

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Gracewood Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 6201 East 36th Street Tulsa, OK 74135	

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 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ staff that are licensed, certified, or registered in accordance with state laws.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33097</p> <p>Based on observation, record review, and interview, the facility failed to ensure staff was licensed in accordance with applicable State laws.</p> <p>The DON identified 78 residents who resided in the facility.</p> <p>Findings:</p> <p>On [DATE] at 12:45 p.m., RN #1 was observed at the nurse station. They stated they were working as the charge nurse for the shift.</p> <p>An employee record documented RN #1 had a valid RN license for the state of Texas. There was no record for a valid RN license for the state of Oklahoma.</p> <p>On [DATE] at 10:50 a.m., the administrator reviewed RN #1's employee file noting a Texas RN license. The administrator stated per documentation found on the Oklahoma Board of Nursing website, RN #1's Oklahoma RN license had expired on [DATE].</p> <p>On [DATE] at 11:10 a.m., the DON stated RN #1 had worked full time hours in the facility since [DATE] with one break in full time status for the month of [DATE]. The DON stated the RN continued full time working status from [DATE] to current. The DON stated they did not know the RN's nursing license had expired for the state of Oklahoma.</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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