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	01/07/2026

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and interview, the facility failed to refer a resident with a newly diagnosed mental illness to the OHCA for a level II PASARR evaluation for 1 (#4) of 1 sampled resident reviewed for PASARR.The ADON identified 110 residents resided in the facility. Findings:A level I PASARR, dated 03/22/16, showed Resident #4 had a primary diagnosis of cerebrovascular accident. The PASARR did not show Resident #4 had been diagnosed with a serious mental illness.An admission record, dated 03/11/25, showed Resident #4 was diagnosed with schizophrenia on 11/22/22.A quarterly assessment, dated 12/10/25, showed Resident #4 routinely received antipsychotic medication.A physician's order, dated 12/16/25, showed Resident #4 received olanzapine 2.5 mg (an antipsychotic medication) at bedtime. A review of Resident #4's health record did not show they were screened for a level II PASARR when they received the new diagnosis of schizophrenia on 11/22/22. On 01/05/26 at 12:10 p.m., corporate nurse #1 stated after Resident #4 was diagnosed with a serious mental illness the facility should have referred them for a level II evaluation.On 01/07/26 at 2:40 p.m., MDS coordinator #2 stated when a resident got a new diagnosis of a serious mental illness they should be referred to the OHCA for a level II screening.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review, and interview, the facility failed to ensure a comprehensive care plan was developed to include a hearing aid for 1 (#1) of 24 sampled residents reviewed for comprehensive care plans. The ADON identified 110 residents resided in the facility.Findings:On 12/30/25 at 12:02 p.m., Resident #1 was observed not wearing hearing aids.A Comprehensive Activity Assessment, dated 9/26/25, showed Resident #1's hearing in both the left and right ear was adequate when using hearing aids.A 5-day assessment, dated 09/27/25, showed Resident #1's cognition was moderately impaired with a BIMS score of 12. The assessment showed Resident #1 did not use hearing aids or other hearing appliances during the assessment.An admission assessment, dated 10/19/25, showed Resident #1 was wearing hearing aids and had minimal difficulty hearing during the assessment. The assessment showed Resident #1's cognition was moderately impaired with a BIMS score of 12. Resident #1's care plan, dated 11/05/25, did not have a focus, goal, and interventions to address hearing aids were used as an intervention to address the resident's communication problem and hearing deficit.Physician progress notes, dated 11/06/25 and 11/11/25, showed Resident #1 was hard of hearing, and used hearing aids for communication.On 12/30/25 at 12:02 p.m., Resident #1 stated they did not know where their hearing aids were at but would like staff to help find them.On 01/05/26 at 12:13 p.m., CMA #1 stated they were not aware Resident #1 had hearing aids.On 01/05/26 at 12:22 p.m., CMA #2 stated Resident #1 had hearing aids, glasses, and misplaced them sometimes. CMA #2 stated the hearing aids should be in the care plan.On 01/05/26 at 1:14 p.m., the ADON stated the hearing aids should be a part of the care plan.On 01/05/26 at 1:16 p.m., MDS coordinator #1 stated Resident #1's hearing aids were not in their care plan to address the resident's communication problem and hearing deficit. MDS Coordinator #1 stated hearing aids should be in the care plan, orders, and tasks.On 01/07/26 at 1:25 p.m., regional director #1 stated there was no care planning policy, and the facility followed the resident assessment instrument manual.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to ensure a care plan for vision had interventions included for orientation, education, and guidance about the facility for a blind resident for 1 (#17) of 1 sampled resident who's care plan was reviewed. The ADON identified 110 residents resided in the facility.Findings:An admission assessment, dated 11/04/25, showed Resident #17's vision was Severely impaired-no vision or sees only light, colors or shapes; eyes do not appear to follow objects.An undated care plan did not show how the staff assisted Resident #17 with mobility or guidance about the facility.On 12/30/25 at 2:00 p.m., Resident #17 stated they had not been shown how to get around the facility. They stated the staff did not assist them to and from the dining room. Resident #17 asked other residents to assist them and felt like the staff were not aware of the assistance they needed. On 12/30/25 at 2:04 p.m., Resident #17 stated their vision was all black and could not see anything. On 01/02/26 at 2:39 p.m., MDS coordinator #1 stated the resident would gain familiarity and independence about the facility by way of constant intervention. MDS Coordinator #1 stated the staff let the resident know their environment and helped them. They stated if the resident could not read the menu, the staff had to assist. They stated it was in the task list (a portion of the electronic medical record for the staff to refer to for the Resident needs), and it was on the care plan to assist with meals.On 01/02/26 at 2:46 p.m., MDS coordinator #1 stated they did not see any specifics about there being an intervention for how to assist Resident #17 and what they needed assistance with. MDS Coordinator #1 stated the care plan only showed to assist them. MDS Coordinator #1 stated they did not have a process in place for assisting blind residents. MDS Coordinator #1 stated they needed to start looking at that.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review and interview, the facility failed to perform an assessment before and after dialysis for 1 (#129) of 1 sampled resident reviewed for dialysis. The administrator identified seven residents received dialysis. Findings:A blank dialysis communication form was reviewed. The form consisted of two sections, section A and section B. The form showed the pre-dialysis section (section A) was to be completed by the nursing facility and sent with the resident to the dialysis unit. The form showed the post-dialysis section (section B) was to be completed by the dialysis facility's nursing staff and the form returned to the facility with the resident. The form did not provide a section for the facility to document their own post-dialysis assessment.A dialysis communication form, dated 10/15/25, showed the following: the resident's pre-dialysis weight was documented as taken on 10/13/25 and section B was empty of documentation. A dialysis communication form, dated 10/17/25, showed the following: the resident's pre-dialysis weight was documented as taken on 10/13/25; and the resident's pre-dialysis temperature, pulse, and respirations were documented as taken on 10/17/25 at 12:20 a.m. A dialysis communication form, dated 10/20/25, showed the following: the resident's pre-dialysis weight was documented as taken on 10/13/25; the resident's pre-dialysis temperature and respirations were documented as taken on 10/20/25 at 12:46 a.m.; and the resident's pre-dialysis blood pressure and pulse were documented as taken on 10/20/25 at 9:30 a.m. A dialysis communication form dated 10/22/25, showed the following: the resident's pre-dialysis weight was documented as taken on 10/13/25 and section B was empty of documentation. A dialysis communication form dated 10/24/25, showed the following: the resident's pre-dialysis weight was documented as taken on 10/13/25; the resident's pre-dialysis temperature, pulse, and respirations were documented as taken on 10/24/25 at 12:42 a.m.; and section B was empty of documentation. A dialysis communication form, dated 10/27/25, showed the following: the resident's pre-dialysis weight was documented as taken on 10/13/25; the resident's pre-dialysis pulse, temperature, and respirations were documented as taken on 10/27/25 at 06:05 a.m.; and the resident's pre-dialysis blood pressure was documented as taken on 10/27/25 at 9:17 a.m.A dialysis communication form dated 12/29/25, showed the following: the resident's pre-dialysis weight was documented as taken on 12/28/25 and section B was empty of documentation. A dialysis communication form dated 12/31/25, showed the following: there was no documentation for the resident's pre-dialysis assessment for the presence of a thrill, bruit, dialysis site examination, or peripheral pulses; the resident's pre-dialysis weight was dated as taken on 12/28/25; the resident's pre-dialysis blood pressure, pulse, temperature, and respirations were documented as taken on 12/31/25 at 12:07a.m.; and section B was empty of documentation. The clinical record was reviewed for the above dates. There was no documentation of when the resident left for dialysis or returned from on the above dates. There was no documentation of how the resident presented to the facility after dialysis (i.e. what were the resident's vital signs upon their return to the facility; what did the resident's dialysis port/fistula look or sound like upon their return; what the resident's pulses were like in their extremities; what was the condition of the resident's site dressing immediately upon their return; how did the resident behave upon return; and did the resident have any complaints) for the above dates. On 01/07/26 at 10:30 a.m., Resident #129 stated the facility staff performed a pre-dialysis assessment, but not a post-dialysis assessment. On 01/07/26 at 11:10 a.m., LPN #1 stated when a resident returned from dialysis, they documented into the electronic medical record, what the dialysis center staff wrote on the dialysis communication form for section B. LPN #1 stated they performed their own post dialysis assessment if the dialysis center failed to document anything on the dialysis communication form. LPN #1 stated they checked the dialysis site for bleeding during their shift, but did not perform an assessment. LPN #1 stated they did not check the thrill and/or bruit, or the resident's vital signs when the resident returned from dialysis. LPN #1 stated when they checked the resident for bleeding post-dialysis, they did not document it, they only charted what was written on (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the dialysis communication form by the dialysis center staff. On 01/07/26 at 11:30 a.m., LPN #2 stated Resident #129 returned from dialysis on their shift. LPN #2 stated they transcribed what the dialysis center staff wrote on the dialysis communication form for section B into the resident's electronic medical record. LPN #2 stated when they sent a resident to dialysis, they fill out the dialysis communication form, check the resident's dialysis fistula or port, obtain their vital signs, obtain their pre-dialysis weight, and document it on the dialysis communication form. LPN #2 stated the dialysis center staff checked the resident's pre-dialysis weight as well as their post-dialysis weight and obtained post dialysis vital signs. LPN #2 stated that information was written on the dialysis communication form by the dialysis nurse and then the facility nurse entered the written information into the resident's electronic medical record. LPN #2 stated they checked the resident's vital signs when the resident returned from dialysis to make sure the resident's vital signs were stable, but they did not document the vital signs taken nor perform an assessment, they just checked to see if the resident's vital signs were stable. LPN #2 reviewed the dialysis communication forms dated 12/31/25. LPN #2 stated they worked on 12/31/25 and were responsible for transcribing the dialysis communication form into the resident's electronic medical record, but must have forgotten to transcribe the information when Resident #129 returned from dialysis. On 01/07/26 at 12:40 p.m., the ADON stated the post dialysis assessment documentation was written by the dialysis center's staff and transcribed into the resident's electronic medical record by the facility charge nurse on shift when the resident returned from dialysis. The ADON stated any additional information, like medications given during or post dialysis, were transcribed as well. The ADON stated the nursing home staff should assess the resident upon their return but, did not have a place to document their assessment. The ADON stated the facility nurses just documented what the dialysis center wrote on their communication form and to the ADON's knowledge, did not document their own assessment. On 01/07/26 at 1:40 p.m., corporate nurse consultant #2 stated the facility nurses documented the post assessment information provided by the dialysis center and section B of the dialysis communication form was there to show the facility communicated with the dialysis centers. Corporate Nurse Consultant #2 stated the treatment sheet documented the nurse checked the resident's thrill/bruit every shift, observed the fistula site for signs and symptoms of trauma and/or infection every shift, and removed the fistula dressing four hours after dialysis treatment. Corporate nurse Consultant #2 stated the nursing staff did not document when the resident returned from dialysis, when the nurse checked the resident's thrill/bruit, when the nurse observed the fistula site for signs and symptoms of trauma and/or infection, what time the nurse removed the fistula dressing, nor what the resident's dressing/fistula site looked like when the nurse removed the dressing. Corporate Nurse Consultant #2 stated they did not know if the staff documented how the resident felt or acted/behaved upon return from dialysis.