STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375467	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairfax Behavioral Health & Memory Care Community	282 County Road 6300 Fairfax, OK 74637

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 34270 Based on observation and interview, the facility failed to ensure residents who require assistance with dressing were not left unclothed in their rooms and resident catheter bags were covered while in public spaces for one (#12) of two residents reviewed for dignity. A midnight census report, dated 06/02/24, documented 48 residents resided in the facility. The administrator stated that was the accurate census at the time the survey began. Findings: The facility's Policy and Procedure for Exercising of Rights policy, undated, read in part, The resident has a right to a dignified existence and the facility will protect and promote the rights of each resident. Resident #12 had diagnoses which included vascular dementia, acquired absence of right leg below the knee, and acquired absence of the left leg above the knee. On 06/03/24 at 2:19 p.m., upon entrance to Resident #12's room they were observed lying sideways on their bed nude from the waist down. They stated they could not reposition themselves or reach the call light to ask for assistance. They stated they had returned from the hospital earlier and were not happy the staff left them there without clothes on. They stated they could not recall how long they had been in that stated but thought it was not too long. On 06/04/24 at 7:47 a.m., Resident #12 was observed eating in the dining room. Their catheter bag was uncovered and half full of urine. On 06/05/24 at 7:54 a.m., Resident #12 was observed sitting in a wheelchair located in the hallway outside of their room. Their catheter bag was uncovered and one third full of urine. On 06/05/24 at 8:27 a.m., Resident #12 was observed eating a meal in the dining room. Their catheter bag was uncovered and half full of urine. On 06/05/24 at 9:27 a.m., Resident #12 was observed sitting in a wheelchair located in the hallway outside of their room. Their catheter bag was uncovered and half full of urine. (continued on next page)

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/05/24 at 10:28 a.m., Resident #12 was observed in their room during wound care. LPN #2 stated the facility does have dignity covers for catheter bags and they would instruct and the aides to keep one on the resident's bag. On 06/05/24 at 11:57 a.m., Resident #12 was observed in the dining room with their catheter bag uncovered and full of urine. On 06/06/24 at 7:35 a.m. Resident #12 was observed in the dining room. Their catheter bag had a dignity bag covering it. 06/07/24 at 11:01 a.m., the DON stated all resident rights must be respected in all situations. They stated Resident #12 should not have been left alone without clothes on and their catheter bag should be covered at all times. They stated they have a good supply of catheter bag covers.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270 Based on record review and interview, the facility failed to provide residents the opportunity to develop or refuse the creation of an advance directive or three (#15, 21 and #36) of five residents reviewed for advance directives. A midnight census report, dated 06/02/24, documented 48 residents resided in the facility. The administrator stated that was the accurate census at the time the survey began. Findings: The facility Policy and Procedure for Residents Rights Regardign (sic) Advance Directives for Health Care & Mental Health Treatment, undated, read in part, Every competent person has a right to determine whether he/she will receive life sustaining treatment , who will make the decisions concerning their health care if they cannot and provide their wishes concerning organ donation. 1. Resident #15 was admitted to the facility on [DATE]. 2. Resident #21 was admitted to the facility on [DATE]. 3. Resident #36 was admitted to the facility on [DATE]. On 06/04/24 at 12:57 p.m., LPN #1 stated the advance directive form for Resident #15 was signed on 06/04/24. Resident #15 admitted on [DATE]. On 06/04/24 at 12:59 p.m., LPN #1 stated Residents #21 and #36 stated there was no documentation that either resident was offered an opportunity to develop and advance directive. They stated the facility had a document used in the admission process for that task. 06/07/24 at 12:45 p.m., the DON stated that during the admission process advance directives were to be completed during the admission process. They stated they expect the documents to be done thoroughly on admission or before.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270 Based on record review and interview, the facility failed to ensure a written notice of discharge was provided to a resident and the ombudsman office was notified when a resident was discharged from the facility to a hospital for one (#12) of two resident reviewed for discharges and hospitalization s. The director of nurses stated six residents had discharged in the previous six months. Findings: The Policy and Procedure for Transfer and Discharge, undated, read in part, The facility will notify the resident, resident's representative if authorized, the person responsible for payment of the resident's care, or legal representative of the resident, of the tranfers or discharge. The reason for the transfer or discharge will be documented in the resident's medical record. Notice will be made as soon as possible before transfer or discharge when an emergency exists. Resident #12 was admitted to the facility on [DATE]. A review of Resident #12's MDS section of their electronic medical records found the resident was discharge from the facility four times since admission. Progress notes dated, 05/07/24, 05/16/24, 05/24/24, and 05/31/24, documented the facility initiated transfers of Resident #12 to a hospital on each of the listed dates for medical reasons. On 06/05/24 at 9:42 a.m., the DON stated they had not given a notice of transfer to a resident when they had been discharged to a hospital and had not reported the discharges to the ombudsman office. They stated they should have given the notices and would create a new form to be given to residents prior to transfers or discharges in the future.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 34270 Based on observation, record review, and interview, the facility failed to accurately assess and code a pressure wound in Section M of a MDS quarterly assessment for one (#12) of one resident reviewed for pressure wounds. A midnight census report, dated 06/02/24, documented 48 residents resided in the facility. The administrator stated that was the accurate census at the time the survey began. Findings: The Policy & Procedure for Assessment Review, undated, read in part, This facility will ensure that each resident's condition will be examined by the nursing facility at least once every three months, and if necessary, will change the resident's assessment to assure the continued accuracy of each resident's assessment. Resident #12 had diagnoses which included vascular dementia, acquired absence of right leg below the knee, and acquired absence of the left leg above the knee. A progress note, dated 05/13/24 at 7:56 p.m., documented Resident #12 had a new wound on the coccyx about 1 cm in length. A progress note, date 05/23/24 at 8:03 a.m., documented Resident #12's sacral wound was much larger than it had been seven days prior. The wound was documented as closed. A progress note, dated 05/28/24 at 2:00 p.m., documented an open area on Resident #12's coccyx was found when the resident had returned from hospital. A quarterly MDS assessment, dated 05/29/24, documented in Section M that Resident #12 was at risk for developing pressure ulcer. The assessment documented the resident had no pressure ulcers. On 06/05/24 at 10:28 a.m., the Resident #12's coccyx area was observed during wound care. An open wound approximately 5 cm X 2.5 cm was observed over the coccyx area. No wounds or scarring on the sacral area was observed. 06/07/24 07:58 a.m., the MDS Coordinator stated they had erred on the quarterly MDS assessment of 05/29/24. They stated they did not document the pressure wound on the coccyx because they were thinking of the Resident #12's surgical wounds at the time they filled out the assessment. They stated they get their information for the assessments from documentation in a resident's medical record and speaking to the floor nurses. On 06/07/24 at 11:01 a.m., the DON stated they were the ones who checked the work of the MDS nurses. They stated they look for things that jump out at them as being incorrect and inform the MDS coordinator. They stated the two MDS nurses do not check each others work. The stated Resident #12's quarterly MDS was incorrect and their expectation was that all assessment would be accurate and timely.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 34270 Based on observation, record review, and interview, the facility failed to ensure a significant change assessment was performed following the development of a new pressure ulcer and partial amputation of a resident's leg for one (#12) of twelve resident reviewed for Minimum Data Set assessments. A midnight census report, dated 06/02/24, documented 48 residents resided in the facility. The administrator stated that was the accurate census at the time the survey began. Findings: The Policy & Procedure for MDS Frequency & Completion, undated, read in part, If a significant change in the resident's condition does occur, an assessment must be done within 14 days of when the change in condition was identified. Resident #12 had diagnoses which included vascular dementia, acquired absence of right leg below the knee, and acquired absence of the left leg above the knee. A progress note, dated 05/13/24 at 7:56 p.m., documented Resident #12 had a wound on their coccyx. A hospital discharge summary, dated 05/13/24, documented Resident # 12 had an above the knee amputation while in the hospital. A progress note, dated 05/23/24 at 8:03 a.m., documented Resident #12 had a closed sacral wound. A progress note, dated 5/28/24 at 2:00 p.m., documented an open area on Resident #12's coccyx. On 06/05/24 at 10:28 a.m., the Resident #12's coccyx area was observed and an open wound approximately 5 cm by 2.5 cm was observed over the coccyx area. On 06/07/24 at 8:11 a.m., the MDS Coordinator stated because they have few skilled residents they employed a part time nurse who does the MDS assessments for the skilled residents. They stated with the amputation and new pressure wound a significant change assessment should have been done. They were asked who supervised the other MDS nurse to which the replied, no one. 06/07/24 at 11:01 a.m., the DON stated they were the ones who checked the work of the two MDS nurses. They stated with the two new issues Resident #12 had occur a significant change assessment would be appropriate. They stated they expected the assessments done at the facility to be done accurately and timely.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270 Based on record review and interview, the facility failed to ensure required interdisciplinary team members participated in the planning process of resident care plans for six (#5, 12, 16, 21, 26, and #36) of twelve residents reviewed for care plans. A midnight census report, dated 06/02/24, documented 48 residents resided in the facility. The administrator stated that was the accurate census at the time the survey began. Findings: The facility Policy and Procedure Regarding Resident Care Plan, undated, read in part, The comprehensive care plan will be developed by the IDT which will include the attending physician, registered nurse with the responsibility for the resident, nurse aide with responsibility for the resident, dietary staff representative, the resident and/or resident representative if possible, and any other healthcare professional as identified by the resident's needs or as requested by the resident. 1. Resident #5 was admitted on [DATE]. 2. Resident #12 was admitted on [DATE]. 3. Resident #16 was admitted on [DATE]. 4. Resident #21 was admitted on [DATE]. 5. Resident #26 was admitted on [DATE]. 6. Resident #36 was admitted on [DATE]. A review of resident records (#5, 12, 16, 21, 26, and #36) found no documentation related to interdisciplinary team care plan meetings. On 06/06/24 at 12:35 p.m., the MDS Coordinator stated they were in charge of care plan meetings. They stated the meeting included the resident's representative and the resident as well if they are cognitive enough, and themselves. She stated the floor nurse, aid, dietary, social services director and DON should attend but do not. They stated the physician had never participated in the meetings or planning unless a concern was raised that required them to be contacted. They stated they had been doing the care plans at the facility since November 2023 and only had a handful of care plan meetings since starting. The MDS coordinator was given a list of resident names (#5, 12, 16, 21, 26, and #36) and asked to provide documentation care plan meeting had occurred. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/06/24 at 12:45 p.m., the DON stated they were the MDS Coordinator's supervisor and randomly checked their work. They stated the MDS Coordinator attended the care plan meetings with the resident and resident representative. The DON stated they attend the meetings when they are available and they believed the social services director attended. They stated the physician was made aware of what came up in the meetings so they could act on issues as required. They stated the care plan meetings should be documented. On 06/06/24 at 12:59 p.m., the MDS Coordinator stated there was no documentation for residents #5 and #12 that care plan meetings had occurred. They stated there were progress notes that family of residents #16, 21, 24, and #36 had been contacted. They stated they had never invited other care team members to the care plan meetings for the six reviewed residents. They stated they had no recollection of contacting the medical director of results from the six care plan meetings. On 06/07/24 at 11:01 a.m., the DON stated the care plan meetings should have occurred. They stated it was their expectation they would be done in the future and would create a system for ensuring that happened.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270 Based on observation, record review, and interview, the facility failed to ensure: a. a resident was educated on the risks and benefits of using bedrails and obtained informed consent; b. bed frames and bed rails were inspected prior to the application of rails to the frame and use of bed rails by a resident; and c. alternatives to the use of bed rails were attempted prior to the use of bed rails for two (#12 and #36) of two sampled resident reviewed for bed rails. The DON reported eight residents had bed rails in use at the facility. Findings: When asked for the facility policy on the use of bed rails the DON offered the Policy and Procedure for the use of Alternative Measures to Restraints which was undated. The policy read in part, Positioning bars may be used by residents who request them as an aid to reposition in bed. Also, residents who are confused or disoriented to the point that they do not recognize the edge of the bed, but who would not attempt to climb over them, may use them to prevent falling from bed. 1. Resident #12 was admitted to the facility on [DATE] and had diagnoses which included vascular dementia, acquired absence of the right leg below the knee, and acquired absence of the left leg above the knee. 2. Resident #36 was admitted to the facility on [DATE] and had diagnoses which included dementia. A review of the medical records of Residents #12 and #36 did not find documentation of the residents having been education on the use of bed rails, that the beds had been inspected prior to the use of bed rails, or that alternatives to the use of bed rails had been tried prior to the use of bed rails. On 06/05/24 at 10:50 a.m., Resident #12's bed was observed to have positioning bars attached to both sides of their bed frame. The resident stated they used the positioning bars attached to the bed frame for positioning. They stated the bars had been attached since they were admitted . They did not recall having a discussion about the risks of using them or if they tried alternatives to the positioning bars. 06/06/24 at 10:15 a.m., the DON stated in regards to Resident #12, they were unable to find documentation that alternate interventions to bed rails had been attempted. They stated they were unable to provide documentation that bed frame and bed rail inspections had been performed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	06/06/24 at 11:47 a.m., Resident #36's bed was observed to have full bed rails attached to the frame of their bed. They stated the bed rails had been on the bed since they arrived at the facility. On 06/07/24 at 10:46 a.m., the DON stated, in regards to Residents #13 and #36, there had been no alternate interventions to the use of bed rails attempted prior to their use. They stated no documentation of bed frame or bed rail inspections having been done prior to the use of those bed rails and no documentation of informed consent for the rails were located. They stated they will correct their process for using bed rails at the facility.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 34270 Based on record review and interview, the facility failed to maintain registered nurses on duty eight hours each day seven days every week. Findings: A Policy Regarding Facility Staffing, undated, read in part, 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 Payroll Based Journal (PBJ) report for the first quarter of 2024 (October 1, 2023 through December 31, 2023) documented registered nurse hours were not submitted for 11/04/23, 11/05/23, 11/18/23, 11/23/23, 12/02/23, 12/03/23, 12/16/23, and 12/17/23. A facility staffing schedule for November 2023, did not document registered nurses as having worked on 11/04/23, 11/05/23, and 11/18/23. A facility staffing schedule for December 2023, did not document registered nurses as having worked on 12/02/23, 12/03/23, 12/16/23, and 12/17/23. A Payroll Based Journal (PBJ) report for the second quarter of 2024 (January 1, 2024 through March 31, 2024) documented registered nurse hours were not submitted for 01/01/24, 01/20/24, 01/21/24, and 02/24/24. A facility staffing schedule for February 2024, did not document a registered nurse as having worked on 02/24/24. On 06/07/24 at 11:01 a.m., the DON stated they were unaware of any dates where registered nurses were not on duty. They stated LPN #3 was in charge of staffing and finds replacements if someone calls in. They stated they expect all staffing holes to be covered by someone. On 06/07/24 at 11:22 a.m., HR #1 stated they were the person that inputted the facility data into the PBJ reporting system. They stated they get the staffing information from various sources including time sheets and agency staffing records directly from the staffing agencies. They stated all the information in the first and second quarter PBJ reports were accurate and they were confident the information was accurate. On 06/07/24 at 11:27 a.m., LPN #3 stated the process for finding replacements on the schedule was they contact staff on the on-call list, then staff who want to work overtime, then they contact staffing agencies, and finally they have an on-call person who would be expected to cover the hours. They stated if no one could be found to work the administrator or DON would be contacted.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34270 Based on record review and interview, the facility failed to ensure medications were administered within the ordered time frame. A midnight census report, dated 06/02/24, documented 48 residents resided in the facility. The administrator stated that was the accurate census at the time the survey began. Findings: A facility Time of Administration policy, undated, read in part, The following schedule will be implemented for administration of medications, unless physician orders indicated otherwise .TID First dose within 2 hours of rising, second dose no sooner than 5 hours, third dose no sooner than 5 hours. A Medication Admin Audit Report, dated 06/04/24, documented 23 of 48 residents who had medications ordered to be administered at 7:00 a.m., were administered those medications after 12:00 p.m. A Medication Admin Audit Report, dated 06/05/24, documented 13 of 49 residents who had medications ordered to be administered at 7:00 a.m., were administered those medications after 12:00 p.m. On 06/05/24 at 1:17 p.m., CMA #2 stated they had not finished passing morning medications as of that time. On 06/05/24 at 1:24 p.m., CMA #2 stated they had then completed passing morning medications. On 06/06/24 at 7:07 a.m., LPN #2 stated they usually have two CMA's pass medications but two had quit suddenly in the last few days. On 06/06/24 at 9:01 a.m., CMA #1 stated they usually pass morning medications between 7:00 a.m. and 11:00 a.m. and the last few days were unusual because two CMA's suddenly quit. On 06/07/24 at 10:46 a.m., the DON stated that three days prior to the survey a CMA quit and then on the first day of the survey a second CMA quit their position. That resulted in two days without two CMA's to pass medications [06/04/24 and 06/05/24]. They stated that normally the administrative nurses would have assisted the CMA's but some of them were out for emergencies as well. They stated they understood there were other nurses in the building that could have passed medications but they were covering those out on emergencies that also occurred during the survey. They stated the medications should have been passed on time.

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 34270 Based on record review and interview, the facility failed to have policy and procedures for obtaining and using feedback from staff, residents, and resident representatives. Findings: A review of the facility QAPI and QAA records did not find documentation of a program to obtain feedback from facility staff, residents, and resident representatives. On 06/07/24 at 12:05 p.m., the Administrator stated although the facility did have a grievance process for residents it did not have a feedback program or policy and procedures for a feedback program.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375467	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 47453 Based on observation, record review, and interview, the facility failed to maintain a functioning call light system for one (#47) of 12 sampled residents reviewed for a functioning call light system. The Administrator identified 48 residents resided in the facility. Findings: The Resident Call System policy, undated, read in part, .In the event of a call light malfunction, the facility will provide alternative methods of alerting staff of needs, ie: bell, buzzer, light. Facility staff will then immediately notify maintenance via verbal communication of call light malfunction for further intervention . Resident #47 had diagnoses which included vascular dementia, atherosclerotic heat disease, bipolar disorder. Resident #47's care plan, revised 04/21/24, documented to keep call light within reach and mark call light with bright tape. On 06/03/24 at 1:01 p.m., Resident #47's call light was out of reach of the resident. The call light was attached to privacy curtain. Resident #47 was sitting in her wheelchair. Resident #47 was unable to state if the call light was working properly. On 06/03/24 at 1:25 p.m., DON was asked if the call light for Resident #47 worked. They stated the call button is not ringing at the front desk. The DON was then asked what intervention had been put in place for the Resident #47 to use the call light when requiring assistance. They stated, Nothing yet, but will get something in place. On 06/05/24 at 9:55 a.m., the Administrator was asked what the policy was for repairs to a call light not working properly. They stated the maintenance man does round on call lights, if out, the facility has a box of hand bells. They were then asked was staff were aware of Resident #47 call light not sounding at the nurse's station when on. They stated they were told of the issue on 06/03/24 and maintenance looked at it and needed to order a part. They were then asked when a hand bell was provided to Resident #47, they stated a while after we discovered it was not ringing at nurse's station.