STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375427	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Fellowship Home for Senior Citizens, Inc	605 East State Road Fairview, OK 73737

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. **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 and catheter care for 2 (#18 and #34) of 2 sampled residents reviewed for enhanced barrier precautions practices by staff. The administrator identified six residents required enhanced barrier precautions during the provision of care. Findings: A facility policy titled Enhanced Barrier Precautions Policy and Procedure, last updated on 07/28/25, read in part, Enhanced barrier precautions expand the use of PPE and refer to the use of gowns and gloves during high-contact resident care activities.Examples of 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 treatment order. 1. On 12/04/25 at 8:36 a.m., LPN #1 was observed performing donning gloves to provide wound care on Resident #34's left lower leg. After wound care LPN #1 took off the gloves, washed their hands and donned new gloves to preform incontinent care for Resident #34. Feces were observed to be on Resident #34's buttocks. After performing incontinent care, LPN #1 was observed using the soiled gloves to apply a cream temporarily to open wounds on bilateral buttocks. LPN #1 was observed to not be wearing a gown during wound care and incontinent care. Physician orders, dated November 2025, showed Resident #34 was admitted on [DATE] with diagnoses which included chronic venous hypertension with ulcer on bilateral lower legs, and stage 2 pressure ulcer of right and left buttocks. A care plan for Resident #34, dated 11/13/25, showed they had open wounds and required enhanced barrier precautions. On 12/04/25, immediately following wound care for Resident #34, LPN #1 was asked if they understood EBP and was the procedure done correctly for incontinent care and wound care for Resident #34. They stated everything was done right. 2. Resident #18's physician's order dated 11/26/25, showed they had an indwelling catheter for comfort measures. On 12/04/25 at 9:57 a.m., CNA #1 and CNA #2 was observed donning gloves performing catheter care for Resident #18. The aides did not wear a gown during the provision of care. Immediately following the catheter care, CNA #1 and CNA #2 were asked if they understood enhanced barrier precaution practices and protocol. They stated yes indicating they used correct procedures with enhanced barrier precautions during care. On 12/04/25 at 10:24 a.m., the ADON was asked how the staff were trained on enhanced barrier precautions during wound care and catheter care, The ADON stated, They have been educated often.

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