DATE], read in part, Plan of removal of IJ XXX[DATE] .The facility will observe resident's DNR code wishes.Removal Plans must include: . 1. How facility will ensure harm will not occur or recur; .In-service all staff regarding resident code status and proper procedure [DATE].Audit to verify all current residents' code status.Compliance rounds continued daily since ,d+[DATE].In-service all staff regarding resident code status and proper procedure [DATE]. 2. Date of implementation- planned implementation (actions do not need fully resolved prior to the survey team exiting the organization) XXX[DATE] . 3. Identify those recipients who have suffered or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and .Residents that have a valid DNR in place. (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	4. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.In-service all staff regarding resident code status and proper procedure on ,d+[DATE] and ,d+[DATE].Audit to verify all current residents' code status.The likelihood for serious harm to any resident no longer exists effective [DATE].QAPI meeting held to review .Root cause analysis of event.Plan of correction implemented on [DATE], and continued with compliance rounds and education through [DATE] at 8:00 p.m.The pan [sic] continues to be monitored by QA committee. The IJ was lifted, effective [DATE] at 8:00 p.m., when all components of the plan of removal had been completed. The deficiency remained at an isolated level with the potential for more than minimal harm. Based on observation, record review and interview, the facility failed to ensure the code status was verified before CPR was initiated for a resident who had become unresponsive in the whirlpool tub for 1 (#1) of 3 sampled residents reviewed for advanced directives. The administrator identified 114 residents resided in the facility. Findings: On [DATE] at 8:15 p.m., green and red color coded name plates were observed at each residents' door. The facility policy titled DNR, Advance Directives and End of Life Decisions, dated [DATE], read in part, It is the policy of the Facility to comply with a Resident's Advanced Directive and Do Not Resuscitate Consent. The facility should implement a procedure for identifying the DNR/code status for all resident in the facility . For example, the facilty could implement the following procedure .Residents with DNR Orders are identified by placing a red name plate on the door to the Resident's room. The original or a cop of the DNR Order will be placed in a red folder in the front of the Resident's chart .Residents with no DNR Order are identified by placing a green name plate on the door to the Resident's room. Resident #1 had diagnoses which included chronic obstructive pulmonary disease, hypertension, recurrent depressive disorder, diabetes with history of ketoacidosis with coma, transient ischemic attack, and cerebral infarction without residual deficits, dysphagia, and acute pylonephritis. A document titled OKLAHOMA DO NOT RESUSCITATE (DNR) Consent Form showed Resident #1 signed the consent on [DATE]. Resident #1's care plan, dated [DATE], read in part, [Resident #1] has a DNR.If [Resident #1] has no respirations or heartbeat, DO NOT START CPR. A physician's order, dated [DATE], showed the resident was a DNR. Resident #1's quarterly assessment, dated [DATE], showed the resident's BIMS was 15 which indicated the resident's cognition was intact. (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 nurse's progress note for Resident #1, dated [DATE] at 9:20 p.m., read in part, Staff alerted this nurse that res was unresponsive in the whirlpool. This nurse responded immediately, Res was sitting in whirlpool with head titled back and back was up against the whirlpool. Resident was lowered to the floor. No rise and fall of the chest, no pulse present, no response to chest rub. CPR was initiated chest compressions 30:2 given, and continued to be administered until [emergency medical service] arrived. [emergency medical service] arrived and took over code. Resident pronounced deceased at 2140 [9:40 p.m.] [Name withheld] on call for [physician name withheld] notified at this time. On [DATE] at 9:25 p.m., CNA #2 stated CNA #1 was in the hall and notified them Resident #1 was in the whirlpool and not breathing. CNA #2 stated they went to the whirlpool room, felt to see if Resident #1 had a pulse, did a sternal rub and chest compressions, while CMA #1 went to get LPN #1. CMA #2 stated when LPN #1 arrived they got Resident #1 out of the whirlpool tub and onto the floor and started doing chest compressions with no response from the resident. CNA #2 stated they had an in-service about not leaving residents in the whirlpool tub alone and could not remember any other in-service after this happened on [DATE]. The CNA did not state they had an in-service about CPR. On [DATE] at 9:40 p.m., CMA #1 was asked how they identified a resident's code status in an emergency. CMA #1 did not answer. They were asked what the red and green colors meant on the resident name plates on the doors. CMA #1 stated the green color indicated the resident could move a little bit and the red meant the resident needed help. They were asked what they would do if a resident's heart stopped or the resident quit breathing. CMA #1 stated they would check the resident's pulse and start CPR until they were told the resident was a DNR. CMA #1 stated Resident #1 was found unresponsive in the whirlpool tub on [DATE] by CNA #1. CMA#1 stated they assisted with getting the resident out of the whirlpool tub and the nurses started CPR right away. CMA #1 stated they did not know Resident #1 was a DNR at the time. On [DATE] at 1:39 p.m. LPN #1 stated CMA #1 was shouting that they needed to go to the whirlpool room. LPN #1 stated Resident #1 was sitting up in the whirlpool with water in the tub and they yelled at Resident #1 and rubbed the resident's chest and did not get a response. LPN #1 stated they started CPR because they did not know the resident was a DNR. LPN #1 stated later they were told by one of the supervisors they could look at the name plates by the residents door. LPN #1 stated the red name plate was for DNR and the green name plate was for a full code. On [DATE] at 1:59 p.m., the RN/regional nurse consultant stated Resident #1 had a DNR order. The regional nurse consultant stated the staff started CPR on the resident because they were in attendance when the resident became unresponsive. The regional nurse consultant stated they did not know who initiated CPR. On [DATE] at 3:45 p.m., the administrator stated they were not sure if the staff knew Resident #1 was a DNR. The administrator was asked if the staff should have known the resident's code status prior to starting CPR. The administrator stated one staff member did go to find out the resident's code status because this happened in the whirlpool room.

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36191 On [DATE] an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure a resident was supervised while in the whirlpool. Resident #1 became unresponsive while in the whirlpool tub alone and was pronounced deceased at 9:40 p.m. On [DATE] at 5:56 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation. On [DATE] at 6:09 p.m., the administrator and regional RN were notified of the IJ situation related to supervision in the whirlpool tub and provided the IJ template. On [DATE] at 5:29 p.m., the administrator was notified of an amended IJ template related to resident supervision while in the whirlpool via phone. On [DATE] at 5:49 p.m., an amended IJ template was provided to the administrator and the regional RN via email. On [DATE] at 11:03 a.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The facility's plan of removal, dated [DATE], read in part, Plan of removal of IJ XXX[DATE] .The facility will monitor and keep resident's safe during bathing.Removal plans must include: . 1. How facility will ensure harm will not occur or recur; .Inservice all staff regarding Whirlpool Tub Bath policy and procedure [DATE] .Audit to verify all current resident's code status.Compliance rounds continued daily since ,d+[DATE].Inservice all staff regarding Whirlpool Tub Bath policy and procedure [DATE]. 2. Date of implementation- planned implementation (actions do not need fully resolved prior to the survey team exiting the organization); XXX[DATE] . 3. Identify those recipients who have suffered or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and .Residents that require assistance with bathing . 4. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.Inservice all staff regarding Whirlpool Tub Bath Policy and procedure on ,d+[DATE] and ,d+[DATE].The likelihood for serious harm to any resident no longer exists effective [DATE].QAPI meeting held to review .Root cause analysis of event. Plan of correction implemented on [DATE], and continued with compliance rounds and education through [DATE] at 8:00 p.m. The pan [sic] continues to be monitored by QA committee. The IJ was lifted, effective [DATE] at 8:00 p.m., when all components of the plan of removal had been completed. The deficiency remained at an isolated level with the potential for more than minimal harm. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on observation, record review, and interview, the facility failed to ensure a resident was not left unsupervised while in the whirlpool tub for 1 (#1) of 3 sampled residents observed for supervision during bathing. The administrator identified 114 residents resided in the facility and no current residents utilized the whirlpool tub for baths. Findings: On [DATE] at 9:42 a.m., the whirlpool rooms on hall 300, 200, and the shower room on hall 100 were observed with the administrator. The emergency call systems in each whirlpool/shower room were activated and could be heard in the halls and at the nurses station on the hall the whirlpool or shower room was located. The staff responded immediately when the emergency lights were activated in the whirlpool and shower rooms. An undated facility policy titled Whilrpool [sic]Tub Bath, read in part, Assist the resident into the tub and remain with resident for safety. Resident #1 had diagnoses which included chronic obstructive pulmonary disease, hypertension, recurrent depressive disorder, diabetes with history of ketoacidosis with coma, transient ischemic attack, and cerebral infarction without residual deficits. Resident #1's ADL care plan, dated [DATE], showed the resident was at risk for ADL self care performance deficit and had the option of when to bathe, what kind of bath to take, with scheduled days suggested, but had the option to change if the resident chose to change the date and time. A document titled Course Completion History, dated [DATE] through [DATE], showed CNA #1 had been provided training related to Bathing without a Battle on [DATE]. There was no other training listed on the document related to supervision with showering or bathing in the whirlpool. Resident #1's quarterly assessment, dated [DATE], showed the resident's BIMS was 15 which indicated the resident's cognition was intact. The assessment showed they required set up or clean-up assistance with bathing/showering, and was independent with transferring in and out of the tub or shower. A nurse's progress note for Resident #1, dated [DATE] at 9:20 p.m., read in part, Staff alerted this nurse that res was unresponsive in the whirlpool. This nurse responded immediately, Res was sitting in whirlpool with head titled back and back was up against the whirlpool. Resident was lowered to the floor. No rise and fall of the chest, no pulse present, no response to chest rub. CPR was initiated chest compressions 30:2 given, and continued to be administered until [emergency medical service] arrived. [emergency medical service] arrived and took over code. Resident pronounced deceased at 2140 [9:40 p.m.] [Name withheld] on call for [physician name withheld] notified at this time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An undated statement from CNA #1 related to Resident #1 dying while in the whirlpool, read in part, took res to get whirlpool, got res in and relaxed and pulled privacy curtain to where could still see [Resident #1] and set timer for 25 minutes, talked w/[with] [Resident #1] until timer rang and res asked for ten more minutes, set timer for another ten minutes and kept talking-res got real quiet and could see [they] was w/ head slumped forward but not underwater. rushed to [them]. no response, rubbed chest and yelled no response, ran for help, saw [CMA #1] and [they] ran to get help while I continued to try to wake [Resident #1] [Resident #1] head was never underwater. On [DATE] at 8:33 p.m., CNA #5 stated Resident #1 was able to use the whirlpool unsupervised. On [DATE] at 8:57 p.m., employee #2 stated Resident #1 only required set up assistance with whirlpool baths and did not like the staff to stay in the whirlpool room with them. They stated CNA #1 took Resident #1 to the whirlpool room located on hall 300, assisted the resident to the whirlpool tub, closed the door and came out of the whirlpool room. Employee #1 stated CNA #1 was observed on hall 200 while Resident #1 was in the whirlpool tub. They stated CNA #1 set the timer for Resident #1 because they requested 10 more minutes in the whirlpool tub and the next thing they knew they were calling staff to go the whirlpool room. On [DATE] at 9:25 p.m., CNA #2 stated CNA #1 was in the hall and reported Resident #1 was not breathing. CNA #2 stated they went to the whirlpool room, felt for a pulse, did a sternal rub while the resident was in the whirlpool tub, assisted the other staff with getting Resident #1 out of the whirlpool tub. CNA #2 stated the facility had working emergency call lights in the whirlpool room. They were asked why CNA #2 had not activated the emergency call light. They stated they thought the CNA just panicked and went down the hall. On [DATE] at 10:15 a.m., Resident #4 stated they had been very close to Resident #1. Resident #4 stated Resident #1 went to take a whirlpool and passed away while in the whirlpool tub. Resident #4 stated Resident #1 had told them before the staff checked on them while they were in the whirlpool, but they did not stay in the whirlpool room with them. Resident #4 stated Resident #1 had been taking whirlpools without supervision for a long time. On [DATE] at 10:45 a.m., CNA #4 stated they had been assigned to hall 300 and observed CNA #1 walking on the halls while Resident #1 was in the whirlpool. CNA #4 stated they heard a muffled sound and stood up and looked down the hall and saw multiple staff running towards the whirlpool room. CNA #4 stated they observed staff lift Resident #1 out of the whirlpool and saw CNA #1 put their hand on their head, crying, and hollering. CNA #4 stated they heard CNA #1 state they were told Resident #1 could be in the whirlpool alone. CNA #4 stated they had told CNA #1 they should not have left Resident #1 in the whirlpool alone, that it was negligent homicide. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:34 a.m., CNA #1 stated they had put Resident #1 in the whirlpool tub and stayed in the room with the resident talking with them. CNA #1 stated the resident requested to stay in the whirlpool for 10 more minutes. CNA #1 stated the resident did not like for the staff to be in the whirlpool room, so they were outside of the door. CNA #1 stated when they came back in the whirlpool room the resident's face was a little under the water and was blue and the resident was laying slumped forward to the side. CNA #1 stated they pulled the resident up and ran out to get help. CNA #1 stated they forgot there was a call light in the whirlpool room. CNA #1 stated they were told Resident #1 only needed set up assistance for bathing. They stated the staff would set a timer, leave Resident #1 in the whirlpool tub, and go back and check on the resident. CNA #1 stated if they would have known they would not have left the resident in the whirlpool. On [DATE] at 1:38 p.m. LPN #1 was asked if they had an in-service recently related to the incident with Resident #1 on [DATE]. They stated they had answered the questions about what happened. LPN #1 they had not been told about supervision in the whirlpool after the incident with Resident #1. They stated they had been told about the name plates for code status. On [DATE] at 1:59 p.m., the RN/regional nurse consultant stated they conducted in-services concerning supervision in the whirlpool just to reiterate not to leave the residents alone in the whirlpool room. The regional nurse consultant stated Resident #1 was never left alone in the whirlpool room. They stated there were no exceptions to policy related to supervision in the whirlpool. The regional nurse consultant stated the staff were instructed to stay in whirlpool room with the resident even if the resident could bathe themselves. The regional nurse consultant stated the facility had privacy curtains in the shower and whirlpool rooms if the residents wanted privacy. The regional nurse consultant was asked if a QAPI meeting was held related to the incident. They stated they started compliance rounds on [DATE]. On [DATE] at 2:58 p.m., CNA #1 was asked about the statement they wrote which showed they were in the room with Resident #1 when they became unresponsive. CNA #1 stated they wrote that statement because they were afraid of going to jail because they were not in the whirlpool room with the resident. CNA #1 stated they had been outside the door of the whirlpool room for less than 10 minutes and CNA #4 was calling them a murderer and told them they were going to go to jail for killing Resident #1. On [DATE] at 11:44 a.m., CNA #9 stated they had their first in-service related to supervision in the whirlpool/shower on [DATE] at 5:30 a.m. and a second in-service on [DATE] at 7:00 p.m. On [DATE] at 5:33 p.m., CNA #1 stated they assisted Resident #1 into the whirlpool tub sometime between 8:00 p.m. and 8:30 p.m. On [DATE] at 6:35 p.m., CNA #2 stated when they first arrived to the whirlpool room on [DATE] Resident #1's color was beige yellowish, eyes were fixed, mouth was opened, and the resident was slumped back to the left side. CNA #2 stated they saw CNA #1 in the hall after supper, but was not sure what time that was or if Resident #1 was in the whirlpool when they saw CNA #1.