STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375524	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beadles Nursing Home	916 Noble Alva, OK 73717

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. On 01/14/26 at 4:00 p.m., an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure staff were adequately trained for transportation of wheelchair bound residents.On 12/30/25, transporter #1 improperly secured Resident #20 in the transport vehicle, which resulted in the wheelchair being tipped over on its side when the driver swerved to miss another vehicle. Resident #20 sustained a fractured rib and moderate damage to the spleen which required admission to a hospital trauma center. The facility was unable to provide documentation of training or competency for securing wheelchairs in transport vehicles.On 01/14/26 at 3:38 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation.On 01/14/26 at 4:00 p.m., the administrator and DON were notified of the IJ situation and provided the IJ template.On 01/15/26 at 9:35 a.m., an acceptable plan of removal was received. The plan of removal, read in part, transport stopped 01/14/26 .a mandatory in-service and hands-on training for all staff assigned to resident transport. Training included correct wheelchair orientation in the vehicle, engaging wheelchair brakes, proper four-point tie-down attachment to wheelchair frame, proper strap tightening until no movement remains, application of separate occupant lap and shoulder belt, final tug test and visual verification before vehicle movement, procedure to follow if securement cannot be achieved. Each designated transporter completed a hands-on demonstration on the facility transport vehicle, the administrator and director of nursing completed and signed a competency validation checklist for each transporter.On 01/15/26 at 1:15 p.m., the immediacy was lifted, effective 01/14/26, after all components of the plan of removal were verified to be completed. In-services were reviewed, staff were interviewed to ensure training was completed and competency skills were reviewed. The deficient practice remained at an isolated level with the potential for more than minimal harm. Based on record review and interview, the facility failed to ensure a resident in a wheelchair was free from accidents or injuries during transportation for 1 (#20) of 1 sampled resident reviewed for injury during transport.The administrator identified 45 residents resided in the facility.Findings: A quarterly assessment, dated 10/27/25, showed Resident #20 had a BIMS of 13 which indicated the resident's cognition was intact. The assessment showed Resident #20 was dependent for positioning and was wheelchair bound. A Transportation and Vehicle Use policy, dated 12/26/25, read in part, All drivers must complete: defensive driving training, wheelchair and mobility device securement training, resident safety and transfer training .facility transportation orientation, drivers must complete refresher training at least annually.Wheelchair and Seatbelt Securement: all residents must be secured before vehicle movement, wheelchair users must have wheelchair locked, four-point tie-down system secured and lap and shoulder belt applied .drivers must visually confirm securement before moving the vehicle. Employee files for transporter #1 and transporter #2 were reviewed and did not show documentation for staff regarding skills checks or training for properly transporting residents. A state reportable facility incident, dated 12/30/25, showed transporter #1 improperly secured (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #20 in the transport vehicle, which resulted in the wheelchair being tipped over on its side when the driver swerved to miss another vehicle. Resident #20 had injuries requiring admission to the hospital trauma center with a fractured rib and moderate damage to the spleen. The facility was unable to provide documentation of training or competency for securing wheelchairs in transport vehicles. A nursing narrative note, dated 12/31/25, showed Resident #20 had a rib fracture and a grade 2 spleen injury. A significant change assessment, dated 01/12/26, showed Resident #20 had a BIMS of 12 which indicated they were moderately impaired for daily decision making. The assessment showed Resident #20 was dependent for positioning and was wheelchair bound. On 01/13/26 at 9:10 a.m., Resident #20 stated they were in an accident in the facility van where the wheelchair turned over while going to a doctor appointment in the city. Resident #20 stated they were going down the highway and swerved, the next thing they knew they were on the floor. Resident #20 stated they went to the hospital and stayed there a few days and returned home to the facility. Resident #20 stated they still had some pain and discomfort they took medications for. On 01/14/26 at 10:04 a.m., transporter #1 stated they placed Resident #20 in the van facing the front of the vehicle. They stated they strapped the wheelchair with the four-point strap system and placed the seatbelt around Resident #20. Transporter #1 stated they had training 15 years ago when they were hired for the position. Transporter #1 stated they had not had any training since. They stated the securing straps must not have been tight enough to hold the wheelchair in place. On 01/14/26 at 10:30 a.m., the DON stated transporter #1 did not secure the wheelchair in the van tightly enough. They stated the transportation staff had been scheduled for defensive driver training, but they have not completed it yet. The DON stated there was not an annual competency or training program for drivers. The DON stated the current drivers train the new ones when hired.