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	09/05/2024

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.

(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. 42171 On 09/05/24, a Past Noncompliance Immediate Jeopardy situation was determined to exist related to the facilities failure to ensure Resident #1 was supervised and not using oxygen while smoking. A plan of correction document, titled Smoking Incident, the facility documented the facility completed the following actions: - Designated the smoking area as the patio off the north unit. - Posted No Oxygen Beyond This Point signs on the smoking area doors. - Added No Smoking signs to the garden area and the south door. - In-serviced all staff on smoking policy/plan. - Held a resident council meeting to discuss changes with residents. - Reassessed all residents who smoke for safety. - Updated smoking contracts on residents who smoke. - Educated residents on smoking hazards, options for smoking cessation and vaping. - All smoking will now be supervised, all smoking material will be secured by staff. - Smoking will be from 8:00 am until 8:00 pm on even hours. - All units now have a red folder with a current list of residents who smoke. A Quality Assurance Committee meeting was held on 08/28/24 at 1:00pm. On 09/05/24 staff were interviewed regarding recent training related to smoking and safety. All components of the plan of correction were verified. It was determined that the facility was in substantial compliance. (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on record review and interview, the facility failed to ensure a resident who required supervision while smoking was supervised and did not wear oxygen while smoking for one (#1) of four residents reviewed for smoking. The Administrator reported the census was 120. Findings: A facility policy titled Smoking Policy and Procedure, revised 02/24/20, read in parts .Oxygen equipment is not permitted in smoking areas. Smoking is not permitted while in possession of or in the presence of oxygen equipment .If it is determined by the interdisciplinary team that the resident is unable to smoke without supervision, such team will develop a plan that will allow the resident to smoke with supervision . Resident #1 had diagnoses which included dementia and chronic obstructive pulmonary disease. A quarterly assessment, dated 06/05/24, documented Resident #1 was moderately impaired for daily decision making and could independently operate a manual wheelchair. A physician's order, dated 07/29/24, documented the resident was to receive oxygen at 2-4 liters per minute via a nasal cannula as needed to maintain an oxygen saturation above 90 percent. A Smoking/Vaping Supervision Checklist, dated 06/19/24, documented Resident #1 was to be supervised while smoking. A nurse note, dated 08/27/24 at 7:26 p.m., documented that at 4:00 pm the nurse was notified by a CMA that Resident #1 was on fire. The nurse accompanied the CMA outside where Resident #1 was sitting in a wheelchair that appeared burned or melted, Resident #1 was naked and appeared to have multiple areas of burned skin. The note further documented that it appeared Resident #1 had tried to smoke with their oxygen on. The note documented the resident was transported via EMS to a hospital burn center. On 09/09/24 at 10:03 am, a supervised smoke break was observed. Two staff members were present along with eight residents, two residents were observed to be wearing smoking aprons. RA #1 stated that each nurses desk has a red folder with a list of smokers and what interventions are required. They also stated that staff now secures everyones smoking material. On 09/05/24 at 12:10 p.m., LPN #1 stated that on 08/27/24 around 4:00 pm they were called to the courtyard area by a CMA. They stated Resident #1 was no longer on fire when they arrived outside, and several staff members were present trying to assist the resident. They stated that Resident #1 was conscious and complaining they could not breathe, Resident #1 was taken inside and placed on oxygen. LPN #1 stated they provided assistance to Resident #1 until EMS arrived. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/05/24 at 1:00 p.m., the ADON stated that on 08/27/24 around 4:00 pm they were in their office when they heard someone yelling fire, they went to investigate and located the resident outside with several staff members. They stated by the time they arrived the fire was out, and staff were assessing and rendering aid to the resident. They also stated that Resident #1 was alert when EMS took them out of the building and that they were told the next day by Resident #1's hospice provider that the resident had passed away at the hospital. On 09/05/24 at 1:27 p.m., CMA #1 stated that on 08/27/24 around 4:00 p.m. they had gone outside to administer medication to Resident #5 who was under the gazebo. They stated Resident #5 pointed at Resident #1 across the courtyard and yelled that Resident #1 was on fire. CMA #1 stated that they observed Resident #1 seated in their wheelchair burning. CMA #1 stated they did not have anything to put out the fire with, so they ran inside to get help. CMA #1 stated that no staff members had been supervising Resident #1. On 09/05/24 at 3:34 p.m., CNA #1 stated that on 08/27/24 around 4:00 p.m., they were in the dining room passing out drinks for dinner when they heard someone yelling about a fire. CNA #1 reported they observed Resident #1 seated in their wheelchair on fire in the courtyard. They also reported that they got a shower blanket and went outside and began smothering the flames with the blanket. CNA #1 reported that after the fire was out and Resident #1 was transferred to another wheelchair they were brought inside until paramedics arrived. CNA #1 stated Resident #1 was not being supervised while smoking. On 09/05/24 at 2:50 p.m., the administrator stated that their investigation did not indicate Resident #1 was being supervised while smoking on 08/27/24. The administrator also stated fire blankets had been ordered, but had not been received.