STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375209	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairmont Skilled Nursing and Therapy	3233 Northwest 10th Street Oklahoma City, OK 73107

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure the physician was notified of a change in weight for 1 (#75) of 19 sampled residents reviewed for change in weight.The DON identified 88 residents resided in the facility.Findings:On 12/08/25 at 1:15 p.m., Resident #75 was observed to have a continuous feeding pump connected to their feeding tube with formula running through the tube.A policy titled Weight List, revision date 10/21/09, read in part, Residents' weights are routinely and systematically monitored. All residents must be weighed weekly for four weeks upon admission.The resident's physician should be notified of any significant weight changes.A policy titled, Notification of Change, dated 06/2025, read in part, The facility will notify the resident, the resident's physician, and the resident's representative (if applicable) promptly when there is: A significant change in the resident's physical, mental, or psychosocial status. All notifications should be documented in the medical record.A Care Plan, dated 11/17/25, showed Resident #75 was to be weighed weekly for four weeks. The care plan, read in part, Monitor/record/report to MD s/sx of malnutrition: .significant weight loss 3lbs in 1 week.An admission assessment, dated 11/23/25, showed Resident #75 was admitted to the facility on [DATE] with diagnoses to include cerebrovascular accident, aphasia, hemiplegia, and malnutrition. The MDS showed Resident #75 was dependent on staff for all ADLs and required the use of a feeding tube.An undated weight record for Resident #75 showed:a. on 12/01/25 they weighed 169.8 pounds; and,b. on 12/08/25 they weighed 165.8 pounds.On 12/10/25 at 1:57 p.m., LPN #1 was asked to show where Resident #75's physician was notified of their weight loss. They stated, I know I didn't notify [name-deleted physician] about the 4 pound weight loss. LPN #1 was asked when the physician would need to be notified regarding weight loss for Resident #75. They stated they did not think there were parameters for notifying the physician of the resident's weight loss. LPN #1 was asked what the process was for notifying the physician of weight loss. They stated the ADONs monitored the weights and notified the charge nurse if the physician needed to be notified. On 12/10/25 at 2:02 p.m., the DON was asked what the facility's process was for identifying weight loss. They stated the facility would meet monthly and compare the weights. The DON was asked who was responsible for notifying the physician of weight loss. They stated, Typically the charge nurse. The DON stated any physician notification would be documented in the nurse's notes and if the documentation was not in a nurse's note then the physician was not notified.On 12/10/25 at 2:31 p.m., the DON was asked why Resident #75's physician wasn't notified of their 4 pound weight loss. They stated they just got off the phone with the physician to notify them and LPN #1 had also just notified the physician. The DON was asked if the physician had been notified of the weight loss prior to 12/10/25 and they stated no.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to implement comprehensive care plan interventions for:a. physician notification of weight loss for 1 (#75) of 19 sampled residents reviewed for care plans, andb. trauma informed care for 1 (#7) of 1 sampled resident reviewed for diagnosis of post-traumatic stress disorder. The DON identified 88 residents resided in the facility.Findings:1. Monthly physician's orders, dated December 2025, showed Resident #7 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease late onset, bipolar disorder with current episode manic severe with psychotic features, post-traumatic stress disorder, hallucinations and depression, feeding tube status, and dysphagia. A significant change assessment, dated 11/25/25, showed a BIMS score of 8 which indicated moderately impaired cognition, dependence on staff for ADL completion, and received nutrition through feeding tube due to refusing meals. A care plan for Resident #7, updated 12/06/25, showed impaired cognition related to dementia and Alzheimer's disease. Resident #7's care plan did not address post-traumatic stress disorder care. On 12/10/25 at 8:35 a.m., CMA #1 was asked why Resident #7 had diagnosis of post-traumatic stress disorder. They were unable to state why. On 12/10/25 at 8:40 a.m., the activity director was asked why Resident #7 had diagnosis of post-traumatic stress disorder. They were unable to answer. On 12/10/25 at 9:10 a.m., the activity director stated they had learned that Resident #7 had diagnosis of post-traumatic stress disorder due to while in the military in [NAME], Resident #7 stepped on a hidden explosive device which blew up, also resulting in a right leg amputation. On 12/10/25 at 1:35 p.m., the DON and administrator were asked if the care plans included trauma informed care and interventions for residents with diagnoses of post-traumatic stress disorder. They stated no. 2. On 12/08/25 at 1:15 p.m., Resident #75 was observed to have a continuous feeding pump connected to their feeding tube with formula running through the tube. A policy titled Weight List, revised 10/21/09, read in part, Residents' weights are routinely and systematically monitored. All residents must be weighed weekly for four weeks upon admission.The resident's physician should be notified of any significant weight changes. A policy titled Notification of Change, dated 06/2025, read in part, The facility will notify the resident, the resident's physician, and the resident's representative (if applicable) promptly when there is: A significant change in the resident's physical, mental, or psychosocial status.All notifications should be documented in the medical record. A Care Plan, dated 11/17/25, showed Resident #75 was to be weighed weekly for four weeks. The care plan read in part, Monitor/record/report to MD s/sx of malnutrition:.significant weight loss 3lbs in 1 week. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An admission assessment, dated 11/23/25, showed Resident #75 was admitted to the facility on [DATE] with diagnoses to include cerebrovascular accident, aphasia, hemiplegia, and malnutrition. The assessment showed Resident #75 was dependent on staff for all ADLs and required the use of a feeding tube. An undated weight record for Resident #75 showed: a. on 12/01/25 a weight 169.8 pounds; and, b. on 12/08/25 they weighed 165.8 pounds. On 12/10/25 at 1:57 p.m., LPN #1 was asked to show where Resident #75's physician was notified of their weight loss. They stated, I know I didn't notify [physician] about the 4-pound weight loss. LPN #1 was asked when the physician would need to be notified regarding weight loss for Resident #75. They stated they did not think there were parameters for notifying the physician of the resident's weight loss. LPN #1 was asked what the process was for notifying the physician of weight loss. They stated the ADONs monitor the weights and notify the charge nurse if the physician needed to be notified. On 12/10/25 at 2:02 p.m., the DON was asked what the facility's process was for identifying weight loss. They stated the facility would meet monthly and compare the weights. The DON was asked who was responsible for notifying the physician of weight loss. They stated, Typically the charge nurse. The DON stated any physician notification would be documented in the nurse's notes and if the documentation was not in a nurse's note, then the physician was not notified. On 12/10/25 at 2:31 p.m., the DON was asked why Resident #75's physician wasn't notified of their 4-pound weight loss. They stated they just got off the phone with the physician to notify them and LPN #1 had also just notified the physician. The DON was asked if the physician had been notified of the weight loss prior to 12/10/25 and they stated no. The DON was asked if Resident #75's care plan was followed. They stated no.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop and implement a comprehensive person-centered care plan for trauma informed care for 1 (#7) of 1 sampled resident reviewed with diagnosis of post-traumatic stress disorder. The DON identified 88 residents resided in the facility. Findings:Resident #7's December 2025 physician orders showed they were admitted on [DATE] with diagnoses of post-traumatic stress disorder, hallucinations, and depression. A care plan for Resident #7, updated on 12/06/25, did not address trauma informed care for post-traumatic stress disorder. On 12/10/25 at 8:35 a.m., CMA #1 was asked why Resident #7 had diagnosis of post-traumatic stress disorder. They were unable to state why. On 12/10/25 at 8:40 a.m. the activity director was asked why Resident #7 had diagnosis of post-traumatic stress disorder. They were unable to answer. On 12/10/25 at 9:10 a.m., the activity director stated they had learned Resident #7 had diagnosis of post-traumatic stress disorder due to while in the military in Vietnam, Resident #7 stepped on a hidden explosive device which blew up, also resulted in a right leg amputation On 12/10/25 at 1:35 p.m., the DON and administrator were asked if care plans included trauma informed care and interventions for residents with diagnoses of post-traumatic stress disorder. They stated no.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure enhanced barrier precautions were used during wound care for 1 (#44) of 3 sampled residents reviewed for enhanced barrier precautions practices. The administrator identified eight residents who required enhanced barrier precautions during the provision of care. Findings:On 12/10/25 at 9:20 a.m., LPN #2 was observed performing wound care on Resident #44's right lower leg. LPN #2 was observed to don gloves and then performed the wound care. LPN #2 performed wound care without a gown. A facility policy titled Infection Control and Isolation Guideline, dated 07/2025, read in part, Enhanced barrier precautions apply to residents with: MDRO, wounds and/or indwelling medical devices, and refer to the use of gowns and gloves during high-contact care. High-contact resident care activities requiring gown and glove use, include dressing, providing hygiene, changing briefs, device care, urinary catheter care, feeding tube, wound care with any skin opening requiring a dressing. Physician orders, dated November 2025, showed Resident #44 was admitted on [DATE] with diagnoses which included rheumatoid arthritis and shearing to right lower leg with open wound. A care plan for Resident #44, updated 11/03/25, showed enhanced barrier precautions were required during the provision of care due to open wounds. On 12/10/25, at 10:15 a.m., LPN #2 was asked if they understood enhanced barrier precautions and was the procedure done correctly for incontinent care and wound care for Resident #44. LPN #2 replied they did everything right. On 12/10/25 at 1:44 p.m., the DON was asked how the staff were taught about enhanced barrier precautions during wound care. They stated they had routine training subjects and enhance barrier precautions was one of the subjects which was reviewed often.