STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375399	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bell Avenue Nursing Center	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702 Based on record review and interview, the facility failed to ensure accurate wandering risk scale assessments were completed for two (#2 and #3) of three residents sampled for accurate wandering risk scale assessments. The DON identified eight residents were at risk for wandering and elopement. Findings: The facility's Elopement and Wandering Residents policy, dated 01/13/21, read in part, Wandering is random or repetitive locomotion that may be goal directed (e.g., the person appears to be searching for something such as an exit) or non goal directed or aimless. The policy also read, The facility shall establish and utilize a systematic approach to monitoring and managing residence at risk for elopement or unsafe, wandering, including identification and assessment of risk, evaluations of hazards and risk, implementing interventions to reduce hazards and risk, and monitoring for effectiveness and modifying interventions when necessary. The policy also read, Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. 1. Resident #2 was admitted to the facility on [DATE] with diagnoses which included paroxysmal atrial fibrillation, type 2 diabetes, and unspecified dementia. A nurse's note for Resident #2, dated 11/21/23, read in part, Resident has been very upset about being in this facility and was crying stating [they] wanted to go home. Resident was at the front door trying to get outside and was shaking door handle trying to open it. This nurse tried to calm resident down and resident said [they] wanted to go for a walk outside. Took resident for a short wheel/walk in wheelchair outside on sidewalk. Resident calmed down after walk. Not too long after coming back inside, kitchen staff seen resident out in parking lot by herself. Staff was unaware how [they] got out the front door. This nurse and CNA went and got resident and resident again stated she wanted to go home and have [their] [family member] come get [them] and was crying. Got resident back into facility and contacted [their] [family member] to notify [them] of [their] behavior. Resident calm down and went and ate supper. (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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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 12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bell Avenue Nursing Center	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2's comprehensive assessment, dated 01/31/24, documented the resident's cognition was moderately impaired and they required substantial to maximal assistance with activities of daily living. Resident #2's Wandering Risk Scale assessments dated, 02/01/24, 05/01/24, 07/26/24, and 10/23/24 documented the resident had no history of wandering and had no reported episodes of wandering in the past six months. 2. Resident #3 was admitted to the facility on [DATE] with diagnoses which included unspecified dementia with agitation, edema, and age related physical disability. Resident #3's quarterly assessment, dated 01/31/24, documented the resident's cognition was significantly impaired and they were independent for assistance with activities of daily living. Resident #3's incident note, dated 07/13/24, read in part, this resident was walking down the street toward [name withheld]. This nurse stopped resident and brought [them] back into the facility. This nurse asked resident if [they] knew the code to the front door. Resident stated, no, I snuck out the door behind someone. The facility's #1248 Elopement incident report, dated 07/13/24, read in part, Resident was observed by staff walking down the street to the store. Staff intervened and brought the resident back to the facility. Resident #3's Wandering Risk Scale assessment dated , 07/14/24, documented the resident had no history of wandering and has had no reported episodes of wandering in the past six months. Resident #3's nurse progress note, dated 08/03/24, read in part, resident was seen by resident [name withheld] jumping the fence in the back yard. The facility's #1319 Elopement incident report, dated 08/03/24, read in part, resident was seen by resident [name withheld] jumping the fence in the back yard. It also read, Resident is an elopement risk. Resident #3's Wandering Risk Scale assessments dated, 09/09/24 and 12/06/24, documented the resident had no history of wandering and has had no reported episodes of wandering in the past six months. On 12/17/24 at 2:30 p.m., the administrator stated Resident #2 was out front in eyesight on 11/21/23 and never left the property. They stated they were unsure how Resident #2 got out on 11/21/23, but was within eyesight on the front porch sidewalk area. The administrator stated Resident #3's exit was seeking was for cigarettes on 07/13/24 and on 8/03/24. The administrator was asked to review the Elopement and Wandering Residents policy, dated 1/13/21, and the SOM with Elopements and Wandering definitions. The administrator stated that based upon their review, the wandering assessments for Resident #2 and Resident #3 were not accurate because they documented no history of wandering and no wandering in the past six months. They stated there was a confusion as they thought all wandering should be aimless and they were not considering goal directed as wandering.