

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Eastwood Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 6th and Highway 69 Commerce, OK 74339	

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 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42171</p> <p>Based on record review and interview, the facility failed to ensure an admission MDS assessment was completed within 14 days of admission for 1 (#141) of 5 sampled residents reviewed for MDS assessments.</p> <p>The ADON reported the facility census was 36.</p> <p>Findings:</p> <p>An undated facility document titled Policy and Procedure for Frequency of Completion of MDS, read in part, This facility will fulfill its obligation of assessing new residents no later than fourteen (14) days after the date of admission, and may be amended through the twenty-first (21st) day.</p> <p>Resident #141 had diagnoses which included pulmonary fibrosis and diabetes mellitus.</p> <p>Resident #141 was admitted to the facility on [DATE].</p> <p>An MDS 3.0 assessment summary did not show an admission MDS assessment had been completed for Resident #141.</p> <p>On 02/26/25 at 8:36 a.m., the ADON stated they were in the process of completing a significant change assessment for Resident #141 and it was not completed in 14 days as required. They also stated they should have completed an admission MDS assessment instead of a significant change MDS because the resident was a new admission.</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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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>42171</p> <p>Based on record review and interview, the facility failed to ensure a baseline care plan was completed within 48 hours of admission for 1 (#141) of 5 sampled residents reviewed for unnecessary medications.</p> <p>The ADON reported that the facility census was 36.</p> <p>Findings:</p> <p>An undated facility document titled Policy and Procedure Regarding Resident Care Plan, read in part, Effective November 28,2017, the facility will establish and implement a baseline care plan that will be developed within 48 hours of admission.</p> <p>Resident #141 had diagnoses which included pulmonary fibrosis and diabetes mellitus.</p> <p>A review of Resident #141's medical record did show a baseline care plan had been completed.</p> <p>On 02/26/25 at 11:11 a.m., the ADON stated a baseline care plan could not be located for resident #141. They also stated baseline care plans should be completed within 48 hours of admission.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>34270</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident's use of continuous oxygen was included in their care plan for 1 (#7) of 2 sampled residents reviewed for respiratory care.</p> <p>The ADON identified eight residents at the facility who had orders for the use of oxygen.</p> <p>Findings:</p> <p>On 02/25/25 at 12:19 p.m., Resident #7's family member was observed informing staff that the resident's oxygen concentrator was turned off and the resident was required to have continuous oxygen. The concentrator was observed by this surveyor and found the power switch to be in the off position.</p> <p>On 02/26/25 at 9:36 a.m., an observation of Resident #7's oxygen concentrator found it was set to 3 liters per minute.</p> <p>A facility policy, titled Resident Care Plan, dated 03/27/17, read in part, The care plan will be developed with measurable goals to meet the Resident's identified medical, nursing, mental and psychosocial needs.</p> <p>Resident #7 had diagnoses which included chronic obstructive pulmonary disease and chronic respiratory failure with hypoxia.</p> <p>A Patient Care Order (Verbal Order), dated 08/29/24 at 4:32 p.m., showed Resident #7 was to be administered a continuous flow of oxygen at a rate of 2 liters every minute.</p> <p>A care plan focus, dated 09/11/24, showed Resident #7 had a diagnosis of chronic obstruction pulmonary disease. There were no interventions that showed the use of oxygen.</p> <p>On 02/26/25 at 9:20 a.m., LPN #1 stated there was no entry in the resident's care plan regarding the use of oxygen.</p> <p>On 02/26/25 at 9:27 a.m., ADON stated they had reviewed Resident #7's care plan and did not find any documentation regarding the use of oxygen.</p> <p>On 02/26/25 at 11:10 a.m., ADON stated they use temporary nursing staff and the care plan was one place they would look to find a resident's oxygen level.</p> <p>On 02/27/25 at 10:48 a.m., DON stated there had been a breakdown in communication in regard to the resident's oxygen order getting into the care plan and order section of the EHR.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>34270</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident received the correct amount of oxygen as ordered by a physician for 1 (#7) of 2 sampled residents reviewed for respiratory care.</p> <p>The ADON identified eight residents at the facility who had orders for the use of oxygen.</p> <p>Findings:</p> <p>On 02/25/25 at 12:19 p.m., Resident #7's family member was observed stating the resident's oxygen concentrator was turned off. The oxygen was observed to be turned off and the cannula was observed to be in place on the resident's face.</p> <p>On 02/26/25 at 8:25 a.m., Resident #7's oxygen concentrator was observed to be providing the resident 3.5 liters of oxygen per minute. The resident's order was for 2 liters of oxygen per minute.</p> <p>On 02/26/25 at 9:36 a.m., Resident #7's oxygen concentrator was observed to be providing the resident 3 liters of oxygen per minute.</p> <p>On 02/26/25 at 11:14 a.m., Resident #7's oxygen concentrator was observed by the ADON and this surveyor. The concentrator was working and set to 3 liters per minute. The resident's order was for 2 liters of oxygen per minute.</p> <p>An undated Policy and Procedure of Respiratory Care, read in part, Record oxygen therapy on treatment record: time tanks are changed, rate of flow of concentration, tolerance, chart pertinent observations.</p> <p>Resident #7 had diagnoses which included chronic obstructive pulmonary disease and chronic respiratory failure with hypoxia.</p> <p>A document titled Patient Care Order (Verbal Order), dated 08/29/24 at 4:32 p.m., showed Resident #7 was to be administered a continuous flow of oxygen at a rate of 2 liters every minute.</p> <p>On 02/25/25 at 12:20 p.m., a family member of Resident #7 stated the resident required oxygen at all times.</p> <p>On 02/26/25 at 9:20 a.m., LPN #1, stated Resident #7 was suppose to get 2 liters per minute of oxygen at all times. They were asked to look at the orders in the resident's medical record and confirm that oxygen level. After looking, LPN #1 stated they did not see an order for oxygen in the EHR. They were asked where else the level could be found and they stated the care plan. LPN #1 looked at the care plan and stated the oxygen level was not in the resident's care plan. LPN #1 stated there should be an order, then stated they recalled there was a standing order for newly admitted residents to get 2 liters of oxygen for every resident who required oxygen. They stated Resident #7 was not a new resident. They stated they did not know where the resident's order was.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 02/26/25 at 9:27 a.m., the ADON stated the order for oxygen should be in a resident's EHR in every case. They stated that is where staff look to find such orders. They were asked to find where the resident's oxygen use was care planned. They stated they had looked at the resident's care plan and there was not an entry for oxygen use.</p> <p>On 02/26/25 at 11:10 a.m., ADON stated they had located an order for oxygen use in Resident #7's EHR in the miscellaneous section. The order, dated 08/29/24, documented the resident was to have continuously received 2 liters of oxygen per minute. They were asked if temporary agency nurses work at the facility. The ADON stated they did. The ADON was asked where those nurses look to find the orders to follow when they care for a resident. They stated they look in the orders section of the EHR and the care plan. They stated they would not look in the miscellaneous section of the chart.</p> <p>On 02/27/25 at 10:48 a.m., DON stated they thought there had been a breakdown in communication in that case between the facility staff and hospice staff. They stated both had failed to take the hospice order and move it into the resident's EHR.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>34270</p> <p>Based on record review and interview, the facility failed to ensure psychotropic medications ordered on an as needed basis were limited to a 14 day course for 2 (#7 and #31) of 5 sampled residents reviewed for unnecessary medications.</p> <p>The ADON stated the facility had 11 residents who had PRN psychotropic medications.</p> <p>Findings:</p> <p>A Policy and Procedure for Drug Regimen Review, dated 04/10/17, read in part, The physician will document in the resident's medical record that the identified irregularity has been reviewed and what, if any action has been taken to address it. If there is no change in the medication, the physician will document his/her rationale for the decision in the resident's medical record.</p> <p>1. Resident #7 had diagnoses which included anxiety disorder.</p> <p>A physician's order, dated 12/18/24 at 11:15 a.m., showed Resident #7 was to be administered lorazepam (antianxiety medication) 0.5mg every 4 hours as needed. The order end date was documented as, Indefinite.</p> <p>A pharmacy consult report, dated 12/18/24, read in part, Please evaluate and verify the desire to use 14-day rule - Lorazepam 0.5 Q4H PRN (increased risk of sedation and falls). In addition, new PRN orders are limited to 14 days and require a prescriber to evaluate the resident prior to extending the order. The report also contained the physician response to change the order to Ativan (lorazepam] 0.5mg three times daily.</p> <p>Resident #7's MAR for December 2024, January 2025, and February 2025 found the order for lorazepam 0.5mg every 4 hours as needed remained on the documents. The February 2025 MAR documented the resident received two doses of the medication on 02/19/25 and 02/20/25.</p> <p>2. Resident #31 had diagnoses which included insomnia.</p> <p>A physician's order, dated 05/24/24 at 3:00 p.m., showed Resident #31 was to be administered temazepam (hypnotic medication) 15mg every 24 hours as needed. The order end date was documented as, Indefinite.</p> <p>A pharmacy consult report, dated 05/27/24, read in part, Please evaluate and verify the desire to use 14-day rule - Temazepam 15 Q 24H PRN (increased risk of sedation and falls). In addition, new PRN orders are limited to 14 days and require a prescriber to evaluate the resident prior to extending the order. The report also contained the physician response that read, [They] does not sleep well. The physician did not document a rationale why the medication should have remained a PRN order or an end date.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A pharmacy consult report, dated 06/27/24, read in part, Temazepam 15mg Q 24H PRN - Please note orders for PRN psychotropics are limited to 14 days then reassess . The area of the form for a physician to respond to the pharmacists report was blank.</p> <p>The MAR entries for the dates on and between 08/01/24 and 02/27/25 were reviewed. The MAR showed Resident #31 had received 81 doses of the medication during the reviewed time period.</p> <p>On 02/27/25 at 9:13 a.m., the ADON stated they had reviewed the pharmacy consult reports for the Resident #7 and #31 and did not find any where the physician had addressed the rationale for extending PRN medications beyond 14 days or where they may have given an end date. The ADON stated it was the facility's expectation physicians would address pharmacy consult reports and provide the required rationales or other response required.</p> <p>On 02/27/25 at 9:15 a.m., the DON stated they understood that in regards to Resident #7 and #31 the responses to the pharmacist consultation reports did not meet regulatory requirements and a rationale and end date for the PRN psychotropics should have been provided.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>42171</p> <p>Based on observation, record review, and interview, the facility failed to:</p> <ul style="list-style-type: none"> a. ensure the dish machine temperature and sanitizer concentration were monitored and logged daily; b. open containers of food were labeled with an opened on date; c. food was not stored on the floor; and d. food storage temperatures were documented. <p>The ADON reported 36 residents received meals from the kitchen.</p> <p>Findings:</p> <p>On 02/25/25 at 8:20 a.m., an initial tour of the kitchen was conducted. The following observations were made:</p> <ul style="list-style-type: none"> a. the Dish Machine Monthly Check Sheet, dated 02/25, had no documented temperatures or chemical concentrations since 02/19/25; b. open containers of 2% milk, cranberry juice, mayonnaise, and ketchup were observed in a refrigerator without documentation of the date they were opened; d. a large bag of blueberry muffin mix was observed on the floor in the storage room; and c. the Regular/Pureed Meal Temperature Log, dated 02/25 did not document the holding temperatures of meals served on 02/20/25, 02/21/25, 02/22/25, 02/23/25, or 02/24/25. <p>On 02/26/25 at 11:52 a.m., the DM stated the dish machine temperature and chemical concentration should be completed three times a day. They also stated food items should be labeled with a date the items were opened. The DM stated food holding temperatures should be monitored and recorded for each meal and food should not be stored on the floor.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>42171</p> <p>Based on observation, record review, and interview, the facility failed to ensure catheter bags were not on the floor for 1 (#141) of 1 sampled resident reviewed for urinary catheters.</p> <p>The ADON reported one resident used a urinary catheter.</p> <p>Findings:</p> <p>On 02/26/25 at 3:44 p.m., CNA #1 and LPN #1 were observed providing catheter care for Resident #141. Upon entering the room, Resident 141's catheter bag was observed on the floor. During catheter care CNA #1 picked the catheter bag up off the floor, moved it over and set it back on the floor. After catheter care was completed LPN #1 was observed to hang the catheter bag off the floor.</p> <p>On 02/27/25 at 10:20 a.m., Resident #141's catheter bag was observed laying on the floor under the resident's bed.</p> <p>An undated facility document titled Catheter Care Policy, read in part, Avoid letting the drainage bag touch the floor.</p> <p>Resident #141 had diagnoses which included diabetes mellitus and urinary tract infection.</p> <p>A care plan, initiated on 02/24/25, showed Resident #141 had an indwelling urinary catheter.</p> <p>On 02/26/25 at 4:00 p.m., CNA #1 stated the catheter bag should not be on the floor, and they should have hung it back up when they noticed it was on the floor.</p> <p>On 02/26/25 at 4:01 p.m., LPN #1 stated catheter bags should not be on the floor.</p> <p>On 02/27/25 at 9:45 a.m., the ADON stated catheter bags should not be on the floor.</p>		