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	12/18/2025

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

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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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on record review and interview, the facility failed to ensure 18 of 18 dietary contract employees received abuse training.The DON identified 141 residents resided in the facility. Findings:A facility policy titled Abuse Prevention Program, revised 08/2006, read in part, Comprehensive policies and procedures have been developed to aid our facility in preventing abuse, neglect, or mistreatment of our residents. Our abuse prevention program provides policies and procedures that govern at a minimum: .b. Mandated staff training/orientation programs that includes topics as abuse prevention, identification and reporting of abuse, stress management, dealing with violent behaviors or catastrophic reactions, etc.The facility's contract with the dietary contractor titled Management Service Agreement, dated 10/06/25, read in part, The [name of dietary contractor agency withheld] Mangers will train and manage the Service Employees and oversee the provision of the management services.On 12/17/25 at 4:23 p.m., human resources stated the dietary contractor was responsible for ensuring all dietary staff hired received abuse training. On 12/17/25 at 4:59 p.m., the regional director of operations stated they learned on 12/16/25 that the contract agency they were employed with was responsible for training dietary staff on abuse. The regional director of operations stated dietary staff had not been trained on abuse. The regional director of operations stated that the abuse training was not part of their contract. On 12/17/25 at 6:59 p.m., the DON stated there was an abuse addendum training through the dietary contractor for dietary staff that was not included during dietary staff orientation. The DON stated 18 dietary staff members were not trained on identifying and reporting abuse prior to working. On 12/18/25 at 1:10 p.m., the DON stated the dietary contractor was supposed to train their service employees on abuse, but they forgot the supplemental abuse training for the staff. On 12/18/25 at 2:11 p.m., the administrator stated the facility was expecting the dietary contractor to complete the abuse training and the dietary contractor forgot the supplement for abuse in their training. The administrator stated they were not sure if it was in the contract with the dietary contractor.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure:a. walls and paint were in good repair for 2 (#3 and #6), and b. a resident's bed was in good repair for 1 (#3) of 28 sampled residents reviewed for a safe home like environment. The DON identified 141 residents resided in the facility. Findings:1.On 12/15/25 at 4:25 p.m., Resident #6's room was observed to have chipped and peeled paint in several areas on the wall behind the bed. The sheetrock had deep scratches and was white in color. Sheetrock was observed on the floor from the damaged wall. A facility policy titled Maintenance Service, revised 12/2009, read in part, Maintenance service shall be provided to all areas of the building, grounds, and equipment.Function of maintenance personnel include but are not limited to: a. Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines.Resident #6's comprehensive assessment, dated 09/08/25, showed they were admitted with a diagnosis of Alzheimer's disease. The assessment showed Resident #6's cognition was moderately impaired with a BIMS score of 08. On 12/15/25 at 4:25 p.m., family representative #1 stated the damaged wall bothered the resident and them.On 12/16/25 at 4:10 p.m., CNA #1 was asked to discuss the walls in Resident #6's room. CNA #1 stated the paint was chipped on the wall at the head of the bed, the sheetrock was damaged, and it had been damaged since 10/2025. CNA #1 stated the damaged wall made the room look like it was not taken care of and maintained. On 12/16/25 at 4:16 p.m., the maintenance supervisor stated they did not have any outstanding work orders to repair the wall in Resident #6's room. The maintenance supervisor was asked to look in Resident #6's room and discuss what they saw. The maintenance supervisor stated the bed was an older style bed and it was pushed too close to the wall which caused the damage to the wall. The maintenance supervisor stated two walls in Resident #6's room were damaged and there was chipped paint and sheet rock dust on the floor. 2. On 12/17/25 at 8:59 a.m., Resident #3 was observed in bed. The bed had padding added under the mattress. The resident was positioned at the side of the bed and not in the center. The wall at the foot of the bed was damaged with missing paint and deep scratches in the sheet rock. The wall the bed was pushed against was missing paint and was white in color. Resident #3's quarterly assessment, dated 10/01/25, showed they were admitted on [DATE] with diagnoses which included dementia and diabetes. The assessment showed Resident #3's cognition was intact with a BIMS score of 14. The assessment showed Resident #3 was dependent for bed mobility. On 12/17/25 at 9:03 a.m., CMA #1 stated they reported to the administrator the bed was uncomfortable, and the resident could not sit in the middle because they felt the bars under the bed. CMA #1 stated the family put padding under the mattress to try and make it more comfortable. CMA #1 stated the walls in Resident #3's room at the foot of the bed and side were damaged for the last six months. On 12/17/25 at 9:06 a.m., Resident #3 stated they felt the bar under the bed on their bottom. Resident #3 stated their family put padding under the bed. Resident #3 stated when they laid in the middle of the bed, they could feel a bar or something on their bottom that caused discomfort. On 12/17/25 at 9:44 a.m., the ADON stated they were not aware of any residents with a broken bed and repositioning issues. The ADON stated Resident #3's bed was not level. On 12/17/2025 at 9:50 a.m., the administrator was shown Resident #3's bed. The administrator stated the bed was never reported to them and they had put the bed in Resident #3's room two weeks prior. The administrator stated the bed was not level and needed to be lowered and readjusted. They stated staff did not place the padding under the bed.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review and interview, the facility failed to implement their abuse policy by not ensuring all staff working in the facility were trained on identifying and reporting abuse for 18 of 18 dietary contractor staff members. The DON identified 141 residents resided in the facility. Findings: A facility policy titled Abuse Prevention Program, revised 08/2006, read in part, Comprehensive policies and procedures have been developed to aid our facility in preventing abuse, neglect, or mistreatment of our residents. Our abuse prevention program provides policies and procedures that govern at a minimum: .b. Mandated staff training/orientation programs that includes topics as abuse prevention, identification and reporting of abuse, stress management, dealing with violent behaviors or catastrophic reactionsThe facility's contract with the dietary contractor titled Management Service Agreement, dated 10/06/25, read in part, The [name of dietary contractor agency withheld] Mangers will train and manage the Service Employees and oversee the provision of the management services.On 12/17/25 at 4:23 p.m., human resources stated the dietary contractor was responsible for ensuring all dietary staff hired received abuse training. On 12/17/25 at 4:59 p.m., the regional director of operations stated they learned on 12/16/25 the contract agency they were employed with was responsible for training dietary staff on abuse. The regional director of operations stated dietary staff had not been trained on abuse. The regional director of operations stated the abuse training was not part of their contract. On 12/17/25 at 6:59 p.m., the DON stated there was an abuse addendum training through the dietary contractor for dietary staff that was not included during dietary staff orientation. The DON stated 18 dietary staff members were not trained on identifying and reporting abuse prior to working. On 12/18/25 at 1:10 p.m., the DON stated the dietary contractor was supposed to train their service employees on abuse, but they forgot the supplemental abuse training for the staff. On 12/18/25 at 2:11 p.m., the administrator stated the facility was expecting the dietary contractor to complete the abuse training and the dietary contractor forgot the supplement for abuse in their training. The administrator stated they were not sure if it was in the contract with the dietary contractor.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure there were enough trained staff at set meal times for 4 of 4 dining observations.The DON identified 138 residents received nutrition from the kitchen.Findings:On 12/15/25 at 8:48 a.m., kitchen staff were observed preparing trays for a hall cart for delivery to residents. Posted mealtimes for breakfast showed 8:00 a.m.On 12/15/25 at 12:51 p.m., lunch hall trays were delivered to hall 300. Dining room residents had not been served lunch yet. Posted mealtimes for lunch showed 12:00 p.m.On 12/16/25 at 9:00 a.m., breakfast trays were delivered to hall 400. Dining room residents had not been served breakfast yet. Posted mealtimes for breakfast showed 8:00 a.m.On 12/18/25 at 12:50 p.m., dining room residents were observed receiving trays for lunch. Posted mealtimes for lunch showed 12:00 p.m.An undated facility document titled [NAME] Meal Times, read in part, breakfast 8:00 a.m., lunch 12:00 p.m., and dinner 5:00 p.m.On 12/15/25 at 10:57 a.m., Resident #104 stated they ate meals in their room and did not eat breakfast that morning since they received cold pancakes and it was not appetizing. Resident #104 stated meal times were an issue and had been late for last several weeks.On 12/16/25 at 12:51 p.m., CNA #2 stated meal trays had been late coming out since the new company took over the kitchen. CNA #2 stated it was a problem for the residents since they did not know when they would get their meals and some got anxious when they were not on time.On 12/18/25 at 2:50 p.m., the dietary manager stated they were working with several new staff members and not everyone knew what their roles were yet. The dietary manager stated the kitchen was slower getting food prepared and served than they needed to be.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview the facility failed to ensure:a. prepared food items were labelled with the preparation and use-by dates,b. food items were discarded after the expiration date,c. fresh food items with visible mold, discoloration, or soft to touch were discarded,d. opened food items were stored in airtight packaging,e. monitoring of temperatures for refrigerators and freezers containing food, andf. food was prepared in a sanitary environment for 2 of 2 kitchen observations.The DON identified 138 residents received nutrition from the kitchen.Findings:On 12/15/25 at 9:00 a.m., the following temperature log observations were made:a. a freezer temperature log for the reach in freezer, with opening and closing temperature documentation areas, was not completed for 12/15/25, andb. a refrigerator temperature log for the walk-in refrigerator, with opening and closing temperature documentation areas, was not completed for 12/15/25.On 12/15/25 at 9:05 a.m., four clear plastic covered pitchers were observed on a four wheeled cart near the food preparation area. Two had yellow-colored liquid and two had tea colored liquid, without labels or preparation/use-by dates.On 12/15/25 at 9:10 a.m., the hot food holding box was observed in the food preparation area with a small metal container with a plastic lid with cereal looking substance and a small metal container without a lid with a cereal looking substance. Both items did not have a label or date indicating content, preparation and use-by information.On 12/15/25 at 9:14 a.m., the following bread products were observed on shelving unit in food preparation area without manufacturer best-by dates or facility marked dates:a. two packages of unopened hamburger buns,b. two loaves of opened sliced bread,c. four loaves of unopened sliced bread, andd. five packages of unopened English muffins.On 12/15/25 at 9:17 a.m., the following observations were made in the walk-in refrigerator:a. ten fresh cucumbers that were soft to touch and had visible mold,b. an opened plastic package of shredded lettuce that was discolored, soft, and without label or date,c. a plastic zip locked bag labelled ham without open or use-by dates, andd. a plastic container with red colored tomato sauce type contents that was not labeled or dated.On 12/15/25 at 9:19 a.m., the following observations were made in the walk-in freezer without labels, date opened or use-by dates:a. an opened bag of tator tots,b. an opened bag of French fries,c. an opened bag of chicken tenders,d. a plastic zip locked bag labelled fajita chicken, with use-by date of 11/30/25, ande. an open plastic bag of sausage patties, not sealed, and with no label or dates.On 12/15/25 at 9:30 a.m., the following was observed in the dry storage area:a. a package of buttermilk pancake mix was opened, not sealed, labelled, or dated,b. a 16 oz container of cornstarch was opened, not sealed, labelled, or dated,c. a 29.77 oz container of refried pinto bean constitute was opened and not sealed, andd. a Zip lock plastic bag labelled croutons had a use by date of 11/30/25.On 12/15/25 at 9:35 a.m., a 3-compartment sink was observed being utilized for dishwashing since the dishwasher was out of service. The sanitizer dispenser log was not completed for 12/15/25. On 12/15/25 at 9:44 a.m., the salt and pepper storage containers were observed in the dining room drawers with a moderate amount of debris.On 12/15/25 at 9:45 a.m., an ice machine was observed in the dining room with an out of service sign that had brown colored standing water in the drainage tray. On 12/18/25 at 1:20 p.m., the room in the kitchen where the dishwasher was being repaired was observed to have a foggy haze type appearance in the air as well as debris from construction and leaves on the floor. There were maintenance workers in the area, no separation between work area and food storage and preparation areas, and an air curtain was not in use between the exit door and work area per facility policy.A facility provided policy titled Food Storage: Cold, dated 10/2019, read in part, a written record of daily temperatures is recorded.A facility provided policy titled Receiving, dated 10/2019, read in part, all food items will be appropriately labeled and dated either through manufacturer packaging or staff notation.A facility provided policy titled Ware Washing, dated 10/2019, read in part, the dining services director is responsible for ensuring appropriate completion of temperature and/or sanitizer logs as appropriate.A (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility provided policy titled Construction and Remodeling Policy, dated 6/01/25, read in part, install temporary barriers (plastic sheeting, zip walls, hard barriers) to isolate work areas.On 12/15/25 at 9:02 a.m., the dietary manager stated the temperatures had not been checked or logged this morning for the refrigerators, freezers, and dry storage area.On 12/15/25 at 9:10 a.m., the dietary manager stated the cardboard box with the dressing packets showed the date the item was received and there should be another date on the box showing the open date and use-by date.On 12/15/25 at 9:12 a.m., the dietary manager stated containers with prepared drinks and items in the hot box should be covered, labelled, and dated.On 12/15/25 at 9:14 a.m., the dietary manager stated they were unsure of the factory dating processes. They stated they did not label and date bread products when they came in or when they were opened.On 12/15/25 at 9:35 a.m., the dietary manager stated all items should be fresh, opened items should be stored in sealed containers, and packaged items should be labelled and dated with received by, preparation, and use-by dates. The dietary manager stated all items that were past the use-by date should be discarded.On 12/15/25 at 9:36 a.m., the dietary manager stated they thought the sanitizer and temperature was to be checked with every load of dishes washed in the sink to ensure appropriate temperatures and solutions were used.On 12/15/25 at 9:45 a.m., the dietary manager stated the dining room drawers needed to be cleaned and the ice machine needed to have the standing water removed.On 12/18/25 at 1:30 p.m., the maintenance supervisor stated the workers were not using any cutting type of equipment that would produce particles in the air, so they did not need to use a barrier between the work area and food storage or preparation areas. The maintenance supervisor stated the air curtain would help prevent outside debris from coming into the kitchen and it was not in use at this time.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, record review, and interview, the facility failed to ensure bathrooms accessible to residents had call lights for 2 of 2 bathrooms observed accessible to residents.The DON identified 141 residents resided in the facility. Findings: On 12/16/25 at 1:13 p.m., a bathroom located outside of the therapy hall accessible to residents was observed unlocked, the door open, and a sign on the door that read, restroom for patients only. The restroom did not have a call light to alert for assistance. On 12/16/25 at 1:15 p.m., the bathroom on hall 500 was observed to be accessible to residents and did not have a call light to alert in the event of an accident. A facility policy titled Quality of Life- Accommodation of Needs, revised 08/2009, read in part, The resident's individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. On 12/16/25 at 1:11 p.m., medical records was asked about the bathroom outside the therapy room on the main hall. Medical Records stated it was an unlocked and open bathroom residents who were mobile and were able to self-transfer could use without supervision. Medical Records stated there was not a call light in the bathroom. Medical Records stated resident could have a slip and fall would not be able to call for help. On 12/16/25 at 1:21 p.m., LPN #1 stated all resident accessible bathrooms should have a call light. LPN #1 stated the bathroom on the main hall by the therapy room was unlocked, accessible to residents, and did not have a call light. LPN #1 stated residents using that bathroom could have an unforeseen fall or a medical emergency. On 12/16/25 at 1:31 p.m., the DON stated resident accessible bathrooms should have handicap rails, grab bars, and call lights. The DON stated the bathroom on hall 500 was accessible to residents and did not have a call light.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to handle and process linens to prevent the spread of infection for residents on contact isolation in the laundry room. The infection preventionist identified five residents on contact precautions. Findings: On 12/18/25 at 3:00 p.m., an observation of the laundry area was completed. There were no gowns available. A facility policy titled Laundry and Bedding, Soiled, dated September 2022, read in part, Hand hygiene products, as well as appropriate PPE [personal protective equipment] (i.e., gloves and gowns) are available and used while sorting and handling contaminated linen. On 12/18/25 at 3:04 p.m., the housekeeping/laundry manager stated the staff wore gloves to transport the red biohazard to the laundry area. The housekeeping/laundry manager stated the staff would open the bags and place the soiled linen in the washing machine. The housekeeping/laundry manager stated gowns were not worn to place the soiled linen in the washing machine. On 12/18/25 at 3:12 p.m., the infection preventionist stated laundry staff should wear gloves and a gown when handling soiled linen from a room with contact precautions/isolation precautions to prevent the possible spread of infection.