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	06/02/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, record review, and interview, the facility failed to ensure resident's right of choice regarding diet for 1 (#2) of 3 residents sampled reviewed for resident rights. The administrator identified 111 residents resided at the facility. Findings: On 05/28/25 at 8:23 a.m., Resident #2 was observed to be in their room drinking soda. An admission assessment, dated 07/25/23, showed Resident #2 had a brief interview for mental status score of 14 which indicated the resident's cognition was intact. The assessment showed the resident had diagnoses which included history of stroke and aphasia. A physician's order, dated 07/25/23, showed a regular diet of regular texture and thin liquids. A hospital discharge record, dated 01/11/24, showed a diet order for low cholesterol, low fat, and low sodium. A physician's order, dated 01/11/24, showed a regular diet, level 6-soft and bite-sized texture with honey thick liquids. On 05/28/25 at 8:23 a.m., Resident #2 stated they received a soft diet and did not want a soft diet and thickened liquids. They stated they had not ever choked on their food or drink. Resident #2 stated they were told by staff at the facility they would choke if they ate regular food. On 05/29/25 at 12:18 p.m., Resident #2 stated friends had brought them food from outside the facility like pizza, cake, candy chips, and soda pop. They stated the last swallow evaluation they had was while they were at home. Resident #2 stated they had not had a swallow evaluation while at the facility because the facility informed them their insurance would not cover it. Resident #2 stated they had been eating regular food while at home and when they first admitted to the facility. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/29/25 at 1:21 p.m., the ADON stated the nurses transcribed the orders from the hospital and entered them into the electronic clinical record. They stated Resident #2 had signed a waiver to eat regular food while on hospice after their hospitalization, but had since been discharged from hospice and the facility did not offer a waiver. The ADON stated they did not know where the soft diet order had originated from. They stated they did not remember if Resident #2 had a swallow study and were not aware if Resident #2 had any incidents of choking. The ADON stated the only thing they could think of was when Resident #2 returned from the hospital, they had requested over easy eggs instead of scrambled and maybe that was where the soft diet had originated. On 06/02/25 at 10:21 a.m., the social services director stated they did not know where the order had originated. They stated Resident #2 had been on hospice and had signed a waiver for a regular diet, but had since been discharged from hospice and the diet would have reverted back to a soft diet. On 06/02/25 at 10:39 a.m., the administrator stated they would not know why Resident #2 was ordered a soft diet and would need to get with nursing. The administrator stated the facility did not offer any waivers to any residents. They stated they did not tell Resident #2 they could not eat regular food, but they would not offer a waiver. On 06/02/25 at 11:08 a.m., the administrator and interim DON stated they had a physician's order and they were following it. The DON stated they would not question the physician for a justification for the order. On 06/02/25 at 11:14 a.m., the primary physician of Resident #2 was called and a voicemail was left for them to return the call. No return call was received. On 06/02/25 at 12:45 p.m., via phone call, LPN #1 stated after reviewing the hospital discharge orders for Resident #2 they could not trace the soft diet order to the discharge orders. They stated they believed the order on 01/11/25 was an error and the order was meant for another resident. LPN #1 stated they were not the nurse for Resident #2 on that day, but had been the admission nurse for the facility and had entered the orders from the hospital on that date. On 06/02/25 at 12:49 p.m., via phone call, the medical director stated they believed the soft diet order was due to a stroke and Resident #2 had a diagnosis of dysphasia. The medical director was informed the hospital discharge paperwork nor the facility had a diagnosis of dysphasia for Resident #2. The medical director was informed Resident #2 had no incident of choking. The medical director stated they were not the primary physician for Resident #2. On 06/02/25 at 12:51 p.m., via phone call, the office of the primary physician for Resident #2 was called and their office informed the primary physician was out of the office seeing patients and would return the call later in the afternoon. A return phone call was not received before the end of the survey.