

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

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Form Approved OMB
No. 0938-0391

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 07/24/2026
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)		
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview, facility document review, and facility policy review, the facility failed to ensure there was a registered nurse (RN) on duty for eight consecutive hours each day. This deficient practice had the potential to affect all 34 residents who currently resided in the facility. Findings included: An undated facility policy titled, Policy Regarding Facility Staffing revealed, It shall be the policy of this facility to employ sufficient, adequately trained staff, to be on duty 24 hours a day, to meet the needs of the residents residing in the facility, as determined by the Administrator and/or Director of Nursing. A facility document titled, Time & Attendance - Detail Report. TA, for the timeframe 01/01/2026 - 07/22/2026, revealed no evidence of RN coverage for eight consecutive hours on 01/17/2026, 01/18/2026, 03/08/2026, 04/12/2026, 04/16/2026, 04/17/2026, 04/19/2026, 04/26/2026, and 06/28/2026. During an interview on 07/23/2026 at 12:12 PM, the Administrator stated there was no evidence of eight consecutive hours of RN coverage on 01/17/2026, 01/18/2026, 03/08/2026, 04/12/2026, 04/16/2026, 04/17/2026, 04/19/2026, 04/26/2026, and 06/28/2026. During an interview on 07/24/2026 at 9:43 AM, the Business Office Manager stated sometimes the facility had RN coverage for eight consecutive hours each day and sometimes they did not. During an interview on 07/24/2026 at 12:20 PM, the Assistant Director of Nursing stated the facility needed to have a RN on duty for eight consecutive hours each day. During an interview on 07/24/2026 at 3:47 PM, the Director of Nursing stated her expectation was that the facility had RN coverage for eight consecutive hours every day. During an interview on 07/24/2026 at 4:14 PM, the Administrator stated her expectation was that the facility had a RN on duty for eight consecutive hours each day.		

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, facility document review, and facility policy review, the facility failed to ensure followed the menu and provide a one-half cup portion of mashed potatoes during the lunch meal on 07/20/2026. This deficient practice had the potential to affect all residents who received food from the kitchen. Findings included: An undated facility policy titled, Food Preparation, indicated, Policy: Portion-control methods will be used to assure the correct quantities are served to residents to meet the nutritional specifications as determined by the menu. An undated facility document titled Conversions/Measurements posted in the kitchen, indicated a #16 scoop would yield a one quarter cup, equivalent to two ounces. The facility's weekly menu revealed that on 07/20/2026, the facility would serve one half cup of mashed potatoes for the lunch meal. During the lunch meal tray line observation on 07/20/2026 at 12:58 PM, the Dietary Manager (DM) was observed to plate mashed potatoes with a blue handled scoop. During an interview on 07/20/2026 at 1:11 PM, the DM acknowledged she used a #16 scoop to serve the mash potatoes for the lunch meal. The DM reviewed the menu and stated she made a mistake and used the wrong serving utensil for the mashed potatoes. The DM stated she should have served one-half cup of mashed potatoes but she only served the residents a two-ounce portion of mashed potatoes. During a telephone interview on 07/23/2026 at 10:19 AM, the Registered Dietician stated she expected staff to use the menu as a guide for portions and use the utensil guide that was posted in the kitchen to ensure staff used the correct utensil to serve foods in the portions recorded on the menu. During an interview on 07/23/2026 at 4:15 PM, the Administrator stated staff should follow the menus and provide food in the portion according to the menu. The Administrator stated staff should use the utensil guide and the menu together to provide the correct portions.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 items were stored with a date and label and expired food items were discarded. These deficient practices had the potential to affect all residents who received food from the kitchen. Findings included: An undated facility policy titled, Sanitation and Infection Control, with a subject of Refrigerated Storage indicated, 7. All refrigerated foods should be covered properly, labeled and dated. and 10. The opened, unused portions of packaged foods should be dated to assure that they will be used first. An undated facility policy titled, Sanitation and Infection Control, with a subject of Usage and Storage of Leftovers indicated, 2. Leftover food must be covered, labeled dated and refrigerated immediately. 3. Leftover foods must be used within three days of the original cooking date. The policy specified, 5. Freeze leftovers that will not be eaten within three days, label, and date. and 7. Never mix leftover food with fresh food. During a concurrent interview and observation of the reach-in refrigerator on 07/20/2026 at 9:28 AM, the surveyor noted the following:- Eleven pieces of pre-cooked sausage patties were stored in an opened bag, in a box with approximately 50 pieces of uncooked bacon. The Dietary Manager (DM) stated the pre-cooked sausage should not be stored in a box with uncooked bacon.- A five-pound unopened plastic bag of cut celery with a manufacturer best-by date of 06/03/2026. The bag of celery contained a brown liquid, and the pre-cut ends of the celery were a brown/rust color. The DM stated the celery was expired.- Five flour tortillas were wrapped in plastic wrap without a label or date. The DM stated there was no label on the tortillas.- One peeled/cut cucumber was stored in a zipped plastic bag without a label to record the use-by date (UBD). The DM stated there was no label on the bag.- Two pounds of sliced turkey was stored in a zipped plastic bag with a label that recorded an opened date of 07/10/2026 and no UBD. The DM stated she was told that all foods had a three-day shelf life once opened.- Two one-pound containers of fresh strawberries were observed and identified by the DM to have mold. The DM stated the strawberries were molded and should not be served.- Four green bell peppers were stored in a clear plastic container and observed with black, white, and green discoloration. The DM stated the green peppers were expired.- One slice of turkey deli meat was stored in a zipped plastic bag without a label or date. The DM stated there was no label to record the date the package was opened.- One pound of Swiss cheese was stored in a zipped plastic bag without a label or UBD.- A five-pound container of sour cream had a manufacturer best by date of 06/25/2026; the label recorded an opened date of 06/05/2026. Approximately one eighth of the sour cream was left. The DM stated that once the sour cream was opened, it had a seven-day shelf life.- An unopened five-pound container of sour cream had a manufacturer best by date of 05/09/2026. The DM stated the sour cream was expired.- One peeled white onion was stored in a plastic bag with a label that recorded an opened date of 07/15/2026. The DM stated the onion had a three-day shelf life once it was peeled.- A cut tomato was stored in a plastic bag with a brown liquid and white fuzzy growth with a label that recorded a storage date of 06/26/2026. The DM stated the tomato was expired.- Nine cucumbers were observed in a plastic container with black and white discolored spots. During an interview on 07/20/2026 at 9:28 AM, the DM stated she checked the reach-in cooler each morning she worked for expired items, but had been off since 07/17/2026 and she was not sure if staff checked the reach-in cooler on the days she was off. During an interview on 07/20/2026 at 9:40 AM, the Administrator stated she expected staff to monitor the refrigeration units daily for expired food items and to remove food items from refrigeration that were expired or had signs of spoilage. The Administrator stated she expected each item placed in refrigerator to have a date it was opened and a date it would expire.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and facility document review, the facility failed to complete a performance review of every certified nurse aide (CNA) at least once every 12 months for 2 (CNA #7 and CNA #25) of 3 CNAs' personnel files reviewed. Findings included: CNA #7's personnel file revealed the CNA's hire date of 08/16/2022 and there was no evidence found to indicate an annual performance (skills) review had been completed. CNA #25's personnel file revealed the CNA's hire date of 05/08/2023 and there was no evidence found to indicate an annual performance (skills) review had been completed. During an interview on 07/24/2026 at 12:00 PM, the Assistant Director of Nursing (ADON) stated she had been the ADON since 2023. The ADON stated the CNAs were provided 12 hours of in-service training, but there was no documentation of the CNA's performance review. Per the ADON, she was not who was responsible for performance reviews, she thought it would be the Administrator, and then stated the responsibility for training and performance reviews would be a shared responsibility between her and the Director of Nursing (DON). During an interview on 07/24/2026 at 6:02 PM, the DON stated she had not completed CNAs' performance reviews, she was not aware that performance reviews were not being completed and did not know she was supposed to do them. During an interview on 07/24/2026 at 6:30 PM, the Administrator stated performance reviews were to be completed to ensure staff were up to date with the skills to perform their job. The Administrator stated she expected performance reviews to be completed upon hire and annually to ensure staff could continue to perform their assigned job.		

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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 interview, facility document review, and facility policy review, the facility failed to implement their infection prevention and control program to include conducting an outbreak investigation when multiple residents were diagnosed with respiratory syncytial virus (RSV) and failed to perform respirator fit testing according to their policy. These deficient practices affected 8 (Residents #1, #3, #11, #14, #22, #28, #40, and #41) of 13 sampled residents reviewed for infection control. Findings included: A facility policy titled, Respiratory Protection Program, dated 04/28/2021, indicated, d. Fit Testing Employees required to wear tight-fitting respirators will be fit tested: * Prior to being allowed to wear any tight-fitting respirator; * Annually; and * When there are changes in employee's physical condition that could affect respirator fit. A facility policy titled, Infection Outbreak Response and Investigation, with a copyright date of 2026, revealed, The facility promptly responds to outbreaks of infectious diseases within the facility to stop transmission of pathogens and prevent additional infections. Definitions: Outbreak generally refers to the occurrence of more cases of a communicable disease than expected in a given area or among a specific group of people over a particular period of time. The policy specified, 3. Outbreak Investigation: a. When the existence of an outbreak has been established, an investigation will begin. b. The Infection Preventionist will be responsible for coordinating all investigation activities. c. A case definition will be developed in order to identify other staff and residents who may be affected. Criteria for developing a case definition include: i. Person - key characteristics the patients share in common. ii. Place - the location associated with the outbreak. iii. Time - period of time associated with illness onset for the cases under investigation. iv. Clinical features - objective signs and symptoms, such as sudden onset of fever and cough. A facility document titled, Respiratory Surveillance dated 02/2026, revealed Resident #40 had an onset of symptoms to include wheezing on 01/23/2026 and was diagnosed with RSV. A facility document titled, Respiratory Surveillance dated 03/2026, revealed seven residents (Residents #1, #3, #11, #14, #22, #28, and #41) were diagnosed with RSV. Resident #3 had an onset of symptoms to include a cough on 03/04/2026 and was diagnosed with RSV. Resident #11 had an onset of symptoms to include a cough on 03/04/2026 and was diagnosed with RSV. Resident #14 had an onset of symptoms to include a cough on 03/04/2026 and was diagnosed with RSV. Resident #22 had an onset of symptoms to include a cough on 03/04/2026 and was diagnosed with RSV. Resident #28 had an onset of symptoms to include a cough on 03/04/2026 and was diagnosed with RSV. Resident #41 had an onset of symptoms to include a cough on 03/04/2026 and was diagnosed with RSV. Resident #1 had an onset of symptoms to include a cough, sore throat, and diminished lung sounds with slight wheezing upon exhale on 03/10/2026, and was diagnosed with RSV and pneumonia. During an interview on 07/24/2026 at 9:46 AM, the Assistant Director of Nursing (ADON), who served as the facility's Infection Preventionist (IP), stated employee health surveillance and a comprehensive outbreak investigation were important responsibilities of the IP that were not conducted during the 02/2026 - 03/2026 RSV outbreak. The ADON stated the infection prevention program did not meet expectations during the RSV outbreak, and the RSV outbreak could have been managed more effectively. The ADON stated employee health surveillance was not conducted during the RSV outbreak. During an interview on 07/24/2026 at 9:27 AM, the Director of Nursing (DON) stated there was not a comprehensive investigation conducted to determine the source of transmission during the RSV outbreak. The DON stated staff were not investigated to determine whether they might have been a source of transmission. The DON stated employee screening and monitoring activities were not conducted, and staff illnesses were not tracked through the infection prevention and control (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	program. The DON stated employee respirator fit testing was not completed during the facility's RSV outbreak. During an interview on 07/24/2026 at 3:37 PM, the Administrator stated opportunities were missed during the RSV outbreak to conduct enhanced surveillance, employee health monitoring, and a comprehensive outbreak investigation. According to the Administrator, respirator fit testing was an essential component of the facility's infection prevention program.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on interview, record review, and facility policy review, the facility failed to ensure a resident was offered an ongoing program of activities for 1 (Resident #21) of 2 sampled residents reviewed for activities. Findings included: An undated facility policy titled, Policy & Procedure on Activities Program, revealed, This facility will provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Programs shall be designed to encourage rehabilitation and restoration to self care and normal activity. An admission Record revealed the facility admitted Resident #21 on 01/05/2026. According to the admission Record, the resident had a medical history that included diagnoses of depression and muscle weakness. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/20/2026, revealed Resident #21 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #21's Care Plan Report included a focus area initiated 01/12/2026, that indicated the resident was dependent on staff for meeting their emotional, intellectual, physical, and social needs. Interventions directed the staff to provide the resident a program of activities that was of interest and empowered the resident by encouraging/allowing choice, self-expression, and responsibility (initiated 01/12/2026). Resident #21's Activities - Quarterly/Annual Participation Review, dated 03/30/2026 and 06/23/2026, revealed the resident enjoyed 1:1 activities. Resident #21's Progress Notes, for the timeframe 02/01/2025 - 04/30/2026, revealed no evidence that 1:1 activities were offered and/or provided to the resident. During an interview on 07/20/2026 at 11:39 AM, Resident #21 stated no one offered any activities to them. During an interview on 07/23/2026 at 3:08 PM, the Activities Director (AD) stated she had been employed at the facility as the AD since 01/2024. The AD stated she felt bad that she had not been doing her job like she was supposed to. The AD stated she was not tracking activity participation for each resident and had not offered 1:1 activities to Resident #21. During an interview on 07/24/2026 at 3:47 PM, the Director of Nursing stated she expected the AD to ensure all residents received some type of activity on an ongoing basis. During an interview on 07/24/2026 at 4:14 PM, the Administrator stated she expected the AD to document the activity participation for all residents.		

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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 post the nurse staffing data during 2 (07/20/2026 and 07/21/2026) of 5 days of the survey. This deficient practice had the potential to affect all 34 residents who currently resided in the facility. Findings included: During an observation on 07/20/2026 at 10:48 AM, 07/20/2026 at 3:18 PM, and 07/21/2026 at 8:32 AM, the required nurse staffing data was not observed posted in the facility. During a concurrent observation and interview on 07/21/2026 at 8:34 AM, Administrator observed the billboard in the facility and stated the facility did not have a post of the nurse staffing data. The Administrator stated it was her understanding the facility never posted the nurse staffing data. During an interview on 07/21/2026 at 8:35 AM, the Assistant Director of Nursing (ADON) stated she was not aware of the requirement for posting the nurse staffing data. During an interview on 07/21/2026 at 8:37 AM, the Chief Nursing Officer (CNO) stated she had not discussed the posting of the nurse staffing data yet with the ADON. The CNO acknowledged the facility did not post the nurse staffing data, but would begin. During an interview on 07/22/2026 at 9:21 AM, the Business Office Manager stated she kept track of the nurse staffing data, completed a report, but did not post the nurse staffing data. During an interview on 07/24/2026 at 3:47 PM, the Director of Nursing stated her expectation was that the nurse staffing data would be posted every day. During an interview on 07/24/2026 at 4:14 PM, the Administrator stated her expectation was that the nurse staffing data would be posted every day.		