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	03/26/2025

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30875 Based on record review and interview, the facility failed to conduct a comprehensive assessment within 14 calendar days of admission for 2 (#104 and #205) of 13 sampled residents reviewed for comprehensive assessments. The administrator reported 51 residents resided in the facility. Findings: A MDS Completion and Submission Timeframes policy, dated July 2017, read in part, Our facility will conduct and submit resident assessments with current federal and state submission timeframes. 1. Resident #104 had diagnoses which included acute osteomyelitis, right tibia and fibula, encounter for closed fracture with nonunion, and chronic obstructive pulmonary disease. Resident #104's entry assessment, dated 03/08/25, showed an admitted [DATE]. Resident #104's admission/5-day Medicare assessment, dated 03/15/25, showed to be in progress. On 03/26/25 at 9:47 a.m., the MDS coordinator reported they did not complete the admission/5 day-Medicare assessment for Resident #104. They reported they had been out sick. 41873 2. Resident #205 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus. Resident #205's admission assessment, dated 03/13/25, showed to be in progress. On 03/26/25 at 9:47 a.m., the MDS coordinator reported they had not completed the admission assessment for Resident #205 and the assessment was late.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 41873 Based on record review and interview, the facility failed to ensure assessments were accurate for 2 (#37 and #46) of 2 sampled residents reviewed for anticoagulant therapy. The administrator reported 51 residents resided in the facility. Findings: The facility had no policy for coding medication on MDS assessments. 1. Resident #37 had diagnosis which included cerebrovascular accident. A physician order, dated 05/09/24, showed to give the clopidogrel bisulfate (antiplatelet medication), 75 mg by mouth one time a day for cerebrovascular accident. The physician orders contained no anticoagulant medication. A quarterly assessment, dated 12/24/24, showed resident #37's cognition was moderately impaired with a BIMS score of 11. The assessment showed anticoagulant medication and no antiplatelet medication. 2. Resident #46 had diagnosis which included stroke. A physician order, dated 10/15/24, showed to give clopidogrel bisulfate oral tablet 75 mg, one tablet by mouth one time a day for previous stroke and Aspirin (an antiplatelet prevention medication) 81 mg, one capsule by mouth one time a day for cerebrovascular accident prevention. The physician order contained no anticoagulant medication use. A significant change assessment, dated 02/17/25, showed Resident #46's cognition was severely impaired with a BIMS score of 06. The assessment showed anticoagulant and antiplatelet medication use. On 03/26/25 at 10:43 p.m., the MDS coordinator reported they had always coded clopidogrel bisulfate as an anticoagulant and not an antiplatelet on the MDS. The MDS coordinator reported they documented aspirin as an antiplatelet. On 03/26/25 at 10:48 a.m., the MDS coordinator reported they checked the Centers for Medicare and Medicaid Services (CMS) website and confirmed that clopidogrel bisulfate was coded wrong and should have been coded as an antiplatelet for Resident #37 and Resident #46.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 30875 Based on observation, record review, and interview, the facility failed to follow physician orders related to insulin administration for 1 (#205) of 3 sampled residents reviewed for insulin administration. The DON reported 11 residents received insulin at the facility. Findings: On 03/25/25 at 4:48 p.m., LPN #1 was observed to prepare supplies and obtain a FSBS for Resident #205. The FSBS was 367 mg/dl. They administered 10 units of Humalog. They did not document a follow-up for the high blood sugar reading. An Obtaining a Fingerstick Glucose Level policy, dated October 2011, read in part, Verify that there is a physician's order for this procedure. An Insulin Administration policy, dated September 2014, read in part, Check blood glucose per physician order or facility protocol. Resident #205's care plan, dated 03/07/25, showed the resident had diabetes mellitus and to administer diabetes medication as ordered and monitor for side effects and effectiveness. Resident #205's physician order, dated 03/17/25, showed a sliding scale for insulin. The order showed to inject 10 units of Humalog insulin for a FSBS between 351 mg/dl and 450 mg/dl every 60 minutes. The order showed to Redose every 60 minutes until less than 300 and notify primary care physician if not less than 400 mg/dl after three doses, call the primary care physician. On 03/26/25 at 10:44 a.m., the DON was asked about the FSBS readings recorded on 03/25/25 as 354 mg/dl and 367 mg/dl. They stated the nurse should have rechecked them and did not recheck them or document in the nurse's note. The DON stated the nurse did not follow the physician orders. The DON reported LPN #1 was not available today for interview. On 03/26/25 at 1:07 p.m., LPN #3 was asked about a FSBS recorded for Resident #205 on 03/21/25 as 401 mg/dl and 353 mg/dl. They stated they did not document in the nurse's note, but they knew they rechecked the residents blood sugar. They reported they were aware of the physician orders to check the FSBS every 60 minutes and to notify the physician.