

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  04/06/2026
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Based on observation and interview the facility failed to: a. ensure a safe and sanitary kitchen floor, b. residents were not served meals on paper products, and c. ensure hot water was available in their restroom for 1 (#21) of 17 sampled residents reviewed for access to hot water in their restroom. The administrator identified 69 residents ate from the kitchen. Findings: On 03/31/26 at 10:18 a.m., the tile floor between the two sinks on opposite sides of the kitchen was observed to have been ripped up and was filled in with gravel. On 03/31/26 at 11:01 a.m., [NAME] #2 stated All I can do is wipe down and sanitize as much as I can. A pipe busted that is what caused the flood and why the floor is busted and filled in with gravel. On 03/31/26 at 11:41 a.m., [NAME] #1 stated the floor had been filled in with gravel for a year since the flood happened. They stated they did the best they could to keep the floor clean. On 03/31/26 at 12:15 p.m., the food was observed to be plated onto paper plates. Plastic silverware was also observed. On 03/31/26 at 12:36 p.m., Resident # 21's restroom hot water was observed to not work. The sink was observed to be pulled away from wall with paint chips on the back of the sink and some on wall behind the sink where it had previously been touching. The paint on the wall was observed torn away around the sink, and the toilet lid was observed sitting below the sink and not on the back of the toilet. On 04/02/26 at 1:29 p.m., the administrator stated the dishwasher was not currently being used due to ongoing construction in the kitchen. The administrator stated the residents had been using paper products since last Friday, but were hoping to have the dishwasher running again soon. On 04/03/26 at 10:33 a.m., Resident #21 stated they did not want to change rooms, they just wanted hot water available to wash their face. On 04/03/26 at 10:46 a.m., the ADON stated they knew the hot water in Resident #21's room was an issue that needed to be addressed, but it was a financial issue, and the maintenance person could only do what they were approved to do. The ADON stated they would have to ask maintenance about the toilet and sink in Resident #21's restroom.</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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F 0600  Level of Harm - Actual harm  Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on record review and interview, the facility failed to ensure a resident was not physically abused by another resident for 1 (#79) of 4 sampled residents reviewed for abuse. The administrator identified 69 residents resided in the facility. A Resident to Resident Incidents policy, dated 01/2024, read in part, Upon admission to the facility, each person will be assessed through the MDS process to determine if they are at risk for abusing others. Care plans will address interventions designed to prevent occurrences. An Oklahoma State Department of Health final report, dated 05/11/25, showed a staff member witnessed Resident #79 pour water on Resident #61. Resident #61 then pushed Resident #79 causing them to fall. Resident #79 was sent to the hospital. An undated nurse note showed that around 5:30 p.m., Resident #79 was found yelling and was on the ground in the smoking area. Resident #79 stated Resident #61 pushed them down. The note showed, We tried to get [Resident #79] up but [Resident #79] said [they] could not get up as [they] were in great pain. The note showed Resident #61 stated to nurses that Resident #79 poured water on them, so they pushed Resident #79 away and Resident #79 fell. A hospital x-ray record, dated 05/11/25, showed Resident #79 sustained a fracture to their leg. An annual assessment, dated 02/23/26, showed Resident #61 had diagnoses that included bipolar, PTSD, depression, and anxiety. The assessment showed Resident #61 had a BIMS score of 12 which indicated moderate cognitive impairment. On 04/02/26, Resident #61's care plan was reviewed and did not show any behaviors. On 04/01/26 at 9:29 a.m., Resident #61 denied any altercations with staff or other residents and stated they felt safe in the facility. On 04/02/26 at 1:01 p.m., LPN #2 stated there was not a behavior care plan initiated for Resident #61 and there should have been. On 04/02/26 at 1:29 p.m., the administrator stated the investigation showed Resident #79 was the aggressor in the situation. The administrator stated Resident #61 was not a problem unless they did not get to smoke.</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>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, record review, and interview, the facility failed to ensure adequate supervision to prevent an elopement for 1 (#20) of 2 sampled residents reviewed for elopement. The administrator identified 21 residents resided in the memory care unit. Findings: On 03/31/26 at 11:29 a.m., Resident #20 was observed resting in bed with their eyes closed. No elopement behaviors were observed. On 04/01/26 at 9:37 a.m., Resident #20 was observed resting in bed with their cover pulled up over their head. No elopement behaviors were observed. On 04/01/26 at 1:55 p.m., Resident #20 was observed walking out of their room in their pajamas. Res #20 was pleasant and easily redirected to their room by staff to get dressed. No elopement behaviors were observed. An undated face sheet showed Resident #20 admitted to the facility with diagnoses which included Alzheimer's, dementia, protein-calorie malnutrition, and hypertension. An Elopement Risk Assessment, dated 01/09/26, showed Resident #20 was not an elopement risk. An admission assessment, dated 01/19/26, showed Resident #20 did not exhibit any wandering behaviors. The assessment showed Resident #20's cognition was severely impaired. On 03/23/26, a new elopement risk assessment was completed on Resident #20. Resident Safety Checks, dated 03/23/26, 03/24/26, 03/25/26, 03/26/26, and 03/27/26 showed one on one observation with every 15-minute documentation. On 03/23/26, the QA committee met and implemented safety monitoring for all residents. An in-service, dated 03/24/26, showed the facility staff were educated on the elopement policy/procedure. Staff were educated to not let residents follow them out the doors, to pay attention to residents following closely or standing at doors, ensure checks every two hours, report concerns immediately, and nurses to perform head check every two hours while residents were in bed. Resident #20's care plan, dated 04/01/26, showed interventions were implemented for elopement. On 03/31/26 at 11:29 a.m., CNA #1 stated the staff kept close tabs on where Resident #20 was at all times. On 04/06/26 at 3:00 p.m., the administrator stated the staff should have made sure no resident followed them out of the exit door.</p>		