STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375488	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Commons	301 South Oakwood Road Enid, OK 73706

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 21731 Based on observation, record review and interview, the facility failed to provide ADL care to dependent residents for two (#21 and #64) of three sampled residents reviewed for ADLs. The administrator identified 95 residents resided in the facility. Findings: 1. Resident #21 had diagnoses which included dementia. A Significant Change Assessment, dated 09/09/24, documented Resident #21's daily decision making was severely impaired. It documented the resident was dependent on staff for personal hygiene. On 10/27/24 at 9:41 a.m., Resident #21 was observed seated in their gerichair in their room. Their hair was observed uncombed, and their facial hair was observed to be straggled, and unshaven. On 10/28/24 at 1:34 p.m., Resident #21 was observed in bed. Their hair was observed uncombed, and their facial hair was observed to be straggled, and unshaven. On 10/29/24 at 9:53 a.m., Resident #21 was observed seated in their gerichair in their room. Their hair was observed uncombed, and their facial hair was observed to be straggled, and unshaven. 2. Resident #64 had diagnoses which included dementia. A Quarterly Assessment, dated 09/12/24, documented Resident #64's cognition was severely impaired. It documented the resident had upper extremity impairment to one side. On 10/27/24 at 9:53 a.m., Resident #64 was observed seated in their wheelchair in their room. Their hair was observed uncombed and their facial hair was observed to be unshaven. On 10/28/24 at 1:35 p.m., Resident #64 was observed seated in their wheelchair in their room. Their hair was observed uncombed and their facial hair was observed to be unshaven. On 10/28/24 at 2:30 p.m., Resident #64 was observed being shaved by CNA #4. CNA #4 stated they shaved the male residents as often as they could. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/29/24 at 1:38 p.m., the administrator, DON, and corporate #1 was asked what was their expectation for the resident's hair to be combed and shaved. They stated it needed to be brushed in the shower, when they got up, or when it needed it. They stated not all mens hair grows the same and shaving should be completed two to four times a week or when they were looking scruffy. They were asked how staff were aware of how often to provide the care. The DON stated they expected residents to look presentable.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 21731 Based on observation, record review, and interview, the facility failed to ensure medications were not left at a resident's bedside for one (#55) of 24 sampled residents observed for bedside medications. The administrator identified 95 residents resided in the facility. Findings: Resident #55 had diagnoses which included dementia. Resident #55 had the following physician orders, dated 08/19/24, documented Vicks Vapor rub 4.8 % - 1.2 % -2.6% topical ointment, apply by topical route two times per day to toenails for nail fungus; nystatin 100,000 unit/gram topical powder apply by topical route two times per day under bilateral breasts for rash; and Aquaphor or equivalent to bilateral lower extremities every day for dryness and itching. There were no self administrating of medications orders. An Annual Assessment, dated 09/12/24, documented Resident #55's cognition was moderately impaired. On 10/27/24 at 12:50 p.m., Resident #55 was observed seated in their wheelchair in their room. Resident #55 was not interviewable. Two medication cups with white cream and one medication cup with a powder substance was observed on the counter near the sink. Resident #55 was observed to be able to propel their wheelchair in their room. On 10/28/24 at 1:37 p.m., the medication cups were observed on the counter near the sink in the resident's room. On 10/29/24 at 9:02 a.m., Resident #55 was observed seated in their wheelchair in their room. They were observed feeding themselves breakfast. The medicine cups containing the creams and powder were observed at the sink. On 10/30/24 at 8:45 a.m., CMA #2 was observed to enter Resident #55's room. The medicine cups containing the creams and powder were observed at the sink. On 10/30/24 at 8:47 a.m., CMA #2 was asked what were in the medicine cups. They stated, Probably remedy powder. They stated the resident had yeast. CMA #2 was observed to don gloves and applied a portion of the powder substance on the resident. CMA #2 was asked if it was normal to leave medicine in the resident's room. They stated the residents can have it if they have a physician's order to leave it. CMA #2 stated they did not know if the resident had an order. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/30/24 at 8:49 a.m. LPN #4 was asked if Resident #55 had a physician's order to have medication at bedside. They stated the resident did not have an order and should not have any medication left in their room.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 21731 41318 Based on record review and interview, the facility failed to submit payroll based staffing information to CMS as required for the 3rd quarter of 2024. The administrator identified 95 residents resided in the facility. Findings: A PBJ Staffing Data Report - FY Quarter 3 2024, documented there was no data submitted for the third quarter. On 10/31/24 at 10:08 a.m., the administrator stated they did not think anyone had been completing it. They were asked what was the process for ensuring it was accepted. They stated, I don't think it was getting done. 47453