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	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Skilled Nursing and Therapy Jenks	711 North 5th Street Jenks, OK 74037

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on record review and interview, the facility failed to ensure range of motion services were provided for 2 (#7 and #8) of 2 sampled residents who were reviewed for range of motion services.The ADON identified 49 residents had limited range of motion.Findings: 1. On 08/26/25 at 10:47 a.m., Resident #8 was observed to be unable to raise their bilateral arms past the level of their shoulders. A policy titled Restorative Nursing Program, dated 05/2025, read in part, Purpose: To maintain residents' highest practicable level of physical, mental, and psychosocial well-being .Restorative proms should be planned, monitored, evaluated, and documented. Including: Restorative assessment .Care plan .Flowsheet documentation .Weekly oversight by licensed nurse. A quarterly assessment, dated 08/08/25, showed Resident #8 had a BIMS score of 15, which indicated they were cognitively intact for daily decision making, had impairment in range of motion to one side of the upper extremity, both sides of the lower extremity, and had not received restorative services during the look back period. A care plan, updated 08/13/25, showed nursing rehab was to assist the resident with active and passive range of motion to the bilateral upper and lower extremities. Review of the electronic clinical record for August 2025 did not show the resident had received range of motion services. On 08/26/25 at 10:47 a.m., Resident #8 stated they had limited range of motion in both arms. They stated they had not received any range of motion services in the past several months. On 09/02/25 at 11:08 a.m., CNA #1 stated Resident #8 was unable to use their legs and had limited range of motion in their arms. They stated Resident #8 could not put their own hat on their head, so they had assisted them. They stated they had not been instructed to provide range of motion services or exercises for Resident #8. On 09/03/25 at 11:36 a.m., CMA #1 stated they were not aware of any services for limitation in range of motion for Resident #8. On 09/03/25 at 11:38 a.m., LPN #2 stated Resident #8 did not have any limitation in their range of motion. They stated the resident was able to utilize all of their extremities without issue. On 09/03/25 at 11:59 a.m., the care plan coordinator reviewed the care plan for Resident #8 and stated the restorative aide was to provide active and passive range of motion. On 09/03/25 at 12:38 p.m., the care plan coordinator stated they had added active and passive range of motion to the care plan because they had discussed restorative therapy for Resident #8 in May 2025. They stated they had not started restorative services for Resident #8 because the facility had not yet hired a restorative aide. On 09/03/25 at 1:21 p.m., the DON and ADON reviewed the clinical record for Resident #8. The DON stated the resident had limitation in their range of motion for the upper and lower extremities and was to receive active and passive range of motion. The ADON stated the CNAs were to perform range of motion exercises with activity of daily living care. The ADON stated the CNAs were to document range of motion services in the electronic clinical record. The ADON stated they did not know why range of motion services had not been documented by the CNAs. 2. A quarterly assessment, dated 07/23/25, showed Resident #7 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making, had impairment in range of motion on one side of their upper and lower extremities, and had not received restorative services during the look back period. A care plan, dated 07/25/25, showed Resident #7 had a right-hand contracture and that nursing rehab was to provide active and passive range of motion to (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the right upper and right lower extremities. Review of the electronic clinical record did not show range of motion services had been provided in July or August 2025. On 09/03/25 at 5:46 p.m., the DON stated they did not have restorative program in place, but the CNAs were to complete range of motion.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review and interview, the facility failed to ensure residents were assessed before and after dialysis for 2 (#8 and #4) of 2 sampled residents who were reviewed for dialysis.The DON identified three residents required dialysis.Findings: 1. A Dialysis Communication form for Resident #8, dated 07/08/25, read in part, Pre-Dialysis This section to be completed by nursing facility and sent with resident .Post Dialysis This section is to be completed by dialysis unit and returned with resident. The form showed the assessment before dialysis contained a weight and blood pressure obtained on 07/07/25 and the pulse, temperature, and respirations had been obtained on 07/05/25. The section for the post dialysis assessment had not been completed. A Dialysis Communication form for Resident #8, dated 07/19/25, read in part, Pre-Dialysis This section to be completed by nursing facility and sent with resident .Post Dialysis This section is to be completed by dialysis unit and returned with resident. The pre dialysis section of the form showed the thrill and bruit were present, the weight was obtained on 07/08/25 and the pulse, temperature, and respirations were obtained on 07/20/25. The post dialysis section of the form showed vital signs, a pre dialysis weight, and the time dialysis started and ended. The post dialysis section read in part, Signature: per dialysis nurse. A Dialysis Communication form for Resident #8, dated 07/22/25, read in part, Pre-Dialysis This section to be completed by nursing facility and sent with resident .Post Dialysis This section is to be completed by dialysis unit and returned with resident. The pre dialysis section of the form showed the thrill and bruit were present, the weight was obtained on 07/08/25, and the pulse, temperature, and respirations were obtained on 07/20/25. The post dialysis section of the form had not been completed. A Dialysis Communication form for Resident #8, dated 07/29/25, read in part, Pre-Dialysis This section to be completed by nursing facility and sent with resident .Post Dialysis This section is to be completed by dialysis unit and returned with resident. The pre dialysis section of the form showed the thrill and bruit were present, the weight was obtained on 07/08/25, and the pulse, temperature, and respirations were obtained on 07/20/25. The post dialysis section of the form had been completed by the nurse at the dialysis center. A Dialysis Communication form for Resident #8, dated 08/05/25, read in part, Pre-Dialysis This section to be completed by nursing facility and sent with resident .Post Dialysis This section is to be completed by dialysis unit and returned with resident. The pre dialysis section of the form showed the thrill and bruit were present, the weight was obtained on 07/08/25, and the pulse, temperature, and respirations were obtained on 07/20/25. The post dialysis section of the form had not been completed. A quarterly assessment, dated 08/08/25, showed Resident #8 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making, had a diagnosis of end stage renal disease, and had received dialysis. A Dialysis Communication form for Resident #8, dated 08/09/25, read in part, Pre-Dialysis This section to be completed by nursing facility and sent with resident .Post Dialysis This section is to be completed by dialysis unit and returned with resident. The pre dialysis section of the form showed the (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	thrill and bruit were present, and the weight was obtained on 07/08/25. The post dialysis section of the form had not been completed. A care plan, updated 08/13/25, showed Resident #8 was to receive dialysis every Tuesday, Thursday, and Saturday. A Dialysis Communication form for Resident #8, dated 08/14/25, read in part, Pre-Dialysis This section to be completed by nursing facility and sent with resident .Post Dialysis This section is to be completed by dialysis unit and returned with resident. The pre dialysis section of the form showed the thrill and bruit were present, the weight was obtained on 08/11/25, and the pulse, temperature, and respirations were obtained on 08/09/25. The post dialysis section of the form had not been completed. A Dialysis Communication form for Resident #8, dated 08/16/25, read in part, Pre-Dialysis This section to be completed by nursing facility and sent with resident .Post Dialysis This section is to be completed by dialysis unit and returned with resident. The pre dialysis section of the form showed the thrill and bruit were present, the weight was obtained on 08/11/25, and the pulse, temperature, and respirations were obtained on 08/09/25. The post dialysis section of the form had not been completed. A Dialysis Communication form for Resident #8, dated 08/21/25, read in part, Pre-Dialysis This section to be completed by nursing facility and sent with resident .Post Dialysis This section is to be completed by dialysis unit and returned with resident. The pre dialysis section of the form showed the thrill and bruit were present, the weight was obtained on 08/11/25, and the pulse, temperature, and respirations were obtained on 08/16/25. The post dialysis section of the form showed a pre and post dialysis weight and the time dialysis started and time of when dialysis ended. A Dialysis Communication form for Resident #8, dated 08/26/25, read in part, Pre-Dialysis This section to be completed by nursing facility and sent with resident .Post Dialysis This section is to be completed by dialysis unit and returned with resident. The pre dialysis section of the form showed the thrill and bruit were present, the weight was obtained on 08/11/25, the blood pressure and pulse had been obtained on 08/25/25, and the temperature and respirations had been obtained on 08/09/25. The post dialysis section of the form had not been completed. A Dialysis Communication form for Resident #8, dated 08/28/25, read in part, Pre-Dialysis This section to be completed by nursing facility and sent with resident .Post Dialysis This section is to be completed by dialysis unit and returned with resident. The pre dialysis section of the form showed the thrill and bruit were present, the weight was obtained on 08/11/25, the blood pressure and pulse had been obtained on 08/27/25, and the temperature and respirations had been obtained on 08/09/25. The post dialysis section of the form had not been completed. A Dialysis Communication form for Resident #8, dated 09/02/25, read in part, Pre-Dialysis This section to be completed by nursing facility and sent with resident .Post Dialysis This section is to be completed by dialysis unit and returned with resident. The pre dialysis section of the form showed the thrill and bruit were present, the weight was obtained on 08/11/25, the blood pressure and pulse had been obtained on 09/01/25, and the temperature and respirations had been obtained on 08/09/25. The post dialysis section of the form had been completed by the dialysis center nurse. On 08/26/25 at 10:44 a.m., Resident #8 stated the nursing staff at the facility did not check their (continued on next page)

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	375358	A. Building B. Wing	09/03/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dialysis port before or after dialysis. On 09/02/25 at 11:10 a.m., LPN #2 stated they listened to the port, checked the dressing at the dialysis access site, and obtained the resident's vital signs before and after dialysis. They stated they documented the assessments on the dialysis communication form. On 09/02/25 at 1:46 p.m., the ADON stated the facility's nurse was to document their assessment before dialysis, send the paper to the dialysis center, and document a progress note with the dialysis center's assessment. On 09/03/25 at 10:18 a.m., LPN #2 stated Resident #8 had a dialysis port to the right chest and assessed for thrill and bruit with their stethoscope at the port site before the resident went to dialysis. They stated they did not always receive the Dialysis Communication forms from the dialysis facility to document the post dialysis assessment. On 09/03/25 1:37 p.m., the ADON stated the pre dialysis assessments which documented a thrill and bruit had been present were not accurate because Resident #8 had a port. The ADON stated the vital signs on the pre dialysis assessment were automatically input onto the form from the last set of vital signs in the electronic clinical record. By the end of the survey progress notes containing pre/post dialysis assessments had not been provided. 2. A physician's order for Resident #4, dated 03/19/25, showed to monitor the arteriovenous fistula for signs and symptoms of trauma and/or infection every shift. The order showed to check for thrill and bruit every shift due to dependence on renal dialysis. A physician's order for Resident #4, dated 03/19/25, showed to schedule visits to dialysis center and coordinate care accordingly for Monday, Wednesday, and Friday with a chair time of 1:05 p.m. A review of the June, July, and August 2025 medication administration records for Resident #4 did not show the dialysis event on Monday, Wednesday, and Friday. A review of July and August 2025 progress notes showed no notes regarding dialysis or assessment/monitoring of the fistula site for Resident #4. By the end of the survey progress notes showing assessment/monitoring of the fistula site for Resident #4 were not provided. A dialysis communication form for Resident #4, dated 07/02/25, showed a pre dialysis assessment, completed LPN #5, but no post dialysis assessment. A dialysis communication form for Resident #4, dated 07/04/25, showed a pre dialysis assessment completed by LPN #6, but no post dialysis assessment. A dialysis communication form, dated 07/07/25, showed a pre dialysis assessment completed by LPN #5, but no post dialysis assessment. A dialysis communication form for Resident #4, dated 07/09/25, showed a pre dialysis assessment completed by LPN #5, but no post dialysis assessment. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A dialysis communication form for Resident #4, dated 07/11/25, showed a pre dialysis assessment completed by the ADON, but no post dialysis assessment. A dialysis communication form for Resident #4, dated 07/14/25, showed a pre dialysis assessment was completed by LPN #5, but no post dialysis assessment. A quarterly assessment, dated 07/31/25, showed Resident #4 had a BIMS of 15 which indicated they were cognitively intact. The assessment showed diagnoses which included end stage renal disease, diabetes, and hypertension. A dialysis communication form for Resident #4, dated 08/27/25, showed a pre dialysis assessment was completed and a post dialysis assessment. The note showed vitals were not completed by dialysis and the post assessment was completed upon return, with complaints of weakness and pain reported by Resident #4 of nine out of 10 in their knees and back, with general malaise. On 09/02/25 at 1:46 p.m., the ADON stated the facility's nurse was to document their assessment before dialysis, send the paper to the dialysis center, and document a progress note with the dialysis center's assessment.

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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.

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	375358	A. Building B. Wing	09/03/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to ensure a bed hold notification was provided for 1 (#36) of 1 sampled resident who was reviewed for hospitalization.The administrator identified 107 residents resided in the facility.Findings: The policy titled Bed Hold, dated 10/14/19, read in part, Resident shall be given notice of the bed hold option at the time of hospitalization or other leave. An undated face sheet showed Resident #36 had a power of attorney and their primary payer source was Medicaid. An annual assessment, dated 05/21/25, showed Resident #36 had a BIMS score of 00, which indicated the resident was severely impaired in cognition for daily decision making. A nurse note, dated 08/20/25, showed Resident #36 was sent to the hospital for altered mental status. The note did not show notification of a bed hold had been provided. A nurse note, dated 08/26/25, showed Resident #36 returned to the facility. On 08/29/25 at 3:54 p.m., LPN #1 stated the marketer, or administration provided the notice of bed hold to residents/resident representatives. On 09/02/25 at 9:47 a.m., the DON stated the admission coordinator provided the notice of bed hold to residents/resident representatives. On 09/02/25 at 9:52 a.m., the admission coordinator stated the nursing department provided the notice of bed hold at the time of transfer. On 09/02/25 at 10:08 a.m., the administrator stated the nursing department was to provide the resident/resident representative of the notice of bed hold upon transfer to the hospital. On 09/02/25 at 11:10 a.m., LPN #2 stated they had not provided the notice of bed hold to Resident #36 or the resident's representative for the hospitalization on 08/20/25 because it was an emergency transfer.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 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 notied [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 themself or even turn themself. 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 (continued on next page)

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	375358	A. Building B. Wing	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 was observed partially on the fall mat when they fell. They stated the event was so rushed they were trying to remember. LPN #4 stated they were not sure if Resident #48 hit their head on the nightstand, bed side table, or a clothes hamper that was close to them. They stated they did not see blood on anything, so they were not sure, but were sure Resident #48 had the fall mat because they used it anytime Resident #48 was in bed.

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	375358	A. Building B. Wing	09/03/2025

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 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.

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	09/03/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure infection control measures were implemented when providing peg tube treatments for 1 (#34) of 1 sampled resident who was reviewed for infection control.The DON identified three residents received peg tube care.Findings: On 08/28/25 at 1:29 p.m., LPN #3 was observed to administer PEG tube medications and provide a PEG tube dressing change for Resident #34. LPN #1 was not observed to don appropriate personal protective equipment, a gown, for enhanced barrier protocol. A quarterly assessment, dated 07/21/25, showed Resident #34 had a BIMS score of 2, which indicated they were severely impaired for daily decision making. The assessment showed diagnoses which included a traumatic brain injury and dysphagia. On 08/28/25 at 1:57 p.m., LPN #3 stated they should have followed enhanced barrier protocol, but had forgotten to put on the gown.

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	09/03/2025

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation and interview, the facility failed to clean the lint build-up from the compartment which housed the gas lines and burner assemblies for 4 of 4 gas dryers in the laundry room. The administrator identified 107 residents resided in the facility. Findings:On 09/03/25 at 11:05 a.m., Laundry aide #1 assisted with the observations of the four gas dryers in the laundry room. Laundry Aide #1 pulled open each of the lint trap doors housed under each dryer drum. All four lint trap screens were thickly covered with lint. The space behind the dryers was observed to have lint covering the ceiling, the fire sprinkler, and the mechanical space above each of the four dryer drums. The mechanical space above the dryer drums housed the gas lines and dryer burner tube assembly. The lint covered the ceiling, floor, walls, electrical conduit, wires, switches, gas lines, and air intakes/holes for the gas dryer burner tube assembly of the mechanical space. Pictures were taken of the observations described above. On 09/03/25 at 11:10 a.m., Laundry aide #1 stated they cleaned the lint screens once daily and swept the space behind the dryers once a week or so. Laundry Aide #1 stated they were usually the one assigned to sweep behind the dryers. Laundry Aide #1 stated they did not clean the mechanical space above the dryer drums because they were never instructed to do so.On 09/03/25 at 4:35 p.m., the laundry supervisor stated the laundry aides were to clean the lint traps multiple times a day. The laundry supervisor stated Laundry Aide #1 usually swept behind the dryers approximately once a week as the other laundry aides had difficulty accessing the area behind the dryers. The laundry supervisor stated the facility had a company that serviced the laundry area monthly to switch out the chemicals, check the traps, and make sure the mechanical system which delivered the chemicals worked properly. The laundry supervisor looked at pictures of the area behind the dryers and of the mechanical area above each of the four dryers and stated they did not realize there was so much lint build-up on the ceiling, water sprinkler, and walls. The laundry supervisor stated the lint build-up in the mechanical area above each of the four dryers was a fire hazard.