

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  09/03/2025
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 0620</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide.</p> <p>Based on record review and interview, the facility failed to ensure a resident's damaged personal property was replaced for 1 (#66) of 1 resident sampled who was reviewed for personal property. The administrator identified #107 residents resided in the facility. Findings: A quarterly assessment, dated 07/16/25, showed Resident #66 had a BIMS of 14 which indicated the resident's cognition was intact and diagnosis which included stroke. Review of the grievance log showed no grievance for Resident #66 regarding their television. On 09/02/25 at 9:49 a.m., Resident #66 stated after a power outage at the facility, their television would not come on. They stated he screen would stay black and they only had sound. Resident #66 stated the facility took their television and loaned them one of theirs to use, but did not replace their television. They stated the administrator told them the facility would not replace their television. On 09/02/25 at 10:41 a.m., the administrator stated they were not aware of an issue with the television for Resident #66. They stated if a power outage had fried their television the family would have to replace it because the facility did not replace personal property. The administrator stated it was in their admission agreement.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, record review, and interview, the facility failed to ensure fall interventions were implemented for 2 (#3 and #48) of 2 sampled residents who were reviewed for falls. The administrator identified 107 residents resided in the facility. Findings: 1. On 09/02/25 at 9:45 a.m., a visitor was observed in the room of Resident #3. A floor fall mat was not observed on the floor next to the bed. An over the bed grab bar was observed to be hooked onto the boom of the grab bar. On 09/02/25 at 10:17 a.m., a fall mat was not observed on the floor next to the bed or under the bed of Resident #3. On 09/03/25 at 10:19 a.m., a fall mat was not observed on the floor next to the bed of Resident #3. On 09/03/25 at 2:05 p.m., a fall mat was not observed on the floor next to the bed of Resident #3. A care plan, dated 03/31/25, showed a focus for risk for falls related to decondition, gait/balance problems, psychotropic medications, psychoactive drug use and history of falls. The care plan showed interventions which included to ensure the call light was within reach, encourage to request assistance, falling star program, Hoyer lift for transfers, replace bolsters on bed to cue resident to the edge of bed, replace posey cover to mattress, and positioning bars. An unwitnessed fall report, dated 05/12/25 at 2:00 a.m., showed Resident #3 was on the floor and upon nurse assessment, Resident #3 kept yelling they wanted to go to the hospital and did not know how they fell. The nurse assessment showed no new injuries noted, vital signs normal, and Resident #3 denied pain with notifications made to all parties. The report showed the intervention was to place a floor mat at bedside. An incident note, dated 05/12/25 at 2:48 a.m., read in part, CNA notified nurse of resident on the floor. Resident kept yelling .to go to the hospital .Head to toe [assessment] preformed on resident. No new injuries noted [sic]. An admission note, dated 05/14/25 at 4:39 p.m., showed, an incision site to left thigh with five staples noted. The note showed a bandage wrap to the left leg and immobilizer to the right leg. Review of a final state report, dated 05/16/25, showed Resident #3 sustained a closed fracture of the distal (a location farther away from the origin) end of the left femur and a tibial plateau fracture (a break in the shinbone (tibia) at the knee joint) of the right femur. An annual assessment, dated 06/12/25, showed Resident #3 had a BIMS of 13 which indicated the resident's cognition was intact and diagnoses which included arthritis, anxiety, bipolar, and respiratory failure. The assessment showed Resident #3 required supervision or touching assistance with bed mobility and transfers were not attempted due to medical condition or safety concerns. On 09/03/25 at 2:05 p.m., CMA #2 stated Resident #3 was on hospice and would normally require a fall mat, but Resident #3 did not move out of the bed. On 09/03/25 at 2:07 p.m., LPN #3 stated measures to prevent falls/injury for Resident #3 were to position them with pillows to prevent falling out of bed, keep the bed low, ensure frequent checks, and they were right by the nurse's station. LPN #3 was asked if Resident #3 required a fall mat. They stated Resident #3 could not get out of bed by themselves or even turn themselves. They stated the ADON or DON were responsible to ensure the care plan was updated. 2. On 08/29/25 at 2:34 p.m., Resident #48 was observed in bed with the fall mat under their bed. On 08/29/25 at 3:40 p.m., Resident #48 was observed in bed with the fall mat under their bed. On 09/02/25 at 9:32 a.m., Resident #48 was observed in bed with the bedside table near the head of the bed in front of their nightstand and the fall mat under their bed. An annual assessment, dated 05/21/25, showed a BIMS of 00 which indicated severely impaired for daily decision making. The assessment showed diagnoses which included chronic obstructive pulmonary disease, anxiety, and Bell's palsy. A fall risk assessment, dated 07/16/25, showed Resident #48 was a high fall risk. A progress note, dated 07/16/25 at 4:00 a.m., showed a focused assessment related to a fall on 07/16/25. The note showed Resident #48 had a laceration to the right side of the head with a hematoma (bruise) noted to the forehead. The note showed abrasions were noted to both knees with the fall mat in place. The note showed neurological checks were initiated, and Resident #48 had complained of generalized pain. The note showed an order was received to send Resident #48 to the hospital for evaluation and treatment. A care plan, revised 08/12/25, showed interventions for falls to include ensure a baby doll was in bed with Resident #48, assist with toileting at night, concave mattress while in bed, educate to not remove oxygen, fall mat at bedside, sign in room to ask for help, keep call light in reach, keep bed in lowest position, and nonskid footwear before transfers. On 09/02/25 at 11:09 a.m., CNA #1 stated the interventions for Resident #48 were a fall mat and to keep the bed low. On 09/03/25 at 2:03 p.m., CNA #4 stated interventions in place for Resident #48 were a fall mat and low bed. They stated they did not know why the fall mat was not there. On 09/03/25 at 2:20 p.m., the DON stated they provided in-service and education to the staff and observed to ensure the interventions were in place. On 09/03/25 at 5:29 p.m., LPN #4 stated Resident #48</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>Based on observation, record review, and interview, the facility failed to ensure sufficient staff to meet the needs of 1 (#110) of 1 sampled resident who was reviewed for sufficient staffing. The administrator identified 107 residents resided in the facility. Findings: On 08/26/25 at 2:10 p.m., Resident #110 was observed to be calling out for help to the bathroom. CNA #2 came down the hall to get the dirty linen cart and did not check on Resident #110. Resident #110 continued to call out for help to the bathroom. A quarterly assessment, dated 06/05/25, showed Resident #110 had a BIMS of 06 which indicated severe cognitive impairment. The assessment showed Resident #110 required supervision for sitting to standing and partial to moderate assistance with toilet hygiene. On 08/26/25 at 2:15 p.m., LPN #3 stated CNA #2 monitored the hall for residents who required assistance. LPN #3 was informed staff were not on the hall to monitor, and Resident #110 was yelling out for help to the bathroom. LPN #3 went down the hall and entered the room of Resident #110. On 09/03/25 at 5:26 p.m., CNA #6 stated they should get to call lights in a minimum of five minutes. They stated they did not feel there was enough staff to answer call lights that fast. On 09/03/25 at 5:27 p.m., CNA #2 stated they had five minutes to answer a call light, and they did not have enough staff to answer them that fast. On 09/03/25 at 5:29 p.m., CNA #7 stated they had five minutes to answer call lights, and they did not have enough staff to answer them that fast.</p>