

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375457	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/12/2025
NAME OF PROVIDER OR SUPPLIER Betty Ann Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 South Main Street Grove, OK 74344	

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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 05/08/25, an Immediate Jeopardy (IJ) was determined to exist related to the facility's failure to protect residents from abuse. The failure resulted in nine physical assaults by Res #2 on eight other residents between 01/03/25 and 05/01/25.</p> <p>On 05/08/25 at 5:30 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation.</p> <p>On 05/08/25 at 6:04 p.m., the administrator and DON were notified of the IJ situation and provided the IJ template.</p> <p>On 05/09/25 at 9:06 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part,</p> <p>1. Resident # [2] is currently in inpatient psychiatric facility, [name withheld]. [NAME] Nursing Center is working with [name withheld] to find alternate placement for resident other than this facility. If alternative placement cannot be arranged prior to discharge, resident will return to [NAME] nursing center where [they] will remain under supervision of staff until other placement is found. Resident will have direct supervision when in close proximity to other residents and behaviors will be addressed immediately by staff for the safety of all residents.</p> <p>Date of Compliance: pending resident discharge to facility</p> <p>2. Residents who have been or may have been affected include resident numbers 9, 2, 4, 5, 3, 6, 7, 8, 1, and other residents residing in the facility at the time of the incidents. DON/ADON/ADMIN [administrator]/Designee have reviewed resident records and care plans to identify residents with increased needs for monitoring, interventions or clinical follow up for new or increased behaviors. They will ensure care plans and assessments are updated to current resident status and follow up routinely.</p> <p>Date of Compliance: 5/10/25 12 noon</p> <p>3. Training</p> <p>Administrator, Director of Nursing, Assistant Director of Nursing and nursing staff will be provided training by GeriPsych Nurse Practitioner on 5/9/25 over:</p> <p>(continued on next page)</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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Recognizing behavior changes and triggers</p> <p>Interventions for redirection and de-escalation of aggressive or inappropriate behaviors.</p> <p>Documentation of behaviors and interventions</p> <p>Date of Compliance: 5/9/25 11:59 pm</p> <p>Administrator, Director of Nursing, ADON, MDS will be inserviced on 5/9/25</p> <p>Incident reporting process, including timeliness of reporting, notification of necessary parties, documentation of notifications, immediate on ongoing interventions.</p> <p>Routine review of daily documentation and risk management reports to ensure timely reporting and follow-up of incidents, behaviors or other resident concerns.</p> <p>Date of Compliance: 5/9/25 11:59 pm</p> <p>On 5/9/25 Facility staff, including nursing staff, and ancillary staff will be provided training on:</p> <p>Prompt and appropriate intervention for resident behaviors</p> <p>De escalation and redirection of residents exhibiting unsafe or inappropriate behaviors</p> <p>Recognizing and reporting incidents including resident to resident encounters</p> <p>Timely notifications to Administration, Director of Nursing, physician, Geri psych nurse practioner [sic], OSDH [Oklahoma State Department of Health], local law enforcement, if appropriate, responsible party, other third party providers</p> <p>Complete and detailed documentation of incident and interventions immediately following incident as well as follow up interventions and resident actions, reactions or behaviors.</p> <p>Date of Compliance: 5/9/25 11:59 pm</p> <p>Care Plan</p> <p>Administrator, Director of Nursing, MDS Nurse, ADON will be in serviced on 5/9/25 on timely updates of resident care plan after incident and implementation of appropriate interventions.</p> <p>Care plans will be reviewed by DON/ADON to ensure interventions are in place and if current interventions are not successful new interventions are put in place. New or existing residents exhibiting behaviors that could be harmful to themselves or other residents will be identified timely, assessments and interventions will be implemented in accordance with physician and geri psych recommendations. Complete documentation will be done and reviewed by DON/ADMIN/Designee to ensure compliance. Date of Compliance: 5/10/25 12:00 noon</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 05/12/25, after interviewing facility staff, reviewing documentation of in-service trainings, communication between the facility and the hospital and care plan audits, the IJ was lifted effective 05/12/25 at 12:24 p.m. The deficient practice remained at a pattern level with the potential for more than minimal harm.</p> <p>Based on record review and interview, the facility failed to ensure residents were free from resident-to-resident abuse for 8 (#1, 3, 4, 5, 6, 7, 8, and 9) of 9 sampled residents reviewed for abuse.</p> <p>The DON reported the facility census was 49.</p> <p>Findings:</p> <p>An undated facility policy titled Resident-to-Resident Altercations, read in part, Facility staff will monitor residents for aggressive/inappropriate behavior toward other resident, family members, visitors or to staff .If two residents are involved in an altercation, staff will: .Make any necessary changes in the care plan approaches any or all of the involved individuals; .If, after carefully evaluating the situation, it is determined that care cannot be readily given within the facility, transfer the resident; and report incidents, findings, and corrective measures to appropriate agencies as outlined in our facility's abuse reporting policy.</p> <p>An admission record, dated 12/29/22, showed Res #2 had diagnoses which included schizophrenia, anxiety disorder, depression, restlessness and agitation.</p> <p>A care plan, initiated 01/11/23, showed Res #2 had hit other residents on 01/03/25 and 04/10/25. No new interventions had been implemented since 01/11/23.</p> <p>An ODH form 283, dated 01/03/25, showed Res #9 yelled at Res #2 and Res #2 hit Res #9 in the side of the head. The form also showed they were separated and assessed for injuries and staff would monitor and intervene if behaviors were noted.</p> <p>An ODH form 283, dated 01/08/25, showed Res #2 was observed with one hand on the back of Res #4's head and was about to hit Res #4 again when a CNA intervened. Res #4 had a small amount of blood on their nose. The form showed neuro checks were initiated.</p> <p>An ODH form 283, dated 02/08/25, showed Res #2 hit Res #3 in the back and side of their head in the hallway. The form also showed the residents were separated and assessed for injuries and staff were to monitor and intervene if further behaviors were noted.</p> <p>An ODH form 283, dated 03/07/25, showed Res #5 wandered into Res #2's room and Res #2 grabbed Res #5. The form also showed the residents were assessed for injuries and separated, and staff were to monitor and intervene if further behaviors were noted.</p> <p>An ODH form 283, dated 03/13/25, showed Res #2 hit Res #6. The form showed the residents were separated and assessed for injuries and staff were to monitor and intervene if further behaviors were noted.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An ODH form 283, dated 03/16/25, showed Res #2 approached Res #3 in the hallway and hit them in the nose. The form showed the residents were separated and staff were to monitor and intervene if further behaviors were noted.</p> <p>An ODH form 283, dated 03/28/25, showed Res #2 walked up to Res #7, who was seated in a wheelchair and hit Res #7 in the back of the head. The form showed the residents were separated and assessed for injuries and staff were to intervene if further behaviors were noted.</p> <p>An ODH form 283, dated 04/10/25, showed Res #2 entered Res #8's room Res #8 stated Res #2 hit them. The form showed the residents were separated and assessed for injuries.</p> <p>A quarterly assessment, dated 4/10/25, showed Res #2 had a BIMS summary score of 9, which was indicative of moderate impairment in cognition for daily decision making.</p> <p>An ODH form 283, dated 05/01/25, showed Res #2 wandered into Res #1's room, a CNA entered the room and observed Res #2 hit Res #1 in the head. The form showed the residents were separated and assessed for injury.</p> <p>A Written Notice of Transfer/Discharge, dated 05/02/25, showed Res #2 was transferred to an inpatient psychiatric hospital on [DATE].</p> <p>On 05/08/25 at 1:40 p.m., Res #3 stated in March Res #2 hit them in the face for no reason.</p> <p>On 05/08/25 at 2:20 p.m., CNA #1 stated Res #2 was confused and required frequent redirection. They also stated they were not aware of any special monitoring for Res #2.</p> <p>On 05/08/25 at 2:30 p.m., CNA #2 stated they tried to keep an eye on Res #2, but they were not on any type of additional monitoring.</p> <p>On 05/08/25 at 2:35 p.m., licensed practical nurse # 1 stated they tried to keep Res #2 busy as much as possible, but they were not on any special monitoring or precautions. They also stated the facility was planning on taking Res #2 back when they were discharged from the hospital.</p> <p>On 05/08/25 at 2:45 p.m., the DON stated they had tried to find Res #2 placement at another facility, but they are unable to locate a facility that would accept the resident, The DON stated the resident was out of the facility at the hospital right now, but they had agreed to take the resident back. They also stated they had not updated Res #2's care plan and the interventions in the care plan have not been effective.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on record review and interview, the facility failed to revise a resident's care plan for 1 (#2) of 9 sampled residents whose care plans were reviewed.</p> <p>The DON identified 49 residents resided in the facility.</p> <p>Findings:</p> <p>An undated facility policy titled Care Plans, Comprehensive Person-Centered, read in part, Assessments of residents are ongoing, and care plans are revised as information about the resident and the residents' conditions change.</p> <p>An admission record, dated 12/29/22, showed Res #2 had diagnoses which included schizophrenia, anxiety disorder, depression, restlessness and agitation.</p> <p>A care plan, initiated 01/11/23, showed Res #2 had hit other residents on 01/03/25 and 04/10/25. No interventions have been added to this care plan since 01/11/23.</p> <p>An ODH form 283, dated 01/03/25, showed Res #9 yelled at Res #2 and Res #2 hit Res #9 in the side of the head. The form also showed the residents were separated and assessed for injuries and staff would monitor and intervene if behaviors were noted.</p> <p>An ODH form 283, dated 01/08/25, showed Res #2 was observed with one hand on the back of Res #4's head and was about to hit Res #4 again when a CNA intervened. Res #4 had a small amount of blood on their nose. The form showed neuro checks were initiated.</p> <p>An ODH form 283, dated 02/08/25, showed Res #2 hit Res #3 in the back and side of their head in the hallway. The form also showed the residents were separated and assessed for injuries and staff were to monitor and intervene if further behaviors were noted.</p> <p>An ODH form 283, dated 03/07/25, showed Res #5 wandered into Res #2's room and Res #2 grabbed Res #5. The form also showed the residents were assessed for injuries and separated and staff were to monitor and intervene if further behaviors were noted.</p> <p>An ODH form 283, dated 03/13/25, showed Res #2 hit Res #6. The form showed the residents were separated and assessed for injuries and staff were to monitor and intervene if further behaviors were noted.</p> <p>An ODH form 283, dated 03/16/25, showed Res #2 approached Res #3 in the hallway and hit them in the nose. The form showed the residents were separated and staff were to monitor and intervene if further behaviors were noted.</p> <p>An ODH form 283, dated 03/28/25, showed Res #2 walked up to Res #7, who was seated in a wheelchair and hit Res #7 in the back of the head. The form showed the residents were separated and assessed for injuries and staff were to intervene if further behaviors were noted.</p> <p>(continued on next page)</p>		

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