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	11/21/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview the facility failed to ensure a clean comfortable homelike environment for 1 (#4) of 3 sampled residents reviewed for environment.The administrator identified 100 residents resided in the facility. Findings: On 11/05/25 at 9:05 a.m., Resident #4's room was observed. Two slats on the mini blinds were broken off and were missing. A one foot by one foot area on the North wall was missing paint, and several other smaller areas along the North and East wall were observed to be missing paint.On 11/05/25 at 9:05 a.m., Resident #4 stated the blinds had been broken and the paint had been missing for the three years they had been at the facility.On 11/05/25 at 9:15 a.m., CNA #1 stated they were new and they were unsure who was responsible for painting the rooms and replacing the blinds.On 11/05/25 at 9:20 a.m., LPN #2 stated that maintenance was responsible for the blinds and paint. LPN #2 stated they were unaware if maintenance was aware of the condition of Resident #4's room.On 11/05/25 at 9:25 a.m., the maintenance supervisor stated they were responsible for repainting resident rooms and replacing broken mini blinds.On 11/06/25 at 10:55 a.m., the administrator stated issues with the rooms should be reported to maintenance so they can be addressed.

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on record review and interview, the facility failed to ensure nutritional supplements were provided as ordered for 1 (#2) of 3 sampled residents reviewed for nutrition. The DON identified 48 residents were ordered supplements.Findings:A weight entry, dated 09/11/25, showed Resident #2 weighed 130.8 pounds. An annual assessment, dated 09/12/25, showed Resident #2 had a BIMS score of 00, which indicated the resident was severely impaired in cognition for daily decision making, had a diagnosis of dementia, and had a feeding tube.A care plan, updated 09/25/25, showed Resident #2 had a potential nutritional problem and was at risk for weight fluctuations.A nutrition note, dated 09/26/25, showed a recommendation from the dietician for 2.0 cal (a nutritional supplement) 30cc twice daily via feeding tube.A nurse note, dated 10/01/25, showed the facility had received a new order for 2.0 cal 30cc twice daily via feeding tube. The note was signed by the ADON. A physician order, dated 10/01/25, showed Resident #2 had been ordered 2.0 cal 30cc twice daily via feeding tube twice daily.A weight entry, dated 10/14/25, showed Resident #2 weighed 131.6 pounds.Review of the medication/treatment administration record, dated 10/01/25 through 10/31/25, did not show the order for 2.0 cal 30cc twice daily via feeding tube.Review of the medication/treatment administration record, dated 11/01/25 through 11/03/25, did not show the order for 2.0 cal 30cc twice daily via feeding tube.On 11/05/25 at 10:18 a.m., LPN #1 reviewed the medication/treatment record for Resident #2 and stated the only supplements they were ordered and received vitamin C, zinc, and a multivitamin. LPN #1 stated they or an ACMA were responsible to administer supplements via feeding tube to Resident #2.On 11/05/25 at 10:22 a.m., ACMA #1 reviewed the medication/treatment record for Resident #2 and stated they were currently ordered supplements to include vitamin C, iron, zinc, and a multivitamin.On 11/05/25 at 11:32 a.m., the ADON stated when the order was entered into the electronic clinical record for the 2.0 cal nutritional supplement it had not carried over onto the medication/treatment record for administration.On 11/05/25 at 3:50 p.m., the DON stated the order for 2.0 cal had not been placed on the medication/treatment record for administration for Resident #2. They stated they audited new orders daily, but they had not identified the nutritional supplement had not been placed on the medication/treatment record for administration by the charge nurse or the ACMA.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to ensure wound care was documented for 2 (#2 and #5) of 3 sampled residents reviewed for pressure ulcers.The DON identified 10 residents had pressure ulcers. Findings: 1.A physician order, dated 07/29/25, showed to cleanse the stage 3 pressure ulcer to Resident #2's left lateral buttock with normal saline, pat dry, and paint with Betadine (antiseptic) every shift. A physician order, dated 09/09/25, showed to cleanse the abrasion to Resident #2's right lateral buttock with normal saline, pat dry, apply Xeroform (gauze dressing), and cover with bordered foam every Tuesday, Thursday, and Saturday. An annual assessment, dated 09/12/25, showed Resident #2 had a BIMS score of 00, which indicated the resident was severely impaired in cognition for daily decision making, had a diagnosis of dementia, and had pressure ulcers. A care plan, updated 09/25/25, showed Resident #2 had impaired skin integrity and required wound care. A physician order, dated 10/07/25, showed to cleanse the stage 3 pressure ulcer to Resident #2's right medial knee with normal saline, pat dry, apply Durafiber (wound dressing), and wrap with gauze. Review of the treatment administration record, dated 10/01/25 through 10/31/25, did not show documentation wound care had been completed on 10/09/25 or 10/30/25 to the right medial knee or right lateral buttock. The treatment administration record did not show documentation wound care had been completed on 10/01/25, 10/08/25, 10/09/25, 10/29/25, or 10/30/25 for the day shift. On 11/05/25 at 10:30 a.m., wound care nurse #1 stated wound care was completed by the wound care nurses Monday through Saturday and on Sunday the charge nurses completed wound care, and they were to document on the treatment administration record. On 11/05/25 at 11:39 a.m., wound care nurse #1 stated there had been a failure to document. On 11/05/25 at 3:41 p.m., the DON stated they performed daily audits with the wound care team, followed them daily, and monitored the treatment administration records weekly. On 11/06/25 at 8:27 a.m., wound care nurse #2 stated they needed to complete more thorough documentation when wound care was completed. They stated they had completed the wound care for Resident #2 on the scheduled days in October 2025, but had missed documenting on the treatment administration record. On 11/06/25 at 10:36 a.m., the DON stated they had reviewed the treatment administration record for October 2025 and the wound care nurses had completed the wound care but they had not documented on the treatment administration record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. An admission record, dated 09/01/25, showed Resident #5 had diagnoses which included a stage 3 pressure ulcer of the sacral region and schizophrenia. A significant change assessment, dated 09/13/25, showed Resident #5 had a BIMS score of 4 which was indicative of severe cognitive impairment. A physician's order, dated 10/12/25, showed to cleanse the stage 3 pressure ulcer to Resident #5's sacrum with normal saline, pat dry, apply Triad (wound dressing) and cover with bordered foam every Tuesday, Thursday and Saturday. Review of the treatment administration record from 10/12/25 through 11/01/25 did not show documentation wound care had been completed on 10/18/25, 10/25/25 or 11/01/25. On 11/06/25 at 8:30 a.m., wound care nurse #2 stated they had performed the wound care for Resident #5 on 11/01/25, but they had not documented it.