STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375358	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Skilled Nursing and Therapy Jenks	711 North 5th Street Jenks, OK 74037

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 41809 Based on record review and interview the facility failed to ensure notification to the physician of a change in status for one (#1) of three residents reviewed for notification of change. The Business Office Manager identified 126 residents who resided in the facility. Findings: A Resident's Family or Physician Notification of Change Guideline policy, effective 12/01/09, read in parts, . The facility will .consult with the resident's physician .a significant change in the resident's physical, mental, or psychosocial status . Resident #1 had diagnoses which included congestive heart failure, chronic kidney disease, and a sacrum pressure ulcer. A Physician's Order, dated 04/04/24, documented to obtain blood pressure twice a day and to report to the physician if the systolic blood pressures were greater than 170 or below 90, and if diastolic blood pressure was greater than 100 or below 70. The Medication Administration Record, dated April 2024, documented a blood pressure of 99/59 at 6:00 p.m. on 04/11/24 and a blood pressure of 78/40 on 04/12/24. Review of the progress notes did not reveal the physician had been notified of the blood pressures. On 04/18/24 at 1:14 p.m., LPN #1 stated they were 99% sure they had not documented notification because they failed to call the physician. On 04/18/24 at 2:18 p.m., the nurse practitioner stated they were not notified via telephone of the low blood pressure. They stated they had identified the low blood pressure during a review of the clinical record. The nurse practitioner stated after an unsuccessful attempt to intervene related to Resident #1's low blood pressure at the facility, the resident was sent to the hospital for evaluation and treatment.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 35474 Based on record review and interview, the facility failed to ensure dependent residents were offered/provided showers for two (#2 and #4) of six sampled residents who were reviewed for ADL care. The DON identified 63 residents who were dependent on staff for bathing. Findings: 1. Resident #2 had diagnoses which included fracture of the left femur. The five day assessment, dated 11/26/23, documented Resident #2 required moderate assistance from staff with bathing. A Skilled Nurses Note, dated 11/28/23, documented the resident had received a shower. Review of the electronic health record revealed one shower/bath had been offered/provided from 11/20/23 through 12/02/23. On 04/19/24 at 3:33 p.m., Regional Nurse #1 stated they had reviewed the electronic health record and did not find documentation baths/showers had been offered/provided other than 11/28/23 for Resident #2. 2. Resident #4 admitted with diagnoses which included right and left humerus fractures. The admission assessment, dated 04/07/24, documented Resident #4 required maximum assistance with showers/bathing. Review of the bathing task for Resident #4 documented bathing was scheduled for Wednesday and Saturday. The task documented one bath/shower occurred since admission on 04/01/24. On 04/19/24 at 3:47 p.m., the DON stated themselves and the ADON monitored showers during Q2 meetings and asked residents on Fridays if their showers had been completed. The DON stated they had realized showers were not being completed so they began staffing shower aides in January 2024. They stated when a resident refused a shower, a refusal sheet was to be signed by the aide and the resident.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 41809 Based on record review and interview, the facility failed to ensure wound care was provided as ordered for one (#1) of three residents reviewed for pressure wounds. The DON identified 18 residents with pressure wounds. Findings: Resident #1 was admitted with diagnoses which included a sacral pressure ulcer. A Physician's order, dated 03/07/24, documented to cleanse the sacrum with normal saline, apply medihoney/durafiber ag (silver), and cover with bordered foam daily. The Treatment Administration Record, dated March 2024, revealed wound care had not been documented as completed eight times out of 22 opportunities. A Physician's Order, dated 03/14/24, documented to paint the left heel with skin prep and leave open to air every shift and as needed. The Treatment Administration Record, dated March 2024, documented the left heel wound treatment had not been documented as completed nine times out of 31 opportunities. A Physician's Order, dated 04/04/24, documented to cleanse the sacrum wound with normal saline, pack wound with dakins soaked gauze, cover with an ABD (abdominal) pad, and secure with tape daily. The Treatment Administration Record, dated April 2024, revealed the wound care to the sacrum had not been documented as completed one time out of eight opportunities. On 04/18/24 at 1:14 p.m., the wound nurse stated they did not know why the wound care had not been completed on Sunday 04/17/24. The wound nurse stated they must not have documented wound care for Resident #1 because they had provided it as ordered. On 04/19/24 at 4:25 p.m., the DON stated corporate staff monitored to ensure wound treatments were completed and they usually received a report if treatments were missed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 35474 Based on record review and interview, the facility failed to ensure weights were monitored as ordered by the physician for two (#4 and #8) of five sampled residents reviewed for nutrition. The DON identified nine residents who had experienced significant weight loss. Findings: The Weight List policy, dated 10/21/09, read in part, .Residents weights are routinely and systematically monitored . 1. Resident #8 had diagnoses which included osteoporosis. The Care Plan, dated 02/13/24, documented the resident was at risk for a nutritional problem related to anemia and GERD and an intervention for weekly weights. The electronic health record, dated 03/07/24, documented a weight of 83.6 pounds. A Physician's Order, dated 03/14/24, documented to obtain weekly weights every seven days for weight loss. The Treatment Administration Record, dated 03/14/24 through 03/31/24, documented a weight had been obtained on 03/18/24 and 03/25/24. The electronic health record did not contain documentation of the value of the weight. The Treatment Administration Record, dated 04/01/24 through 04/18/24, documented a weight had been obtained on 04/01/24, 04/08/24, and 04/15/24. The electronic health record did not contain documentation of the value of the weight on 04/01/24 or 04/15/24. The electronic health record, dated 04/08/24, documented a weight of 83.0 pounds. On 04/19/24 at 3:46 p.m., the DON stated weekly weights should be documented in the electronic health record. They stated they would need to review the records but there may not be a space to document weekly weights on the treatment record. 2. Resident #4 had diagnoses which included right and left humerus fractures. A Care Plan, dated 04/05/24, documented Resident #4 was at risk for unplanned weight loss. An intervention documented to monitor and report signs and symptoms of malnutrition, i.e. emaciation, muscle wasting, and significant weight loss which included a three pound loss in one week, >5% loss in one month, >7.5% loss in three months, or >10% loss in six months. The intervention documented to administer multivitamins, and to provide and serve a regular diet as ordered with superceral at breakfast. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/16/24 at 10:13 a.m., Resident #4 stated they usually do not eat breakfast. The breakfast meal was observed to be uneaten. Resident #4 stated they had unintentionally lost weight since they admitted to the facility. Review of weights for Resident #4 revealed an admission weight on 04/02/24 of 136 pounds and a weight on 04/16/24 was of 123 pounds which was a 13 pound loss in 14 days. On 04/19/24 at 6:04 p.m., the DON stated they did not find any further documentation of the weight values for Resident #4 or Resident #8.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 41809 Based on record review and interview, the facility failed to ensure pain management was provided for one (#1) of three sampled residents who were reviewed for pain management. The DON identified six residents who received routine pain medication. Findings: Resident #1 had diagnoses which included a sacral pressure wound and fracture of the sixth and seventh cervical spine. A Physician's Order, dated 04/05/24, documented to administer hydrocodone/acetaminophen 5/325 mg one tablet by mouth every six hours for pain. The Medication Administration Record, dated April 2024, did not contain documentation of the effectiveness of the pain medication. Review of the electronic health record did not reveal documentation of the effectiveness of the routine pain medication. On 04/18/24 at 1:39 p.m., CMA #1 stated they did not monitor for effectiveness of routine pain medication. On 04/18/24 at 1:50 p.m., LPN #1 stated they did not document the effectiveness of routine pain medication. They stated staff asked the resident if the medication were effective but do not document the response. On 04/19/24 at 5:12 p.m., the DON stated pain assessments were completed every three months and one hour after pain medication was administered the charge nurses were to monitor for effectiveness. The DON stated monitoring for effectiveness of routine pain medications was not documented in the clinical record.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 35474 Based on observation, record review, and interview, the facility failed to ensure snacks were provided for four (#2, 6, 9, and #10) of five residents reviewed for nutrition. The DON identified 27 residents who were diabetic. Findings: 1. Resident #2 had diagnoses which included diabetes mellitus. The Documentation Survey Report v2, dated November 2023, did not contain documentation snacks had been offered/provided from 11/20/23 through 11/30/23. The Documentation Survey Report v2, dated December 2023, did not reveal snacks had been offered/provided on 12/01/23. 2. Resident #6 had diagnoses which included diabetes mellitus. Review of the electronic health record, dated 04/09/24 through 04/18/24, did not reveal snacks had been offered/provided. On 04/19/24 at 4:07 p.m., Resident #6 stated they were not offered snacks and was unaware they were available. 3. Resident #10 had diagnoses which included GERD. The admission assessment, dated 01/30/24, documented the resident was cognitively intact for daily decision making. Review of the electronic health record, dated 04/19/24, revealed documentation the resident had been offered and accepted a snack once during the 30 day look back period. On 04/19/24 at 2:20 p.m., the dietary manager stated they delivered snacks to the nurses stations at 2:00 p. m. for the afternoon snack and at 4:00 p.m. for the bedtime snack. On 04/19/24 at 2:27 p.m., the dietary manager delivered snacks to the nurses station for 100, 200, 300, and 400 halls. On 04/19/24 at 3:18 p.m., Resident #10 was observed to wheel themselves to the nurses station and obtained a snack from CNA #1. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/19/24 at 3:35 p.m., Resident #10 stated they wheeled to the nurses station to obtain snacks. They stated staff did not offer snacks but they could get a snack if they went to the nurses station and asked. 4. Resident #9 had diagnoses which included cerebrovascular disease. On 04/19/24 at 2:44 p.m., Resident #9 stated they received snacks but did not always eat them. Review of the electronic clinical record revealed the resident was offered a snack seven days out of 30 days reviewed. The electronic health record did not document if snacks were offered and refused. On 04/19/24 at 3:38 p.m., CNA #1 stated residents could ask for snack anytime but they did not offer them to the residents. They stated residents just came to the nurses station if they wanted a snack. CNA #1 stated they were not sure how bed bound residents obtained a snack. On 04/19/24 at 3:40 p.m., CNA #2 stated most residents would come to the nurses station to obtain snacks and sometimes they passed them out on the hall. They stated they were not aware of where to document snacks. On 04/19/24 at 3:51 p.m., the DON stated CNAs were to pass snacks at bedtime and if residents asked for snacks they were available at the nurses station. They stated bed bound residents would need to use their call light and ask the CNAs to obtain a snack for them. They stated residents who had a diagnosis of diabetes mellitus had orders for snacks at bedtime.