

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375349	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER Bellevue Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46216</p> <p>Based on observation, record review, and interview, the facility failed to provide double portions as ordered for one (#52) of three residents observed for meal service.</p> <p>The DON identified 143 residents received meal service from the kitchen.</p> <p>Findings:</p> <p>Resident #52 admitted on [DATE] with diagnoses which included DM II, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.</p> <p>A physician's order, dated 10/13/23, documented, LCS diet, mechanical soft texture, regular consistency, double portions for heart healthy.</p> <p>On 06/02/24 at 12:07 p.m., Resident #52 was observed to receive their meal tray. Resident observed to receive a tray with single portions.</p> <p>On 06/02/24 at 12:12 p.m., CNA #4 verified there were no double portions on Resident #52's tray. They stated they had not noticed double portions on the meal ticket.</p>

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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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>33148</p> <p>Based on observation, record review, and interview, the facility failed to ensure an enteral tube feeding bottle was properly labeled for one (#54) of two sampled residents reviewed for tube feeding management.</p> <p>The DON identified three residents received enteral tube feeding via continuous pump.</p> <p>Findings:</p> <p>A Enteral Tube Feeding via Continuous Pump policy, dated November 2018, read in part, .The purpose of this procedure is to provide a guideline for the use of a pump for enteral feedings .On the formula .document initials, date and time the formula was hung/administered .</p> <p>Res #54 had diagnoses which included dysphagia, oropharyngeal phase gastrostomy status.</p> <p>A physician order, dated 05/21/24, documented Vital AF 1.2 Cal. Give 55 ml/hr via PEG-tube every shift.</p> <p>A physician order, dated 05/25/24, documented enteral H2O. Auto flush PEG-tube every shift with 23 cc of H2O every hour.</p> <p>06/02/24 at 8:37 a.m., the resident was observed receiving 55 ml/hr of Vital AF 1.5 Cal via PEG-tube. There were no staff initials, date, or time on the formula bottle or H2O bag.</p> <p>On 06/02/24 at 8:44 a.m., LPN #1 was asked what was the protocol when tube feeding was initiated. They stated the the formula bottle and the H2O bag should be labeled with staff initials, date, and time. They were asked to verify when the resident's tube feeding was initiated. They stated the tube feeding was not labeled and it should have been.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>33148</p> <p>Based on observation, record review, and interview, the facility failed to administer O2 according to physician orders and/or label O2 tubing for two (#13 and #54) of three sampled residents reviewed for respiratory care.</p> <p>The DON identified 29 residents received O2.</p> <p>Findings:</p> <p>1. Res #13 had diagnoses which included SOB.</p> <p>A physician order, dated 01/01/24, documented oxygen 2 LPM via nasal cannula as needed to maintain O2 saturations.</p> <p>On 06/02/24 at 8:24 a.m., there was an O2 concentrator observed the resident's room. The O2 tubing was not labeled.</p> <p>On 06/02/24 at 8:50 a.m., LPN #1 was asked to verify when the resident's O2 tubing was last changed. They stated O2 tubing should be changed weekly and labeled. They stated the O2 tubing was not labeled.</p> <p>2. Res #54 had diagnoses which included SOB.</p> <p>A physician orders, dated 05/21/24, documented administer O2 at 2 LPM via nasal cannula every shift; and change O2 tubing weekly on Wednesdays and date with tape.</p> <p>On 06/02/24 at 8:37 a.m., the resident was observed with O2 being administered via nasal cannula. The O2 concentrator was set at 1.5 LPM. The O2 tubing was not labeled.</p> <p>On 06/02/24 8:44 a.m., LPN #1 was asked how many LPM of O2 the resident was to be administered. They stated 2 LPM and the O2 tubing should be changed weekly. They were asked to verify the O2 setting on the resident's O2 concentrator and when their O2 tubing was last changed. They stated the resident's O2 was set at 1.5 LPM and it should have been set at 2 LPM. They stated there was no indication when the O2 tubing was changed. They stated the O2 tubing should be labeled.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46216</p> <p>Based on record review and interview, the facility failed to complete ongoing assessments of a resident pre and post dialysis for one (#67) of one resident reviewed for dialysis services.</p> <p>Findings:</p> <p>The Facility's Dialysis Care/Arterial-Venous Fistula policy, approved 01/20/23, read in parts, All residents receiving dialysis will have monitoring before and after their dialysis treatment to ensure condition is stable after treatment. The policy also read, The Charge Nurse prior to and upon return from dialysis shall evaluate the resident's condition, including but not limited to vital signs and the graft/fistula site.</p> <p>Resident #67 admitted on [DATE] with diagnoses which included dependence on renal dialysis and end stage renal disease.</p> <p>A physician's order, dated 01/11/23, documented to monitor each shift for complications of dialysis.</p> <p>A physician's order, dated 01/11/23, documented, to dialysis Monday, Wednesday, and Friday; notify dialysis center, attending physician and responsible party if refused. Complete Pre and Post Dialysis Progress Note for patient evaluation. Send copy of physician orders, recent labs and blank progress note. One time a day every Monday, Wednesday, and Friday for end stage renal disease.</p> <p>The May 2024 pre and post dialysis notes were reviewed. There was no documentation on 05/01/24, 05/03/24, 05/15/24, 05/20/24, and 05/29/24 for pre dialysis assessment. There was no documentation on 05/24/24 and 05/31/24 for post dialysis assessment.</p> <p>On 06/05/24 at 8:52 a.m., the DON stated staff were required to document dialysis assessment before and after each dialysis visit.</p> <p>On 06/05/24 at 9:17 a.m., the DON stated the dialysis assessment for the dates above were not done.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>33148</p> <p>Based on record review and interview, the facility failed to ensure medications were administered as ordered by the physician for one (#24) of three sampled residents reviewed for respiratory care.</p> <p>The DON identified 148 residents resided in the facility.</p> <p>Findings:</p> <p>Res #24 had diagnoses which included congestion an allergic rhinitis.</p> <p>A physician order, dated 10/04/23, documented loratadine (an antihistamine) 10 mg tablet. Give one tablet by mouth every 24 hours as needed.</p> <p>A significant change assessment, dated 03/12/24, documented the resident's cognition was intact.</p> <p>A physician order, dated 05/26/24, documented guaifenesin ER (an expectorant) tablet 600 mg. Give one tablet by mouth every 12 hours for seven days.</p> <p>An order administration note, dated 05/26/24 at 7:56 p.m., documented guaifenesin was on order.</p> <p>The May and June 2024 MARs documented guaifenesin was administered 12 out of 14 opportunities.</p> <p>On 06/02/24 at 10:45 a.m., the Resident #24 stated the had a respirator infection over the holiday weekend and was not able to take their prescribed medication.</p> <p>A health status note, dated 06/03/24 at 2:48 p.m., documented the resident reported they had sinus drainage. It was documented loratadine was on order from the pharmacy.</p> <p>There was no documentation loratadine had been administered.</p> <p>On 06/04/24 at 7:41 a.m., the Administrator was ask to to provide documentation when the Resident #24 guaifenesin was received from the pharmacy.</p> <p>On 06/04/24 at 7:46 a.m., the Administrator stated guaifenesin was a house stock medication. They stated the facility had the medication all of the time.</p> <p>On 06/04/24 at 10:16 a.m., the DON was made aware it was documented the Resident #24 received 12 out of 14 doses of the guaifenesin the physician ordered on 05/26/24. They stated they should have received all of the doses.</p> <p>On 06/04/24 at 11:23 a.m., ACMA #3's medication cart was observed. There were two packages with a total of three tablets of loratadine for the Resident #24. The fill date on the packages was 06/03/24.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/04/24 at 11:41 a.m., the ADON was asked when the Resident #24 loratadine was received from the pharmacy. They stated the medication packages documented the medication was filled on 06/03/24. They stated the medication would have been delivered between 10:00 p.m. and 11:00 p.m. or earlier.</p> <p>On 06/04/24 at 11:45 a.m., the ADON was shown the progress note where the Resident #24 reported they had sinus drainage and their loratadine was on order from the pharmacy. They were made aware there was no documentation the medication had been administered to the Resident #24. The ADON called the pharmacy and stated the medication was delivered to the facility at 12:08 a.m. on 06/04/24. They stated nursing staff should have reported to each other during shift change they were waiting on the Resident #24 medication.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20960</p> <p>Based on observation, record review, and interview, the facility failed to ensure:</p> <p>a. staff used personal protective equipment and sanitized a blood pressure cuff for a resident with contact precautions for one (#93) of two sampled residents reviewed for transmission based precautions;</p> <p>b. staff used personal protective equipment for a resident with enhanced barrier precautions for one (#56) of one enhanced barrier precaution observation; and</p> <p>c. staff maintain infection control practices during incontinent care for one (#52) of seven incontinent care observation.</p> <p>The infection preventionist identified eight residents who were on transmission based precautions and 31 residents who were on enhanced barrier precautions resided in the facility. The DON identified 45 residents required assistance with incontinent care.</p> <p>Findings:</p> <p>The Isolation-Categories of Transmission-Based Precautions policy, revised 09/22, read in part, Staff and visitors wear gloves .when entering the room. The policy also read, Staff and visitors wear a disposable gown on entering the room.</p> <p>The Enhanced Barrier Precautions policy, revised 04/01/24, read in part, An order for enhanced barrier precautions will be obtained for residents with any of the following: feeding tubes. The policy also read, PPE for enhanced barrier precautions is only necessary when performing high contact care activities.</p> <p>The Equipment and Supplies Used During Isolation policy, revised 10/18, read in part, Nursing staff shall be responsible for cleaning and sanitizing supplies between residents, i.e., BP cuffs.</p> <p>1. Resident #93 had diagnoses which included MRSA bacteremia and osteomyelitis of the left great toe.</p> <p>A physician's order, dated 04/30/24, documented contact precautions every shift for MRSA bacteremia.</p> <p>On 06/02/24 at 1:16 p.m., LPN #3 was observed assisting Resident #93 in bed. LPN #3 was not wearing a gown and did not have gloves on while providing care to the Resident. They did not sanitize or washed their hands.</p> <p>Resident #93's posted sign on their door documented contact isolation, to clean hands, wear a gown and gloves before entering the room. Remove gown and gloves, clean hands when leaving the room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/03/24 at 9:45 a.m., CMA #1 was observed entering Resident #93's room without a gown and gloves. They took the Resident's blood pressure and walked out. They did not clean or sanitize the blood pressure cuff after completing the task. CMA #1 did not wash or sanitized their hands.</p> <p>On 06/03/24 at 12:40 p.m., CMA #1 stated they did not wear a gown or gloves because they only took the Resident's blood pressure. They stated they were not aware they had to clean or sanitize the medical equipment.</p> <p>On 06/03/24 at 12:46 p.m., the ADON stated anyone who entered Resident #93's room should wear a gown and put on gloves. They stated the posted sign is visible to all who entered the room. The ADON stated they have bleach wipes and disinfecting wipes for cleaning equipment used in contact isolation rooms.</p> <p>2. Resident #56 had a diagnosis of gastrostomy.</p> <p>A physician's order, dated 03/29/24, documented enhanced barrier precautions every shift related to peg tube.</p> <p>On 06/04/24 at 6:17 a.m., CNA #2 and CNA #3 went into Resident #56's room to provide care. Neither CNA used PPE per enhanced barrier precautions guidelines.</p> <p>On 06/04/24 at 7:15 a.m., CNA #2 and CNA #3 got Resident #56 up and took them to the shower. Neither CNA wore a gown or gloves.</p> <p>On 06/04/24 at 7:47 a.m., CNA #2 stated they did not wear a gown or gloves while providing care to Resident #56.</p> <p>On 06/04/24 at 7:59 a.m., CNA #3 stated Resident #56 had a feeding tube and they were on enhanced barrier precautions. They stated they had to wear a gown and gloves while proving care.</p> <p>On 06/04/24 at 8:09 a.m., the ADON stated Resident #56 was on enhanced barrier precautions.</p> <p>3. Resident #52 admitted on [DATE] with diagnosis which included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.</p> <p>On 06/04/24 at 6:08 a.m., CNA #1 was observed to don gloves to provide incontinent care to Resident #52. Upon completion of providing incontinent care, CNA #1 asked Resident #52 if they would like a drink. Without changing gloves, CNA #1 touched the handle of the cup on the bedside table, gave Resident #52 a drink and placed the cup back on the bedside table. CNA #1 wearing the same gloves pulled the bedside table up to Resident #52's bed and leaned over and pulled the cord to turn off the light.</p> <p>On 06/04/24 at 6:19 a.m., CNA #1 stated they had not changed their gloves prior to touching the cup, the bedside table, or the light cord.</p> <p>46216</p>		