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	06/05/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to ensure food was stored properly; failed to ensure staff utilized facial hair restraint/covers when preparing, distributing, and serving food during 2 of 2 meal preparation observations; and failed to ensure staff washed/sanitized their hands when serving meals to residents during 1 of 1 meal service observations. These deficiencies had the potential to affect all residents who received food from the facility kitchen, and all residents who received staff assistance with meals in the dining room.Findings included: 1. A facility policy titled, Dining Services Policies and Procedures Receiving Food and Supplies, revised 06/25/2012, indicated, Food items will be received and handled in accordance with established sanitary practices. The policy further indicated, 7. All foodstuffs are to be dated. During a concurrent initial tour of the kitchen and interview on 06/01/2026 at 10:30 AM, an observation of the walk-in freezer revealed frozen chicken in a stainless-steel pan covered with clear plastic wrap and dated 02/17/2026. The chicken contained areas of pink, light tan, and white discoloration on the top layer. The observation further revealed 19 raw hamburger patties stored in an open, clear plastic bag inside a cardboard box dated 05/27/2026. The hamburger patties had brown, pink, and light tan discoloration around the edges. The Dietary Supervisor (DS) stated that the chicken and hamburger patties were not properly stored and that the hamburger patties were not properly sealed. An observation of the walk-in refrigerator on 06/01/2026 at 10:37 AM revealed a partially opened container of yellow American cheese that was undated and exposed to air and three individual dishes of cake covered with plastic wrap that lacked dates, The observation further revealed two containers of raw chicken dated 05/20/2026 that were surrounded by a thick liquid substance. Further observation revealed white American cheese wrapped in plastic wrap and dated 12/21/2025, a bag of bacon bits with a use-by date of 05/25/2026, a 3-inch by 4-inch piece of butter with a use-by date of 04/08/2026, turkey bologna with a use-by date of 04/08/2026, a container of chopped beef brisket with a use-by date of 05/16/2026, cottage cheese with a use-by date of 05/30/2026, bacon bits in a resealable plastic bag dated 04/20/2026, potato salad with a use-by date of 05/29/2026 stored in a pan covered with plastic wrap, and individual 0.75-ounce cups of cream cheese with a use-by date of 08/22/2025. The DS stated the cheese was not dated or properly sealed, that the containers of chicken were past their discard date, and that the other food items were not discarded in a timely manner. During a concurrent tour of the kitchen and interview with the DS on 06/01/2026 at 11:20 AM, an observation of the tray-line refrigerator revealed white cheese in an almost empty container covered with clear plastic wrap. The cheese had pale, tan discoloration around the sides of the container. The observation also revealed an uncovered, undated container of tartar sauce with dried residue on the interior sidewalls of the container. The DS stated that the food items were not stored properly. During a concurrent tour of the kitchen and interview on 06/04/2026 at 4:00 PM, an observation of the walk-in refrigerator revealed an open, undated bag of Parmesan cheese that was approximately three-quarters full, wrapped in clear plastic wrap, and a sheet pan that was approximately three-quarters full of cake covered with plastic wrap and undated. The DS stated that the food was not stored properly. 2. A facility policy titled, Dining Services Policies and (continued on next page)

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

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	06/05/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procedures Dress, Hygiene, and Conduct, with an effective date of effective 01/01/2022 indicated, Hairnets or hair covers must be worn at all times. Facial hair must also be covered with a protective covering. During a kitchen tour on 06/01/2026 at 11:24 AM, Dietary Aide (DA) #10, DA #11, DA #13, [NAME] #16, [NAME] #17, and [NAME] #18 were observed preparing food and handling clean dishes and utensils with facial hair exposed. Their beards and mustaches were not completely covered with a hair restraint/protective covering. During a tour of the kitchen on 06/04/2026 at 4:06 PM, 3 dietary staff members (DAs #10, #11, and #14) were observed in the kitchen preparing food and washing dishes. Their facial hair was not completely covered with a hair restraint. During a lunch meal observation in the main dining room on 06/01/2026 at 11:40 AM, DA #15 was observed wearing a surgical mask, which did not fully cover their facial hair. During an interview on 06/01/2026 at 12:36 PM, DA #15 stated the facility had beard nets, but that he always used a surgical mask instead. He was unsure whether a surgical mask was an appropriate replacement for a facial hair restraint. During an interview on 06/01/2026 at 12:41 PM, the Dietary Supervisor (DS) stated that a surgical mask was not enough to replace a beard net. During an interview on 06/05/2026 at 9:38 AM, the DS stated that all facial hair, including facial hair on the upper lip, should be completely covered. During an interview on 06/05/2026 at 9:41 AM, the Director of Nursing (DON) stated his expectation was that all facial hair, including facial hair on the upper lip, needed to be completely covered. During an interview on 06/05/2026 at 9:55 AM, the Administrator (ADM) stated his expectation was that staff followed facility policy regarding facial hair covering. The ADM stated he had observed staff wearing facial hair coverings that covered only the lower portion of the face and beard area rather than all facial hair.3. A facility policy titled, Hand Hygiene Guideline, with an effective date of 06/2025, indicated, When to perform hand hygiene: Before: direct contact with a resident, preparing or administering medications, handling food or feeding a resident, performing a clean or aseptic procedure. After: contact with a resident, contact with bodily fluids, mucous membranes, non-intact skin, or wound dressings, removing gloves, handing soiled equipment or linen, using the restroom, sneezing coughing, or touching the face. During a lunch meal observation in the main dining room on 06/01/2026 at 11:40 AM, Dietary Aide (DA) #15 used a resident's already unwrapped utensils to cut up their meat at the resident's request. He then returned to the meal counter to continue serving plates without performing hand hygiene. DA #15 was observed with his thumbs inside his waist band pulling his pants up. He did not perform hand hygiene afterwards and returned to serving plates. He was also observed adjusting his surgical mask but did not perform hand hygiene afterwards and returned to serving plates. DA #15 was also observed to pull out a walkie talkie to speak and return to meal service without performing hand hygiene. During the same lunch meal service observation on 06/01/2026 at 11:40 AM, Licensed Practical Nurse (LPN) #5 was observed assisting a resident with cutting their food and feeding them a forkful of food. The observation revealed that LPN #5 then assisted another resident with cutting up their food without sanitizing or washing her hands. LPN #6 was then observed to pick up a resident's used cup, refill it at a water dispense, and return it to the resident. The LPN then returned to helping another resident with feeding assistance without performing hand hygiene. During an interview on 06/01/2026 at 12:36 PM, DA #15 stated that he was not sure what hand hygiene he needed to perform during meal service. However, he stated that he did not sanitize his hands between helping residents, but that he was supposed to. He stated he was not sure whether hand hygiene was needed after using a walkie talkie or pulling up his pants. During an interview on 06/01/2026 at 12:50 PM, LPN #5 stated that hand hygiene required during meal service included using sanitizer between helping every resident. She stated they should sanitize between cutting up food, getting water refills, and feeding if they were switching to help another resident. LPN #5 stated that she helped multiple residents during the meal service and did not sanitize her hands between them but stated she should have. During an interview on 06/01/2026 at 12:41 PM, the Dietary Supervisor (DS) stated that she expected staff to wash their hands after serving every three to five plates or if their hands got something on them. She stated staff would need to wash their hands if they assisted a resident with cutting up their food prior (continued on next page)

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	06/05/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to assisting another resident. The DS stated that staff could use alcohol-based hand sanitizer if they touched anything. but hand washing was preferred. She stated that if staff touched a resident's property, their face, or beard net; pulled up their pants; or touched a walkie talkie, they needed to wash their hands. During an interview on 06/04/2026 at 11:30 AM, the Assistant Director of Nursing/Infection Preventionist (ADON/IP #8) stated she was responsible for staff infection control training. She stated that she did not meet with dietary aides but provided education regarding handwashing to the dietary manager (DM), who was supposed to educate the dietary staff. The ADON/IP #8 stated that for meal service, staff were to complete hand hygiene between each resident when passing plates and if they touched used dishware, they must complete hand hygiene afterward. During an interview on 06/04/2026 at 11:55 AM, the Director of Nursing (DON) stated she expected staff to use hand hygiene before and after serving a resident. She stated that alcohol-based hand sanitizer was appropriate unless hands were visibly soiled. During an interview on 06/04/2026 at 3:18 PM, the Administrator stated he expected all staff to be observing the hand hygiene policy during meal services.

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	06/05/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, and facility policy review, the facility failed to assess a resident for self-administration of medication, failed to obtain a physician's order for self-administration of medication, and failed to obtain a physician's order to keep medication at the bedside for 1 resident (Resident # 34) of 5 residents observed during medication pass.Findings included: A facility policy titled, Self-Administration Of Medications, effective 01/2022, indicated, In order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer. The policy further indicated, A. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process. B. If the resident indicates no desire to self-administer medications, this is documented in the appropriate place in the resident's medical record, and the resident is deemed to have deferred this right to the facility. C. For those residents who self-administer, the interdisciplinary team verifies the resident's ability to self-administer medications by means of a skill assessment conducted on a quarterly basis or when there is a significant change in condition. The policy further indicated, D. The results of the interdisciplinary team assessment of resident skills and of the determination regarding bedside storage are recorded in the resident's medical record, on the care plan. For each medication authorized for self-administration, the label contains a notation that it may be self-administered. An admission Record revealed that the facility admitted Resident #34 on 08/21/2024 and most recently readmitted the resident on 10/26/2025. According to the admission Record, the resident had a medical history that included a diagnosis of dry eye syndrome of an unspecified lacrimal gland. A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/09/2026 revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. The MDS revealed Resident #34 had adequate vision with corrective lenses. Resident #34's Care Plan Report, included a focus area initiated on 09/10/2024, that indicated the resident had a diagnosis of dry eyes. Interventions directed staff to administer Refresh drops per physician orders (initiated 12/05/2024). The Care Plan Report revealed no documentation of any interventions that indicated Resident #34 had been assessed to self-administer medication. A physician's order, dated 04/04/2025, revealed an order for Refresh Ophthalmic solution (an eye drop medication used to treat dry eyes) to be instilled in both eyes four times per day related to dry eye syndrome. The physician's order did not include directions for resident self-administration or instructions for the resident to keep the medication at bedside. Resident #34's June 2026 Medication Administration Record [MAR], revealed staff initialed the entries for Refresh for 06/01/2026 at 8:00 AM through 06/03/2026 at 8:00 AM, indicating that staff had administered the medication four times per day. Resident #34's electronic medical record revealed no documented evidence that an assessment had been completed for self-administration of medication. During an observation and concurrent interview on 06/01/2026 at 11:52 AM, there was a clear plastic cup with two bottles of Refresh eye drops on Resident #34's bedside table. Resident #34 stated the instilled the eye drops independently. During an observation on 06/02/2026 at 1:35 PM, Resident #34 was noted to be sitting in a chair by the bed. The overbed table was across the resident's lap, and the clear cup that contained two bottles of eye drops was on the overbed table and within reach of the resident. During a concurrent observation and interview on 06/03/2026 at 9:35 AM, with Certified Medication Aide (CMA) #3, Resident #34 had two different sized green bottles of eye drops in a plastic cup on the overbed table. CMA #3 handed the resident the larger green bottle of eye drops, and the resident self-administered the Refresh eye drops, placing one drop in each eye. CMA #3 stated that for a resident to self-administer medication, she believed an assessment had to (continued on next page)

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	06/05/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be completed, and the resident's physician had to write an order to keep the medication at the bedside. Per CMA #3, Resident #34 had an order to keep the eye drops at the bedside. During an observation on 06/04/2026 at 10:32 AM, Resident #34 was sitting in a recliner with their eyes closed. The clear cup with the two bottles of Refresh eye drops remained on the resident's bedside table, which was bedside the recliner within reach of the resident. During an interview on 06/04/2026 at 11:56 AM, CMA #7 stated she had worked at the facility for one and one-half years and Resident #34 had eye drops in their room during that time. CMA #7 stated Resident #34 self-administered the eye drops independently and refused to allow staff to administer the eye drops. CMA #7 stated when she started working at the facility, someone told her that Resident #34 was able to keep the eye drops in their room and self-administer them but was unable to remember who had given her that information. CMA #7 stated Resident #34 had an order for the Refresh eye drops, but the order did not include self-administration or the ability to keep the medication at bedside. During an interview on 06/04/2026 at 10:32 AM, Licensed Practical Nurse (LPN) #6 stated before a resident could self-administer medication, staff had to assess the resident to make sure the resident knew how to safely administer the medication, how long to wait between administration times, and how to check the expiration date on the medication. The LPN stated they also had to get a physician's order for the resident to self-administer the medication and to keep the medication at bedside. LPN #6 stated the charge nurse was responsible for completing a self-administration assessment. During an interview on 06/03/2026 at 10:00 AM, Physician #4, who was Resident #34's primary care physician, stated that Resident #34 was not always alert and oriented and was not trustworthy to administer their own medication. Physician #4 stated he was aware that medication sometimes showed up in the resident's room brought in by the resident's family. The physician stated that although he had known for a year that medication appeared in the resident's room, staff had not requested an assessment for medication self-administration, or an order for the eye drops to be kept at bedside. Physician #4 stated he expected the staff to follow the facility's policy for self-administration of medication. During an interview on 06/05/2026 at 1:14 PM, the Director of Nursing (DON) stated that if medication was found in a resident's room, without an order or self-administration assessment, she expected the administrative staff to be notified and the medication removed. The DON stated she was unsure why Resident #34 had eye drops in their room for such a long period of time. The DON stated that if medication were kept in a resident's room, it should be locked so other residents could not get to the medication. During an interview on 06/05/2026 at 2:03 PM, the Administrator stated staff were required to take any medication seen at bedside out of the room. The Administrator stated he was not aware that Resident #34 had eye drops in the room until it was brought to his attention that surveyors had found eye drops at Resident #34's bedside.

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	06/05/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interview, and record review, the facility failed to ensure the physician was notified when medication was not available for administration for 1 (Resident #34) of 5 residents observed for medication administration.Findings included: During an interview on 06/05/2026 at 9:20 AM, the Assistant Administrator stated it was common practice to notify the physician if medication was not available; subsequently, the facility did not have a policy regarding physician notification. An admission Record revealed the facility admitted Resident #34 on 08/21/2024. According to the admission Record, the resident had a medical history that included a diagnosis of systolic congestive heart failure. Resident #34's Order Summary Report, for the timeframe from 06/01/2024 through 06/30/2026, included an order dated 04/30/2025 for Lasix oral tablet 20 milligrams (mg) one tablet daily for systolic congestive heart failure. Resident #34's May 2026 Medication Administration Record [MAR] revealed staff documented 9 for Lasix 20 mg for 05/28/2026 through 05/31/2026. Per the MAR, a chart code 9 indicated Other/See Nurse Notes. Resident #34's Nurses Progress Note dated 05/29/2026 indicated a voicemail was left with a hospice company for a refill of Lasix 20 mg. Resident #34's June 2026 MAR revealed staff documented 9 for Lasix 20 mg for 06/01/2026 through 06/03/2026. Per the MAR, a chart code 9 indicated Other/See Nurse Notes. During an observation of medication administration on 06/03/2026 at 9:03 AM, Certified Medication Aide (CMA) #3 prepared and administered Resident #34's medications. CMA #3 stated that Lasix was not available to administer and had been ordered from a pharmacy. CMA #3 stated that the nurse was responsible for notifying the physician when a medication was not available for administration. During an interview on 06/03/2026 at 9:16 AM, Licensed Practical Nurse (LPN) #5 stated if medication was not available, staff needed to contact the physician to see what they wanted to do and if there was something different the physician wanted them to give until the medication was available. LPN #5 stated she was not aware that Lasix was not available for Resident #34. During an interview on 06/03/2026 at 10:03 AM, Physician #4 stated he was not aware Lasix was not available for Resident #34. Physician #4 stated he expected to be notified of any medication that was not available. Per Physician #4, missing the medication was not critical or significant for the resident. During an interview on 06/04/2026 at 3:17 PM, the Director of Nursing (DON) stated she expected the charge nurse to be notified if medication was not available, and the charge nurse should call the pharmacy and notify the physician. The DON stated staff should have contacted Resident 34's physician about Lasix not being available because he may have ordered a different medication. During an interview on 06/04/2026 at 4:01 PM, the Administrator stated he deferred to the DON for physician notification.

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	06/05/2026

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review the facility failed to submit a Preadmission Screening and Resident Review (PASRR) form to the state-designated authority after the addition of a new psychiatric diagnosis for 1 (Resident #10) of 2 residents reviewed for the accuracy of the PASRR.Findings included: During an interview on 06/05/2026 at 1:43 PM, the Assistant Administrator revealed that the facility had no PASRR policy. An admission Record indicated the facility admitted Resident #10 on 01/02/2025. According to the admission Record the resident had a medical history that included diagnoses of unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety (onset 01/02/2025), delusional disorders (onset 02/11/2025), and unspecified depression (onset 03/17/2025). A Level I PASRR Screen, dated 01/13/2025, indicated Resident #10 had a primary diagnosis of unspecified dementia. The screening form indicated the resident had no evidence of a serious mental illness including possible disturbances in orientation or mood. The screening form revealed Resident #10 also had no diagnosis of a depressive disorder, other psychotic disorder, or another mental disorder that may lead to a chronic disability. A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/22/2026, revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated severe cognitive impairment. The MDS indicated Resident #10 had active diagnoses that included depression and a psychotic disorder. Resident #10's Care Plan Report, included a focus area revised on 01/02/2026, that indicated the resident took medication to help manage their depression and delusional disorder. Interventions initiated on 05/28/2025, directed staff to give the medications as ordered and to monitor for side effects and effectiveness, document the number of behavioral episodes each shift, and record the number of occurrences of demonstrated target behaviors. Resident #10's Order Summary Report, for active orders as of 06/05/2026, included an order dated 02/02/2026 for Seroquel (an antipsychotic medication) 25 milligrams (mg), one-half tablet at bedtime related to the resident's delusional disorder. The order summary report also included an order dated 01/23/2026 for Celexa (an antidepressant medication) 10 mg to be taken at bedtime to help manage the resident's depression. There was no documented evidence that the facility referred Resident #10 to the state-designated authority for review when the resident was diagnosed with a newly evident or possible serious mental disorder. During an interview on 06/04/2026 at 1:20 PM, Assistant Director of Nursing (ADON) #2 stated she functioned as a skilled case manager. ADON #2 stated if a new psychiatric diagnosis was added after the initial submission of a Level 1 PASRR, she called the state agency responsible for PASRR to determine whether a Level II PASRR was required. ADON #2 stated she was unsure what the facility policy or the federal regulations required for a change in the resident's PASRR. During an interview on 06/05/2026 at 1:25 PM, ADON #9 stated that she was aware that a new diagnosis required a new PASRR to be submitted. She stated that the DON was previously responsible for the resubmission of the PASRRs but was not sure who was currently responsible. During an interview on 06/05/2026 at 1:04 PM, the Director of Nursing (DON) stated that either the MDS nurse or the Case Manager was responsible for submitting a new PASRR if a new diagnosis was added. The DON stated she expected the new PASRR to be submitted as soon as the new diagnosis was added. During a telephone interview on 06/04/2026 at 3:02 PM, the Psychiatric Intellectual Disabilities Analyst (PIDA) stated he reviewed Level I PASRRs if they were assigned to him but did not send PASRR determination letters to the facilities. The PIDA stated if a resident was admitted with a Level I PASRR and had a significant change in condition, such as a new diagnosis, then a new Level I PASRR may need to be sent to the state-designated authority responsible for PASRRs. During an interview on 06/05/2026 at 2:11 PM, the Administrator stated it was a collaborative team effort to review PASRRs and submit an updated Level I PASRR if a new diagnosis was obtained.

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	06/05/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, record review, and facility document review, the facility failed to ensure an indwelling urinary catheter tubing was secured and a urine collection bag was stored in a manner to prevent infection for 1 (Resident #60) of 2 residents with a urinary catheter.Findings included: A facility document titled, Catheter Care Guideline, with an effective date of 03/2025, indicated, Our facility is committed to providing proper catheter care in accordance with current professional standards of practice. The document further indicated the Purpose was, To ensure care aligns with safe and effective management of urinary catheters and reduce the risk of infection and promote resident comfort and dignity. The document also indicated, 3. Daily Catheter Care: e. Position properly to prevent pulling. -May use external anchoring device. The document also revealed, 5. Managing the Drainage Bag: a. Keep the bag below bladder level and secure it properly to prevent pulling. b. Empty the drainage bag regularly, ensuring the spout does not touch any surfaces. An admission Record indicated the facility admitted Resident #60 on 07/01/2024. According to the admission Record, the resident had a medical history that included diagnoses of retention of urine and neuromuscular dysfunction of the bladder. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/08/2026, revealed Resident #60 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had an indwelling catheter during the assessment's seven-day look-back period. Resident #60's Care Plan Report included a focus statement initiated 04/07/2026 that indicated the resident required an indwelling urinary catheter due to a neurogenic bladder. Interventions included checking the tubing each shift (initiated 04/07/2026) and monitoring the catheter system for any compromise (initiated 05/18/2026). Resident #60's Order Summary Report with active orders as of 06/03/2026, revealed an order dated 03/30/2026 for an indwelling urinary catheter for diagnoses of neurogenic bladder and urinary retention. During an observation on 06/01/2026 at 9:56 AM, Resident #60 was in bed and the collection bag for the indwelling urinary catheter was lying directly on a fall mat on the floor at the resident's bedside. During a concurrent observation and interview on 06/01/2026 at 10:03 AM, the Assistant Director of Nursing/Infection Preventionist (ADON #8/IP) revealed that Resident #60's urinary catheter tubing was not secured but stated that it should be. The ADON/IP #8 stated the urine collection bag should not be directly on the fall mat because that could allow bacteria into the system. During an interview on 06/04/2026 at 3:17 PM, the Director of Nursing (DON) stated that the indwelling urinary catheter tubing should be secured to the resident's leg. The DON stated that securing the urinary catheter tubing helped prevent pulling and dragging the catheter system. The DON stated that for infection control purposes the catheter tubing should be secured, and that the urine collection bag should not be on the floor or the fall mat. During an interview on 06/04/2026 at 4:01 PM, the Administrator stated he deferred to the DON related to securing the indwelling catheter tubing and for the placement of the urine collection bag.

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	06/05/2026

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and facility policy review, the facility failed to ensure dietary staff were trained on the Personal Protective Equipment (PPE) required for contact isolation for 1 (Dietary Aide [DA] #15) of 1 dietary staff reviewed for infection control competencies.Findings included: A facility policy titled, Infection Control and Isolation Guideline, dated July 2025, indicated, To prevent the spread of infectious diseases and promote a safe environment for residents, staff, and visitors utilizing evidence-based infection control and isolation practices in accordance with current Center for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines. The policy also indicated, Transmission-Based Precautions used in addition to Standard Precautions for known or suspected infections. A. Contact Precautions-PPE: Gown and gloves upon room entry. During an observation and concurrent interview on 06/01/2026 at 9:51 AM, DA #15 was observed entering and exiting a resident room that had signage indicating the resident was on contact precautions. DA #15 stated that he had worked at the facility for almost three years, but he did not know what contact precautions were. DA # 15 was unable to identify the facility Contact Precautions sign posted outside the resident room was for or what it meant. He stated that he had not received any training on infection control. During an interview on 06/01/2026 at 12:41 PM, the Dietary Supervisor stated that the dietary aides reported to her. She stated that infection control for dietary aides included computer training, and dietary staff were required to have a food handler card. During an interview on 06/03/2026 at 2:30 PM, the Regional Nurse stated that the facility did not have any documentation or proof that DA #15 had a food handler card, training on infection control, or training on hand hygiene. The Regional Nurse stated that DA #15 had been working without the required dietary training for infection control, food handling, and handwashing. During an interview on 06/04/2026 at 11:30 AM, Assistant Director of Nursing (ADON #8), who was also the infection preventionist, stated she trained staff on infection control. She stated that she did not meet with dietary aides, but she did meet with the Dietary Supervisor and provided education for her to provide to dietary staff. She stated she educated the Dietary Supervisor on hand washing, enhanced barrier precautions, and contact isolation. She stated that contact precautions were indicated by a sign that stated Contact isolation along with a yellow universal precautions sign and that dietary staff should not enter those rooms to prevent any accidental cross contamination. ADON #8 stated that dietary staff were only allowed to enter enhanced barrier rooms. She stated that a dietary aide should not have even been in a contact isolation room. During an interview on 06/04/2026 at 11:55 AM, the Director of Nursing (DON) stated that for contact isolation, she personally always wore a gown and gloves when entering a room and expected the staff to as well. She stated it was to prevent the spread of infection throughout the facility and protect immuno-compromised residents as well. During an interview on 06/04/2026 at 3:18 PM, the Administrator stated infection control training was the responsibility of the infection preventionist. He stated that the dietary department head trained dietary staff on subjects like handwashing techniques, but enhanced barrier precautions training was done by the infection preventionist. He stated anyone entering a room where a resident had additional precautions in place should have been trained on how to don PPE in order to reduce transmission of disease to an at-risk population, and if they did not have the training, they should not have entered the room. He stated that the facility paid for food handler cards for staff but was not sure if DA #15 had received the training. He stated that no one on his current staff recalled training DA #15 on infection control, handwashing, or food handling.

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	06/05/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and facility policy review, the facility failed to ensure dietary staff donned Personal Protective Equipment (PPE) on entering a resident's room with contact isolation precautions for 1 (Resident #45) of 4 residents reviewed for transmission based precautions. Specifically, Dietary Aide (DA) #15 entered and exited Resident #45's room without donning PPE, when the resident was on contact isolation precautions.Findings included: A facility policy titled, Infection Control and Isolation Guideline, effective 07/2025, indicated, Purpose - To prevent the spread of infectious diseases and promote a safe environment for residents, staff, and visitors utilizing evidence-based infection control and isolation practices in accordance with current CDC [Centers for Disease Control and Prevention] and CMS [Centers for Medicare and Medicaid Services] guidelines. The policy also indicated, 2. Transmission-Based Precautions - Used in addition to Standard Precautions for known or suspected infections. A. Contact Precautions, and PPE: Gown and gloves upon room entry. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/22/2026, revealed Resident #45 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident had an indwelling catheter, a multidrug resistant organism, and a urinary tract infection. Resident #45's Care Plan Report included a focus area, initiated 05/04/2026, that indicated the resident had a urinary tract infection. Interventions directed staff to administer minocycline (a tetracycline antibiotic) as ordered (initiated 05/23/2026). Resident #45's Care Plan Report included a focus area, initiated 10/09/2024 and revised 05/29/2026, that indicated the resident was at risk for infection related to an indwelling catheter and a history of ESBL (extended-spectrum beta-lactamase, enzymes made by some bacteria that break down some antibiotics) resistance. On 06/01/2026 at 9:51 AM, DA #15 was observed entering and exiting Resident #45's room that had signage indicating the resident was on contact precautions. During a concurrent interview, DA #15 stated that he had worked at the facility for almost three years, and he had not received any training on infection control. DA #15 stated he did not know what contact precautions were, and he was not able to identify posted facility signage outside Resident #45's room for Contact Precautions.During an interview on 06/04/2026 at 11:30 AM, Assistant Director of Nursing (ADON) #8, who was the Infection Preventionist (IP), stated that Resident #45 was on contact precautions for ESBL in the urine. The IP stated that for contact precautions staff donned a gown and gloves even for just walking in the room, as staff could never know what their clothes were going to touch. The IP stated a resident's room that was on contact precautions was indicated by a sign that stated the room was to be on contact isolation with a yellow universal precautions emblem. The IP stated staff donned PPE before going into the contact isolation room, they doffed PPE when coming out of the room, and there was a bio-hazard box inside the room to dispose of used PPE. The IP stated, if there was a resident room with yellow universal precautions signage, dietary staff should not go in the room, to prevent any accidental cross contamination. The IP stated dietary staff, as unlicensed individuals, might not be aware of risks. The IP stated that a dietary aide should not have been in a contact isolation room. During an interview on 06/04/2026 at 11:55 AM, the Director of Nursing (DON) stated she always wore a gown and gloves when entering a contact isolation room, and she expected the staff to as well. The DON stated that it was to prevent the spread of the infection throughout the facility and protect immunocompromised residents as well. During an interview on 06/04/2026 at 3:18 PM, the Administrator (ADM) stated anyone going into a contact precautions situation should have been trained on how to don the protective barriers to avoid any transmission of disease to an at-risk population, to keep residents safe, and to keep staff healthy. The ADON stated if a staff member were not trained on contact precautions that staff member should not be going into the contact isolation room, and certified nurse aides would have to go into the room instead.

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	06/05/2026

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to ensure nurse staffing data was posted in a prominent place accessible to residents, staff, and visitors on 1 (06/02/2026) of 5 days of the survey.Findings included: During an interview on 06/05/2026 at 9:35 AM, the Assistant Administrator stated the facility did not have policy related to posting nurse staffing. During an observation of the facility on 06/02/2026, the survey team was unable to locate a nurse staffing data posting. During an interview on 06/02/2026 at 4:00 PM, the Scheduler stated that while she created the nurse schedule in their electronic system, it did not generate the total nursing hours. She stated it was possible to run such a report, but it would be done by Human Resources. She stated she personally did not run a report for daily staffing, nor did she post staffing anywhere in the facility. During an interview on 06/02/2026 at 4:11 PM, the Payroll Clerk (PC) stated that she utilized their electronic employee software to run daily staffing numbers. She stated that she ran a report to get the patient hours per day (PPD) and sent it daily to the Administrator at the start of her shift. She stated she was never instructed regarding a need for daily staff postings available to the public. During an interview on 06/04/2026 at 11:55 AM, the Director of Nursing (DON) stated she was not aware of any daily staff posting requirements/regulations for hours by discipline and did not know whether anyone had been tasked with posting nurse staffing data. During an interview on 06/04/2026 at 3:18 PM, the Administrator stated that he was not previously aware of a regulation requiring daily staff posting and was unsure whether anyone posted daily staffing hours.