STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375325	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burford Manor	505 South 7th Street Davis, OK 73030

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 - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 41873 Based on record review and interview, the facility failed to notify the resident's representative of a change of condition for one (#2) of three sampled residents reviewed for notifications related to changes of condition. The DON reported 47 residents resided in the facility. Findings: A Change in a Resident's Condition or Status policy, dated 09/01/23, read in part Our facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental conditions and/or status .Unless otherwise instructed by the resident, the nurse supervisor will notify the resident's family or representative when: The resident is involved in any accident or incident that results in an injury; There is a significant change in the resident's physical, mental or psychosocial status; and/or it is necessary to transfer the resident to a hospital/treatment center . Resident #2 had diagnoses which included Alzheimer's disease and dysphagia. A nurse's notes, dated 11/27/23, documented resident #2 had a laceration to side of head and was sent to the emergency room for treatment. A nurse's written statement, dated 11/27/23, documented LPN #1 stated Resident #2's representative had not answered the phone when they notified them of the resident's fall and a transfer to the ER. A nurse's note, dated 12/04/24, documented, sutures intact to right forehead and son here to visit. A nurse's note, dated 12/22/23, documented purulent drainage to wound on right forehead .A new order for Bactrim DS 800-160 mg twice a day for 7 days for wound infection .Resident #2's son was called to notify of new medication, no answer, a voice mail was left . Resident #2's care plan meeting notes, dated 12/04/23, documented the Resident #2's representative was upset because they had not been called when the resident had a fall. The care plan meeting notes documented family member #1 was not coming to the care plan meeting because the facility did not call when asked. (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
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An in-service/training, dated 12/04/23, read in part, Topic: Notifying family members .When you need to notify a family member of a resident and can not [sic] reach them, please write attempted to notify family and chart if message was left and that family did not answer .Keep attempting to call family until they answer, even if continues on next shift or takes days .Chart every time an attempt is made to contact family. A comprehensive assessment, dated 03/14/24, documented Resident #2's cognition was severely impaired. On 07/15/24 at 3:45 p.m., resident representative #1 reported not being informed of a fall Resident #2 had on 11/27/23. The resident representative #1 reported not being aware of the fall or the Resident #2's transfer to ER for treatment until a visit on 12/04/23 and the Resident #2 had sutures and bruising to forehead. The resident representative reported #1 they had not been notified of all falls or medication changes. On 07/16/24 at 2:00 p.m., LPN #1 reported residents' representatives should be notified when residents had any changes in condition or were being sent out to the ER. The LPN #1 reported resident's representatives should be repeatedly called until contact was made and each call should be documented. The LPN #1 reported Resident #2's representative was called to notify of the fall and ER visit on 11/27/23 and had not answered. The LPN #1 reported the resident's representative had not called back. On 07/16/24 at 2:27 p.m., the DON reported any increase in medications, physician order changes, or changes in health status should be reported to the resident's representative.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 30875 Based on observation and interview, the facility failed to maintain housekeeping and maintenance services to maintain a sanitary and safe environment for 47 of 47 residents who reside in the facility. Census: 47 Findings: On 07/16/24 at 8:40 a.m., maintenance was asked about the holes in the wood flooring located on the South Hall. They reported they could fill the holes with something, but it was the foundation. Maintenance was asked about the black areas that outline the base in the shower on the East/West Hall. They reported it was soap/grime around the base of shower. They reported they would caulk it every three months or so. They reported the North Hall shower was the same way and they were looking for contractors to replace that tile, because of the black/scum around the base of the shower. On 07/16/24 at 11:45 a.m., DON reported there were holes in the wood flooring on the South Hall and they were going to get that fixed. The East/West Hall observed with a black colored area at the base of the shower. They reported they were looking to hire a contractor to repair all the showers. Chips were observed in the wood flooring in the dining room floor between the common area and the main dining room. The DON reported that needed to be repaired. On 07/16/24 at 12:42 p.m., the DON was asked about the policy for housekeeping/maintenance services. They reported if there was anything not functioning, they would notify maintenance, then they would follow up and repair it. They reported they had discussed the showers with maintenance before and that was something they could not repair.