STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375550	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beadles New Beginnings	730 Share Drive 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop comprehensive care plan interventions for trauma informed care for 1 (#20) of 2 sampled residents reviewed for PTSD.The DON identified 29 residents resided in the facility and two residents had PTSD. Findings: A quarterly assessment for Resident #20, dated 02/11/26, showed the resident was originally admitted on [DATE] and had a BIMS score of 15, indicating intact cognition. The assessment showed Resident #20 had diagnoses which included schizoaffective disorder, major depressive disorder, anxiety, and PTSD. A care plan for Resident #20, updated on 02/23/26, did not show interventions for PTSD. A monthly medication review for Resident #20, dated 04/13/26, showed the resident received the following medications: a. hydroxyzine (an antihistamine) 50mg three times daily for anxiety, b. paliperidone (an antipsychotic) 9mg daily in evenings for schizophrenia,c. duloxetine (a selective serotonin and norepinephrine reuptake inhibitors) 60mg daily for depression, d. fluphenazine (an antipsychotic) 2.5mg twice daily for schizoaffective disorder, ande. trazodone (a serotonin receptor antagonists and reuptake inhibitor) 100mg at bedtime for depression. On 04/30/26 at 10:55 a.m., CNA #1, CNA #3, and CNA #4 stated they did not know Resident #20 had a diagnosis of PTSD. On 04/30/26 at 11:16 a.m., the DON stated they were not aware of any specific care interventions for Resident #20's PTSD. On 04/30/26 at 11:30 a.m., the MDS coordinator verified PTSD should have been included in the resident's comprehensive care plan.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure a resident who utilized a Velcro belt in their wheelchair was assessed for use for 1 (#31) of 1 sampled resident reviewed for accidents. The DON identified one resident used a Velcro safety belt in a wheelchair. Findings: On 04/27/26 at 12:22 p.m., Resident #31 was observed sitting in a wheelchair in the dining room with a loosely fitting Velcro belt in place around their waist. On 04/29/26 at 11:29 a.m., CMA #1 was observed to instruct Resident #31 to remove the Velcro belt. Resident #31 was observed to release the belt only after CMA #1 reassured them they would help secure the belt back in place. A facility policy titled Restraints, updated 05/12/23, read in part, All residents must have an assessment performed to determine the safety and protective needs of the resident prior to application of restraints or medical protective devices.the medical record must include: a. the reason for the restraints, b. symptom condition, and alternative attempts prior to restraint implementation, c. criteria for continued, or discontinued of restraint device, d. assessment at least monthly for continuation of the need for the restraint, and e. an order of a physician permitted by the state and by the facility. A care plan for Resident #31, initiated 01/14/25, showed the resident was at risk for falls related to mobility behaviors. An intervention in the care plan for Resident #31, dated 04/08/25, showed Velcro belt in place on wheelchair. A quarterly MDS assessment for Resident #31, dated 04/21/26, showed the resident was admitted to facility on 04/26/17 with a BIMS score of 0, indicating severe cognitive impairment. A diagnoses list for Resident #31, updated 04/23/26, showed the resident had diagnoses of pervasive developmental disorders, sever intellectual disabilities, and hypersomnia. On 04/28/26 at 8:08 a.m., Resident #31's family member stated the Velcro belt prevented the resident from falling out when they leaned forward to pick up something from the floor. On 04/28/26 at 12:20 p.m., the DON and the MDS coordinator verified a restraint assessment or ongoing documentation had not been completed. The DON stated no physician order or pre-restraining assessment was written. The DON stated they had not documented criteria for the need to discontinue or continue the Velcro belt. The MDS coordinator stated the restraint section was not checked on the MDS because movement was not prevented and was used to enable movement and promote mobility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review and interview, the facility failed to ensure hand hygiene was performed during the provision of wound care to help prevent the development and transmission of communicable diseases and infections for1 (#18) of 1 observation for pressure ulcers. The administrator identified 29 residents resided in the facility. The DON identified two residents with wound care treatments.Findings: On 04/28/26 at 3:09 p.m., during a wound care observation for Resident #18, LPN #1 was observed to clean, dry, measure, and apply treatment and dressing to the wound as ordered. LPN #1 was not observed to change their gloves after cleansing the wound and before applying the clean treatment. On 04/28/2026 at 3:18 p.m., LPN #1 was observed to remove their gloves and placed them in a red bag. A quarterly assessment for Resident #18, dated 04/06/26, showed the resident had a pressure ulcer and was dependent with mobility. A physician's order for Resident #18, dated 04/26/26, showed wound care orders to coccyx every day. An undated policy titled Clean Dressing Change Infection Control Policy, read in part, It is the policy of the facility to ensure dressing changes are performed in accordance with State and Federal regulations and national guidelines.Remove dressing and place in the resident's trash can, doff gloves, perform hand hygiene, don clean gloves, cleanse wound with gauze and prescribed cleaning solution using single outward strokes.Doff gloves, perform hand hygiene, don clean gloves, apply treatment if ordered, doff gloves, perform hand hygiene, don clean gloves, apply clean dressing as ordered. On 04/28/26 at 3:22 p.m., LPN #1 stated the policy and procedure for hand hygiene during wound care was to sanitize in between dirty and clean. They stated when the dirty dressing was removed, gloves should be changed, and again anytime they touched something dirty with those gloves. LPN #1 stated they thought they had changed their gloves before applying the treatment and stated they should have. On 04/29/26 at 1:05 p.m., IP #1 read the entire policy when asked what the policy for hand hygiene was with wound care. On 04/29/26 at 1:13 p.m., IP #1 stated they would expect to perform hand hygiene after cleaning a wound and prior to the application of the treatment.