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	08/19/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review and interview, the facility failed to ensure a resident received care and services to prevent pressure ulcers from developing or worsening for 1 (#1) of 3 sampled residents reviewed for pressure ulcer treatment.The administrator reported 103 residents resided in the facility.Findings: Resident #1s monthly physician orders showed resident was admitted to facility on 12/17/24, with the following diagnoses: history of cardiac arrest resulting in anoxic brain damage, congestive heart failure, hypernatremia, acute respiratory failure with hypoxia, acute kidney injury, and PEG tube status. A skin assessment, dated 12/17/24, showed sacrum with redness and superficial breakdown and had treatment order: cleanse bilateral buttocks with normal saline solution, pat dry, apply Triad cream twice daily and as needed for 14 days for wound prevention. A skin assessment, dated 12/22/24, read in part, Shearing to sacrum, with treatment order in place for wound management, which documented resident has pillow in place underneath 1 side to offload pressure. [Resident #1's family member] confirmed understanding. Will continue to monitor and provide prevention as ordered.A wound care note titled Woundynamics, dated 12/23/24, read in part, stage III pressure injury pressure ulcer, and has received a status of unhealed. Wound measurements, 6cm X 11cm X 0.2cm and small amount of serosanguineous drainage noted. Apply triad cream BID cover wound with bordered foam 4X4.On 08/18/25 at 3:24 p.m., a telephone interview with Resident #1's family member was conducted. They reported Resident #1 obtained a bed sore while a resident at this facility. The family member reported the wound initially looked like a scratch from square fingernails. Resident #1's family member reported Resident #1 was not receiving enough water and was not turned and repositioned as needed. They stated when family visited, they would have to go find nurses to turn Resident #1. On 08/18/25 at 4:03 p.m., the DON reported Resident #1 was not skilled appropriately due to being total care with lots of edema. The DON reported addressing all of Resident #1's family member's concerns. The DON reported the nurse who documented the shearing may not have been as accurate as the wound care person when staging pressure wounds.

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