

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265730	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/27/2026
NAME OF PROVIDER OR SUPPLIER Eastview Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1622 East 28th Street Trenton, MO 64683	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents were allowed to exercise their right to make personal choices regarding their dietary preferences when facility staff limited residents to a maximum of two packets of each condiment per meal and depleted inventory of cold cereal, brown sugar and cottage cheese. This affected three out of the six sampled residents. The facility census was 80. Review of facilities policy titled Promoting/Maintaining Resident Dignity dated 09/21/25 showed the resident's personal choices will be considered when providing services to meet the resident's needs and preferences. Review of facility's policy titled Resident's Rights dated 09/21/25 showed residents had the right receive services with reasonable accommodations of individual preferences. Review of facility's Cost Accounting in Dietary Department policy dated 07/05/23 showed the facility was to have seven days of staples inventory on hand under normal operating procedures. 1. Review of Resident #1's Quarterly minimum data set, (MDS, a federally mandated assessment tool completed by facility staff) dated 03/12/26 showed:-Cognition not intact;-Supervision required for ADL's (activities of daily living);-Diagnosis included: Unspecified dementia, bipolar, PTSD (post-traumatic stress disorder), schizoaffective disorder. Review of the resident's care plan dated 04/23/21 showed staff should provide the resident opportunities to make simple choices in day-to-day life. During an interview on 05/27/26 at 12:30 P.M. the resident said:-Staff limited condiments to one or two packets each;-He/She filled out a menu at each meal for the next meal, requesting his/her condiments;-It doesn't matter what the number of condiments requested; staff only provided residents with two packets of each condiment and one packet of salad dressing;-Residents who do not request condiments on their menu are not asked if they would like condiments with the meal;-Residents who ask for butter are told butter is only provided with toast;-The facility ran out of cold cereal choices regularly. Review of the resident's 05/27/26 lunch menu showed he/she requested four packets of sugar, two packets of salt and pepper, and two packets of ranch salad dressing. Observation of the resident's lunch meal on 05/27/26 at 1:00 P.M. showed:-Resident received four sugar packets, one salt packet, one pepper packet, and one ranch dressing packet;-He/She asked the dining room staff for parmesan cheese for his/her spaghetti and was told staff did not have parmesan cheese, only cheddar was available;-He/She shook head back and forth and lowered his/her head in disappointment when no parmesan cheese was available for spaghetti. During a follow up interview on 05/27/26 at 1:45 P.M the resident said:-He/She was provided two sugar packets no matter how many glasses of tea he/she ordered; -He/She received four packets of sugar today which never happens;-He/She received butter for the biscuit today at lunch, and that never happens;-He/She was upset that parmesan cheese was not available to top his/her spaghetti;-He/She was angry and upset about receiving two sugar packets for three glasses of tea. 2. Review of Resident #2's Quarterly MDS dated : 03/12/26 showed:-Independent with ADL's;-Mild cognitive impairment;Diagnoses included: Schizophrenia, major depressive disorder, mild intellectual disabilities. Review of the resident's care plan, dated 10/26/23., showed:-He/She had nutritional problems;-Staff was to promote additional intake during meals;-Staff should provide the (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
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident with opportunities to make simple choices. During an interview on 05/27/26 at 10:55 A.M., the resident said:-The facility ran out of cold cereal and brown sugar regularly;-Residents were limited to two condiment packets per meal;-He/She felt angry when there was no cold cereal for breakfast. Review of Resident's lunch menu on 05/27/26 showed resident requested two butter packets. Observation on 05/27/26 at 1:00 P.M showed he/she received one butter packet. 3. Review of Resident #3's Quarterly MDS dated , 03/12/26 showed:-He/She was independent with ADL's;-Cognition impaired;-Diagnoses included: Anxiety and depression. Review of the resident's care plan, dated 05/26/26 showed:-Staff was to provide resident opportunities to make simple choices with day-to-day life;-He/She was to have input in her decision making with all care and as much as possible. During an interview on 05/27/26 at 11:30 A.M. the resident said:-He/She was frustrated because the staff limited the resident to two packages of each condiment per meal;-I feel like I live in a concentration camp when I am limited on condiments.-He/She requested more ketchup for breakfast and was told by staff he/she could not have more as he/she was only allowed two packets. During an interview on 05/26/27 at 10:12 A.M. the dietary manager said:-The facility ran out of cold cereal often on Sunday's;-The food deliveries arrive on every Tuesday;-Cottage cheese was an alternate that the facility [NAME] out of occasionally.-Condiments were not supposed to be limited, if the resident orders five packets the resident was supposed to get five. During an interview on 05/27/26 the Administrator said:-Staff were not supposed to limit residents' condiments;-There was an ordering problem if the facility is out of cold cereal;-Residents who request extra sugar, butter, ketchup should be provided at meals. Intake 3021023		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure two residents were treated with dignity and respect when the facility allowed staff to speak to cognitively impaired residents with disrespectful tone. This affected two residents (Resident #4 and #5) out of six sampled residents. The facility census was 80. Review of facility's Promoting/Maintaining Resident Dignity policy, dated 09/21/25 showed:-All staff should treat residents with dignity and respect.-Staff should speak respectfully to residents. 1. Review of Resident #4's Quarterly minimum data set (MDS), A federally mandated assessment tool completed by staff, dated 04/12/26 showed:-Not Cognitively intact;-Diagnoses included: Traumatic brain injury, dementia, major depressive disorder, schizoaffective disorder, profound intellectual disabilities. Review of care plan dated 04/09/26 showed: -He/She had negative behaviors including being verbally aggressive with staff and peers when upset.-At risk for impaired nutrition.-Staff should speak in slow, calm manner.-The care plan did not say what interventions the staff should use to counteract the resident's negative behavior. Observation on 05/27/26 at 10:35 A.M. showed:-Resident was standing at the nurse's station counter near the entrance of the building.-Resident asked Certified Nurse Aide (CNA) A for a snack. -CNA A told resident in a disrespectful tone I already gave you a snack.-CNA A, in the same disrespectful tone said, Backup you know the drill.-Resident became visibly upset and sighed heavily while looking down at the floor and walked away.-The resident did not get the requested snack. During an interview on 05/27/26 at 10:40 A.M. the resident said:-Nursing staff are upset, rude, and short tempered often and speak harshly to me and others.-He/She was mad and sad that CNA A spoke disrespectfully to him/her. 2. Review of Resident #5's Quarterly MDS dated [DATE] showed:-Cognition impaired;-Dependent on staff for all ADL's (activity of daily living);-Diagnoses included: Autistic disorder, epilepsy, severe intellectual disabilities, intermittent explosive disorder, cerebral palsy. Review of the resident's care plan, dated 02/15/26., showed:-He/She had communication problems;-Used facial expressions, gestures and movement that do not match verbal communication;-He/She became nervous with hollering, and restlessness when upset. Observation on 05/27/26 at 12:30 P.M. showed: -Resident sat in a wheelchair at the dining room table and began to move backwards away from the table. CNA A was assisting another resident to the next table. -CNA A, in a loud voice with a disrespectful tone, said to the resident to stop moving!-Resident looked at CNA A and began hollering out at CNA A for stopping the resident from leaving the table. 3. During an interview on 05/27/26 at 04:10 P.M. CNA A said:-Resident's behaviors can be frustrating at times.- I was short tempered with the resident about the snack as I was frustrated.-If staff becomes upset with a resident, staff should walk away and tell charge nurse. 4. During an interview on 05/27/26 at 06:15 P.M. the ADON (assistant director of nursing) said:-She expected all staff to treat residents with dignity and respect.-She expected staff to walk away and not become rude or hateful to the residents.-If a resident is requesting a snack, staff should accommodate this need. 5. During an interview on 05/27/26 at 04:15 P.M. the Administrator said:-He expected all staff to always treat residents with dignity and respect.-If staff are unable to treat residents with dignity and respect they should walk away and find help from other staff.-Staff should not be limiting resident snacks. Intake 3022690 & 3021023		