STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375349	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bellevue Health & Rehabilitation Center	6500 North Portland Avenue Oklahoma City, OK 73116

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 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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan intervention for transfers for 2 (#12 and #13) of 3 sampled residents reviewed for care plans.The DON identified 152 residents resided in the facility. Findings: 1.On 09/09/25 at 11:27 a.m., Resident #12 was observed transferring from their bed to a wheelchair with the assistance of CNA #3 and CNA #5 using a slider board and a gait belt.A facility policy titled Care Plans, Comprehensive Person-Centered, dated 03/2022, read in part, The care plan interventions are derived through analysis of the information gathered as part of the comprehensive assessment.The comprehensive, person-centered care plan:a. includes measurable objectives and timeframes.b. describes the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being.An admission record for Resident #12, dated 06/12/25, showed they were admitted with a diagnosis of acquired absence of the right leg below the knee. An annual assessment for Resident #12, dated 06/18/25, showed their cognition was intact with a BIMS score of 15. The assessment showed Resident #12 was dependent for chair to bed transfers and used a wheelchair to ambulate. An assessment for Resident #12 titled PT Evaluation & Plan of Treatment, dated 08/19/25, showed the resident was dependent for transfers. A care plan for Resident #12, last revised 09/02/25, showed they had an ADL performance deficit for a focus. The care plan did not show interventions for transferring. On 09/09/25 at 11:27 a.m., Resident #12 stated two staff members always assisted them with transfers from the bed to the wheelchair using a slide board. On 09/09/25 at 11:40 a.m., CNA #2 stated Resident #12 transferred from the bed to a wheelchair with the assistance of two staff and a slider board. 2. On 09/09/25 at 11:55 a.m., Resident #13 was observed transferring from their bed to a wheelchair with the assistance from CNA #1 and CNA #2 using a gait belt and a sit to stand lift. An admission record for Resident #13, dated 06/04/25, showed they were admitted with diagnoses which included Parkinsons disease and schizophrenia.A quarterly assessment for Resident #13, dated 08/24/25, showed their cognition was intact with a BIMS score of 14. The assessment showed Resident #13 required substantial to maximal assistance with bed mobility and all transfers. An assessment for Resident #13 titled PT Evaluation & Plan of Treatment, dated 08/20/25, showed they required substantial to maximal assistance with chair to bed transfers.A care plan for Resident #13, last revised 09/03/25, showed they had an ADL performance deficit for a focus. The care plan did not show interventions for transferring. On 09/09/25 at 12:05 p.m., Resident #13 stated they transferred from the bed to a wheelchair with the assistance of two staff and a sit to stand lift. On 09/11/25 at 9:27 a.m., MDS coordinator #1 stated interventions for transfers should be documented in the residents' care plan. MDS Coordinator #1 was asked to review Resident #12 and Resident #13's care plan and asked what interventions were documented for transfers. MDS Coordinator #1 stated there were no interventions for Resident #12 and Resident #13's care plan for transferring. MDS Coordinator #1 stated they were unsure why the interventions were not in the care plans, but they should have been documented there because Resident #12 and Resident #13 were dependent for transfers. On 09/11/25 at 11:30 a.m., the DON stated all interventions for how a resident transferred should be documented in the residents' care plan. The DON stated Resident #12 transferred from the bed to a wheelchair with the assistance of two staff members and a slider board. The DON stated Resident #13 transferred from the bed to a wheelchair with the assistance of two staff and a sit to stand lift. The DON stated there was no documentation in Resident #12 and Resident #13's care plan for interventions to assist with transfers.