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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Bell Avenue Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2301 Bell Avenue Elk City, OK 73644	

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 0600 Level of Harm - Actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 45462 Based on record review and interview, the facility failed to provide an environment free from abuse for two (#7 and #8) of five sampled residents reviewed for resident-to-resident abuse. The Administrator identified 56 residents resided in the facility. Findings: An 'Abuse Prevention Program' policy, revised September 2015, read in parts, .It is the policy of the facility to prohibit abuse .The facility will investigate allegations and reported incidents .The investigation will include preventative measures when possible to prevent reoccurrence .Examples of plans of action may include a change in care, a change in medication . 1. Resident #6 A document titled Annual MDS Assessment, dated 06/24/24, Resident #6 cognition was severly impaired. The assessment further indicated Resident #6 was independent with transfer. Resident #6 was able to ambulate with assistance with a walker and wheel chair. A Physician's Order, dated 04/03/24, documented Resident #6 was started on Provera 2.5mg by mouth daily. A document titled Progress Notes, documented four occurrences of inappropriate behavior by Resident #6 towards female residents on the following days: 03/31/24, 04/01/24, 04/08/24 & 04/19/24 A document titled Psychiatric Progress Note, dated 04/17/24, Resident #6 was starte on Provera 2.5mg to reduce testosterone levels. A document titled Psychiatric Progress Note, dated 05/18/24, documented to increase Provera 2.5mg to Provera 5mg twice a day. Then to follow-up in 3 - 4 weeks. The medication administration record, dated 05/18/24 - 08/22/24, contained no documentation Resident #6 received Provera 5mg twice a day. There was no documentation to indicate that a follow-up was completed in 3-4 weeks. (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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F 0600 Level of Harm - Actual harm Residents Affected - Some	There was no documentation to indicate Resident #6's Provera was increased to 5mg twice a day. Resident #6 careplan, dated 03/31/24, documented Resident #6 had become more focused on women and thinking of sexual urges. It was documented Resident #6 touched another residents breast without consent. A careplan entry, dated 04/19/24, documented Resident #6 touched another residents breast and was slapped. A progress note, dated 04/21/24, documented four occuraences of inappropriate behavior by Resident #6 towards female residents on the following days: 04/21/24, 04/26/24, 04/29/24 & 08/21/24 There was no documentation to indicate that Resident # 6 careplan was updated. 2. Resident #7 had diagnoses that included senile degeneration of the brain and dementia. A 'Functional Abilities and Goals' assessment, dated 06/19/24, documented Resident #7 was wheelchair dependent and required substantial/maximum assistance for ADL's. Nurse Progress Note, dated 03/31/24 1:13 p.m., documented Resident #6 was observed with Resident #7 in a corner groping her breasts. 3. Resident #8 had diagnoses that included vascular dementia and aphasia. A 'Functional Abilities and Goals' assessment, dated 07/10/24, documented Resident #7 was wheelchair dependent and required assistance for ADL's. Nurse Progress Note for Resident #6, dated 04/19/24 8:15 p.m., documented Resident #6 was reported to have approached Resident #8, asked resident to lift their shirt and then tried to reach forward and grab Resident #8's breasts. A Psychiatric Progress Note for Resident #6, written 04/17/24, documented an order to increase Resident #6's Provera to 5mg BID to decrease testosterone due to continued exhibition of sexual behaviors towards other residents. There was no documentation that this order was carried out. A Psychiatric Progress Note for Resident #6, written 05/15/24, documented another order to increase Resident #6's Provera to 5mg BID. There was no documentation that this order was carried out. On 08/20/24 at 2:52 p.m., CNA #1 reported that Resident #6 had a problem with inappropriate touching, and staff were instructed to keep them away from the females, especially the ones that could not speak. On 08/21/24 at 1:10 p.m., the Administrator reported to this surveyor that Resident #6 was observed in the dining room during lunch today sitting beside Resident #8 and touching their breast. (continued on next page)

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	375399	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bell Avenue Nursing Center	2301 Bell Avenue Elk City, OK 73644

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F 0600 Level of Harm - Actual harm Residents Affected - Some	On 08/21/24 at 3:45 p.m., the DON was asked to review these incidents involving Resident #7 and Resident #8, along with four other documented incidents of inappropriate sexual behaviors exhibited by Resident #6 towards unnamed residents. When asked what interventions had been put into place to protect residents from Resident #6's inappropriate sexual behaviors, they stated Resident #6 was placed on medication to decrease their testosterone on 04/02/24. The DON was asked if the orders, written by Physician #1 on the psychiatric MD progress notes on 04/17/24 and 05/15/24, to increase Resident #6's Provera due to continued exhibition of sexual behaviors towards other residents had been carried out. The DON stated they were not aware of these orders. The DON was asked to review the above psychiatric progress notes and acknowledged the orders had not been forwarded to the Medical Director for approval. On 08/21/24 at 4:26 p.m., Physician #1 was asked if they had been notified of Resident #6's repeated inappropriate sexual behaviors that occurred today. They stated no. Physician #1 was asked if they were aware the orders written on 04/17/24 and 05/15/24 to increase Resident #6's Provera dose to decrease testosterone was never carried out. They stated no. Physician #1 was asked if these medication increases could have helped in preventing the abuse from reoccurring. They stated maybe.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 45462 Based on record review and interview, the facility failed to ensure incident reports were created for documented incidents of inappropriate sexual behavior by one (#6) of five sampled residents reviewed for resident-to-resident abuse. The Administrator identified 56 residents resided in the facility. Findings: A 'Resident-to-Resident Altercations' policy, revised August 2011, read in parts, .If two residents are involved in an altercation, staff will .Complete an 'Report of Incident/Accident' form and document the incident, findings, and any corrective measures taken in the resident's medical/clinical record . A Nurse Progress Note, dated 04/01/24 at 9:23 a.m., documented Resident #6 was observed in the back of dining room with an unnamed female resident and had his penis exposed. A Nurse Progress Note, dated 04/08/24 at 4:00 p.m., documented Resident #6 was observed hugging and what appeared trying to kiss an unnamed female resident. A Nurse Progress Note, dated 04/21/24 at 8:35 p.m., documented Resident #6 wrote an unnamed female resident an inappropriate note and left it in her room while she wasn't there. A Nurse Progress Note, dated 04/29/24 at 5:51 p.m., documented Resident #6 left an inappropriate note in another unnamed female resident's room. There was no 'Report of Incident/Accident' form completed for either of the incidents listed above. Neither of the incidents were reported to OSDH or any other state agency. On 08/22/24 at 10:58 a.m., the DON was asked what the policy was for documenting incidents of sexually inappropriate behavior between residents. They stated that an internal report should be done and, if warranted, a report should be submitted within two hours to OSDH and other state agencies notified as needed. The DON was asked if an internal incident report had been completed for either of the incidents listed above. She stated no. The DON was asked if either of the incidents listed above warranted reporting to OSDH or other state agencies. They stated they were not sure.