

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
NAME OF PROVIDER OR SUPPLIER Grace Skilled Nursing and Therapy Jenks		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>20960</p> <p>Based on record review, and interview, the facility failed to ensure a resident who had not had a bowel movement for three more days had their attending physician notified for one (#16) of one sampled resident reviewed for constipation.</p> <p>The DON identified 70 residents who had a diagnosis of constipation.</p> <p>Findings:</p> <p>The facility policy, titled Nursing Policies and Procedures Constipation, dated 10/10/03, read in part, .It is the policy of the facility to identify bowel elimination problems and intervene to assist residents with optimal bowel elimination. Assessment for constipation is initiated from a resident complaint or observation that the resident has been 3 days without a bowel movement .procedure for identification .review the flow sheet documentation to determine frequency .assess for signs and symptoms of constipation .identify usual bowel elimination patterns .procedure for correction notify the attending physician .</p> <p>Resident #16 had diagnoses which included encounter for orthopedic aftercare following a surgical ambulation and constipation.</p> <p>Resident #16's quarterly assessment, dated 08/07/24, documented they had moderate impairment with cognition and was always continent of bowel and bladder.</p> <p>ADL documentation for 08/29/24 through 09/05/24 documented Resident #16 had a bowel movement on 08/30/24.</p> <p>The next documented bowel movement for Resident #16 was five days later on 09/05/24. Resident #16 had not had a bowel movement in five days and the documentation on 09/05/24 indicated the resident was constipated.</p> <p>There was no documentation Resident #16's physician had been notified of them not having a bowel movement for five days and being constipated.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #16's September 2024 MAR documented they received an as needed order of magnesium hydroxide oral suspension (laxative medication) 400 MG/5 ML (magnesium hydroxide) 30 ml for constipation on 09/05/24 at 10:50 p.m.</p> <p>Resident #16's ADL documentation for 09/06/24 documented they did not have a bowel movement.</p> <p>There was no documentation Resident #16's physician had been notified of no bowel movements on 09/06/24.</p> <p>Resident #16 ADL documentation for 09/07/24 documented the they did not have a bowel movement.</p> <p>Resident #16's progress note, dated 09/07/24 at 4:36 p.m., documented, Therapy here working with resident. [He/She] states that resident states that [he/she] is constipated. Abdomen soft, ABS x 4. [He/She] is complaining of [his/her] rectum hurting I checked it and a sm amt of runny BM at entrance. No impaction noted. Bedside commode has wipes in it with smears of BM. No noted BM in commode. Informed [Name withheld] and new order received for Miralax [laxative medication] 17GM daily and Dulcolax [laxative medication] 5mg 2 BID PRN.</p> <p>A progress note, dated 09/07/24 at 4:36 p.m., documented notification to Resident #16's physician.</p> <p>On 09/19/2024 at 9:53 a.m., RN # 1 stated they were not aware Resident #16 was constipated and went five days without a bowel movement. They stated they had never notified the physician. RN #1 stated the physician was not notified until 09/07/24 when the resident went out to the hospital.</p> <p>On 09/19/24 at 11:11 a.m., the DON stated they identified the resident had not had a bowel movement for more then three days when they came back from vacation. They stated they realized nothing had been addressed. They stated the physician had not been notified until 09/07/2024 when the resident went to the hospital.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>20960</p> <p>Based on record review and interview, it was determined the facility failed to report an allegation of neglect to OSDH for one (#86) of one sampled resident reviewed for neglect.</p> <p>The DON identified 123 residents resided in the facility.</p> <p>Findings:</p> <p>The Resident Abuse, Neglect and Misappropriation of Property policy, revised 12/28/17, read in part, . neglect is defined as failure to provide good and services necessary to avoid physical harm, mental anguish or mental illness. Neglect occurs on an individual basis when a resident receives a lack of care in one or more areas .Facility responsibility .All allegations and incidents of abuse, neglect .must be reported to appropriate Federal and State Agencies including OSDH and investigated .</p> <p>Resident #86's quarterly MDS assessment, dated 07/18/24 , documented their cognition was intact and they had no cognitive impairments.</p> <p>The facility form, Quality Assurance Patient Concern Form, dated 09/10/24, read in part, .Resident complained about nurse aide not providing good care. Nurse Aide was told to help change people but refused .</p> <p>There was no documentation the facility had reported the allegation of neglect to OSDH.</p> <p>On 09/17/24 at 8:28 a.m., Resident #86 stated they had turned on their call light and after several hours an aide shut it off without providing care to both their roommate and themselves. The resident stated the nurse aide, after shutting off the call light, stated they would come back and provide care to the roommate and never returned. The resident stated they had spoken with and filed a complaint of the care not being provided with the ADON about two weeks previously. They stated nothing was done about it.</p> <p>On 09/18/24 at 3:12 p.m., the ADON confirmed Resident #86 had complained about the lack of care and they stated they reported it to the administrator. The ADON stated a grievance form was filled out and the administrator completed everything after that. They stated they did not document the report from the resident and was not sure who it all was reported to.</p> <p>On 09/19/24 at 2:10 p.m., the administrator confirmed they had spoken with the ADON and a grievance form was filled out. They stated they only reported to OSDH if they felt abuse occurred and it was the opinion of Resident #86 care was not provided.</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>35474</p> <p>Based on record review and interview, the facility failed to ensure assessments were transmitted within the time frame for one (#53) of one sampled resident who was reviewed for timely transmission of assessments.</p> <p>The DON identified 123 residents who resided in the facility.</p> <p>Findings:</p> <p>Resident #53 had diagnoses which included dementia.</p> <p>The electronic clinical record documented a significant change assessment had an ARD date of 06/20/24 and was completed 07/04/24.</p> <p>A Assessment History form, dated 09/20/24, documented the significant change assessment, dated 06/20/24, had been transmitted on 09/16/24.</p> <p>On 09/20/24 at 1:23 p.m., corporate MDS coordinator #1 stated during the time of the transmission of the significant change assessment the facility had not had an MDS coordinator. They stated they had been assisting with MDS completion and transmission.</p> <p>On 09/20/24 at 1:34 p.m., corporate MDS coordinator #1 stated the facility's MDS coordinator and the corporate office were responsible to monitor to ensure assessments were transmitted timely. They stated monitoring occurred twice a week and they were looking into the reason the significant change assessment for Resident #53 had been transmitted late.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>41220</p> <p>Based on record review and interview, the facility failed to keep medication records in order and keep an accurate account of reconciled controlled drugs for one (Resident #110) of one sampled resident reviewed for drug reconciliation.</p> <p>The administrator reported 123 residents received medications in the facility.</p> <p>Findings:</p> <p>A policy titled Medication Storage in the Facility, dated January 2022, read in part, .Completed accountability records are submitted to the director of nursing and kept on file for 5 years at the facility .</p> <p>A facility policy titled Specific Medication Administration Procedure, dated January 2022, read in part, Chart medication administration on Medication Administration Record immediately following each resident's medication administration.</p> <p>Resident #110 had diagnosis which included an unspecified fracture of right pubis.</p> <p>A physician order, dated 03/15/24, documented oxycodone (opioid medication) 5 mg. Give one table by mouth every 4 hours as needed for pain. The order was discontinued on 07/31/24.</p> <p>A review of the MARS for March, April, May, June, and July of 2024 documented the resident had received a total of 18 doses of oxycodone during this period.</p> <p>A review of the narcotics sheets for oxycodone for March, April, May, June, and July of 2024 documented a total of 49 doses of oxycodone was administered from 03/15/24 to 07/31/24. The first page of the narcotics count sheet was not provided.</p> <p>On 09/19/24 at 2:02 p.m., CMA #4 stated narcotics were counted at the end of each shift. They stated CMAs and LPNs would do the controlled medication counts.</p> <p>On 9/19/24 at 2:02 p.m., The corporate nurse stated an investigation was conducted into Resident #110's controlled medication due to a report of a missing medication card. They stated the investigation determined medication had been ordered, but the pharmacy had not sent the medication. They stated during their investigation it was discovered the CMAs and LPNs were not documenting the medication given in the electronic record, but were frequently only documenting on the narcotic sheets. The corporate nurse stated they looked at the narcotic sheets to determine if there was potential medication diversion, but determined there was not evidence of diversion. They stated there was a problem with documentation in the electronic record. They stated after the investigation and drug reconciliation with the pharmacist, the first sheet of the narcotic record had been misplaced. The corporate nurse stated they and the DON and medical records staff were searching for the missing sheet.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/19/24 at 04:07 p.m., the pharmacist stated they were confident the missing count sheet was available during medication destruction.</p> <p>The missing count sheet was not provided to the survey team by the end of the survey.</p>