STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375425	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gregston Nursing Home, Inc.	711 South Broadway Marlow, OK 73055

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. Based on observation, record review, and interview, the facility failed to ensure dignity was maintained for residents who required staff assistance for eating for 7 (#2, 3, 31, 34, 44, 47, and #52) of 7 sampled residents observed during dining.The DON reported three residents were dependent on staff for eating. Findings:On 08/19/25 at 12:21 p.m., CNA #1 was observed standing up to feed and assist Residents #31, #44, #47, and #52 at the feeding assist table on the East side of the dining room. The CNA was observed to have a chair available at the table but failed it use it and continued to stand over the residents and assist with feeding for the entire meal.On 08/19/25 at 12:25 p.m., CNA #2 was observed standing up to feed and assist Residents #2, #3, and #34 at the feeding assist table on the [NAME] side of the dining room. CNA #1 was observed to have a chair available at the table but failed to use it and continued to stand over the residents and assist with feeding for the entire meal.A policy Assistance with Meals, dated 09/01/13, read in part, Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: Not standing over residents while assisting them with meals.On 08/20/25 at 4:50 p.m., the administrator reported for residents' dignity, staff should not be standing up or standing over residents while assisting them with eating.

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on record review and interview, the facility failed to ensure all meals were served from the kitchen at an appetizing temperature. The DON reported 54 residents received meals from the kitchen. Findings: A significant change assessment, dated 08/10/25, showed Resident #64's cognition was intact with a BIMs score of 15. The assessment showed the resident was independent with eating. On 08/20/25 at 11:00 a.m., the resident council meeting minutes were reviewed for July 2025. The minutes showed complaints related to cold food. On 08/19/25 at 11:40 a.m., Resident #64 reported the food was served cold a lot. The resident reported this weekend (08/16/25 and 08/17/25) all meals were cold and had to have their soup sent back three times to get it hot enough. The resident reported that they ate their meals in the dining room. On 08/19/25 at 3:18 p.m., a resident council meeting was conducted with Residents #9, 10, 15, 16, 17, 21, 23, 27, 29, 39, 57, and #64. All in attendance were in agreement the food this weekend was served cold and was occasionally cold during the week. The residents agreed there were too many residents in the dining room to have the staff reheat all their meals at the same time. On 08/20/25 at 4:53 p.m., the dietary manager reported being aware of complaints regarding cold food on weekends. The dietary manager reported three new kitchen staff had been hired for the weekends, and they were working on the complaints of cold food.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to ensure staff used proper infection control practice while assisting residents with eating for 3 (#2, 3, and #34) of 7 residents observed during dining. The DON reported three residents were dependent on staff assistance for eating. Findings:On 08/19/25 at 12:25 p.m., CNA #2 was observed assisting Residents #2, #3, and #34 with eating. CNA #2 was observed blowing on Residents #34's spoon of beans to cool them off before feeding the resident. CNA #2 was observed touching their face and hair, then picking up a pepper with their bare hands and feeding it to Resident #34. CNA #2 was observed touching Resident #3's arm to arouse the resident to eat and then assisting Resident #2 with eating from a spoon. CNA #2 was observed not to use hand gel or wash hands throughout the entire meal. A policy Assistance with Meals, dated 09/01/13, read in part, All employees who provide resident assistance with meals will be trained and shall demonstrate competence in the prevention of foodborne illness, including personal hygiene practices and safe food handling. On 08/20/25 at 4:50 p.m., the administrator reported staff who were feeding residents should at least be using hand gel between assisting and feeding each resident. The administrator reported staff feeding residents and providing assistance with eating should not touch their hair and should not touch other residents without performing hand hygiene. The administrator reported a staff member blowing on a resident's spoon to cool off the food and touching food with bare hands was an infection control concern.