| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375467 | A. Building<br>B. Wing | 07/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fairfax Behavioral Health & Memory Care Community | 282 County Road 6300<br>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 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(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 |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375467 | A. Building<br>B. Wing | 07/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fairfax Behavioral Health & Memory Care Community | 282 County Road 6300<br>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 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Based on observation, record review, and interview, the facility failed to prevent resident-to-resident abuse for 2 (#33 and #45) of 4 sampled residents reviewed for abuse, which resulted in Resident #45 being hospitalized . The administrator reported four incidents of resident-to-resident abuse in the past 90 days. Findings: An undated policy titled Abuse By A Resident To Other Residents, read in part, In the case of abuse from one resident to another resident, any employee observing the abuse, shall immediately intervene in an effort to protect the resident. If there is an actual physical altercation, the employee shall immediately gain the assistance of another employee to assist in separating the residents involved by moving one resident away from the other. The residents will be geographically separated and supervised until both are calm and not a risk to harm themselves or others, or until it can be determined that the incident is isolated, and no threat or harm exists. 1. On 07/17/25 at 11:57 a.m., Resident #33 was observed in the dining room with their family member who was feeding the resident. A care plan for Resident #33, dated 06/04/25, showed the resident had diagnoses which included Alzheimer's disease, vascular dementia, peripheral vascular disease, anorexia, and acute kidney failure. A quarterly MDS assessment for Resident #33, dated 06/11/25, showed the resident had a BIMS of 01, which indicated the resident was severely cognitively impaired. On 07/17/25 at 12:05 p.m., Resident #33's family member reported the resident had been to a psychiatric facility twice and had gradually declined over the past couple of months. On 07/21/25 at 2:19 p.m. , CMA #1 reported Resident #33 had been known to wander in the past and they were aware of the incident with Resident #45. CMA #1 reported they were not aware of Resident #33 being aggressive with any other resident and did not know of any other incidents of resident-to-resident abuse. 2. On 07/15/25 at 3:29 p.m., during the resident group meeting, Resident #45 reported they had been beat up approximately three weeks previously and required hospitalization. The resident did not indicate if the incident occurred with a staff member or another resident. A care plan for Resident #45, dated 03/07/25, showed the resident had alteration in musculoskeletal status related to compression fracture of the L1, L2, L4, and T12 [thoracic] vertebras. The care plan showed the resident had acute and chronic pain related to wedge compression fractures. A nursing incident note, dated 06/04/25 at 5:47 a.m., showed an unidentified certified nursing assistant alerted the nurse Resident #45 was on the floor and was being punched and kicked by another resident. The note showed upon entering Resident #45's room, the other resident had already left, and Resident #45 was attempting to get back into bed. The note showed there was no visible injury noted, but the resident complained of left hip pain rated 9/10. The note showed the resident was assisted back to bed. The note showed Resident #45 stated the other resident attempted to get into their bed and then began punching and kicking the resident. The note showed Resident #45 was transported to the emergency room for evaluation and treatment. An Oklahoma State Department of Health incident report, dated 06/04/25, showed an incident occurred between Resident #45 and Resident #33. The report showed staff was alerted to a commotion in Resident #45's room where they found the two residents in an altercation. The report showed the residents were immediately separated. The report showed after the residents were assessed, Resident #45 was transferred to the emergency room for evaluation and treatment related to complaints of hip pain. The report showed an investigation was conducted and it was determined Resident #33 entered Resident #45's room and attempted to get in the resident's bed. Upon seeing the bed was already occupied, Resident #33 began yelling at which time a physical altercation occurred. The report showed Resident #45 suffered a sacral fracture. The report investigation showed staff members and residents were interviewed on 06/04/25 regarding other potential incidents of abuse. The report showed Resident #33 was placed on 1:1 observation until the resident was sent out for evaluation. The report showed Resident #33 had a diagnosis of Alzheimer's disease with severely impaired cognition. A nursing note for Resident #45, dated 06/10/25 at 4:40 p.m., showed the resident arrived back at the facility from the hospital with diagnoses of L4, L5 and sacral fractures. A quarterly MDS assessment, dated 06/20/25, showed Resident #45 had diagnoses which included alcohol abuse, fracture of the lumbar vertebrae and sacrum, encephalopathy, depression, and anxiety. The assessment showed the resident required substantial assistance with most activities of daily living. The assessment showed the resident had a BIMS score of 15 which indicated the resident was cognitively intact. On 07/17/25 at 1:45 p.m., the DON provided documentation, dated 06/04/25, related to the incident investigation. The documentation showed two staff members, and four residents were interviewed at the time of the incident between Resident #45 and Resident #33. The DON provided documentation which |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375467 | A. Building<br>B. Wing | 07/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fairfax Behavioral Health & Memory Care Community | 282 County Road 6300<br>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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>Based on record review and interview, the facility failed to ensure side effect monitoring was completed for a resident receiving psychotropic medications for 1 (#40) of 5 sampled residents reviewed for unnecessary medications.The administrator reported the facility census was 48.Findings:A facility policy titled Management of Routine Antipsychotic Medications in Long-Term Care, dated 11/01/23, read in part, 3. Monitoring and Documentation -Nursing staff must document: -the resident's response to the medication. -Any side effects, including extrapyramidal symptoms or sedation.An admission record, dated 03/28/25, showed Res #40 had diagnoses which included delusional disorders and unspecified anxiety disorder.A care plan, revised 04/03/25, showed the resident received psychotropic medications and that Res #40 was to be monitored every shift for side effects of the medication.An admission assessment, dated 04/10/25, showed Res # 40 had a BIMS score (a test of cognition) of 15 which was indicative of intact cognition. The assessment also showed Res #40 was receiving an antipsychotic medication.A physician's order, dated 06/27/25, showed Res #40 was to receive 10 milligrams of haloperidol (an antipsychotic medication) daily at bedtime.A review of Res #40's TAR for June 2025 and July 2025 did not show side effect monitoring.On 07/17/25 at 2:31 p.m., the DON stated residents on antipsychotics should be monitored every shift for side effects and the documentation should be in the TAR. They also stated if it was not documented on the TAR, it was not done. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375467 | A. Building<br>B. Wing | 07/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fairfax Behavioral Health & Memory Care Community | 282 County Road 6300<br>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 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.<br><br>Based on record review and interview, the facility failed to transmit MDS assessment data within 14 days after completion of the resident assessment for 4 (#2, 19, 21, and #48) of 4 residents sampled for transmitting resident assessments. The administrator reported 48 residents resided in the facility. Findings: An MDS Assessments policy, dated 11/01/23, read in part, The facility will complete MDS assessments for all residents in accordance with CMS requirements .All assessments must be accurate, reflect the resident's status during the designated observation period, and be submitted electronically to the Quality Improvement and Evaluation System (QIES) within mandated timelines .Completed MDS assessments will be locked and submitted to the QIES ASAP system with 14 days. On 07/16/25 at 1:00 p.m., a review of MDS assessments for sampled residents was conducted. MDS assessments were not transmitted within 14 days as required for Resident #2, 19, 21, and #48. On 07/17/25 at 1:46 p.m., the DON provided batch transmittal forms dated 05/24/25 and 06/25/25. The forms showed the following: a. Resident #2 had a discharge return anticipated assessment completed on 05/31/25 and was transmitted on 06/25/25,b. Resident #19 had a quarterly assessment completed on 06/10/25 and was transmitted on 06/25/25,c. Resident #21 had a quarterly assessment completed on 05/24/25 and was transmitted on 06/25/25, andd. Resident #48 had a quarterly assessment completed on 04/21/25 and was transmitted on 05/24/25. On 07/16/25 at 4:42 p.m., the ADON/MDS coordinator reported they had recently taken responsibility of MDS assessments. The ADON/MDS coordinator reported they had another person helping, but they were still behind in getting the assessments completed and submitted in the timeframe required. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375467 | A. Building<br>B. Wing | 07/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fairfax Behavioral Health & Memory Care Community | 282 County Road 6300<br>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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on record review and interview, the facility failed to ensure a care plan was developed to address the use of an indwelling urinary catheter for 1 (#40) of 13 sampled residents whose care plans were reviewed. The administrator reported two residents had an indwelling urinary catheter.Findings:A facility policy titled Care Plans, dated 11/01/23, read in part, Each resident will have an individualized care plan that is developed and maintained by the interdisciplinary team (IDT). The plan will address the resident's identified needs, strengths, goals and risks, and it will guide consistent, coordinated care delivery by all staff.An admission record, dated 03/28/25, showed Res #40 had diagnoses which included unspecified retention of urine and dementia.An admission assessment, dated 04/10/25, showed Res #40 had a BIMS (a test of cognition) of 15, which was indicative of intact cognition. A physician's order, dated 06/27/25, showed Res #40 had a size 16 French indwelling urinary catheter for a diagnosis of unspecified retention of urine.A review of Res #40's care plan did not show the use of an indwelling urinary catheter was addressed on the care plan.On 07/21/25 at 10:08 a.m., ADON #2 stated catheter use should be addressed on the resident's plan of care.On 07/21/25 at 2:50 p.m., the acting DON stated the use of a catheter should be included on the care plan and they were usure why Res #40's care plan did not include the use of a catheter. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375467 | A. Building<br>B. Wing | 07/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fairfax Behavioral Health & Memory Care Community | 282 County Road 6300<br>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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>Based on record review and interview, the facility failed to follow physician orders for 1 (#4) of 13 sampled residents whose orders were reviewed.The administrator identified 48 residents resided in the facility. Findings: An admission assessment, dated 05/08/25, showed Resident #4 had diagnoses which include diabetes mellitus type 2 and acquired absence of right leg below the knee. The assessment showed Resident #4 had a BIMS score of 9, which indicated a moderate impairment of cognitive ability. A physician's order, dated 07/05/25, showed to cleanse the left great toe with normal saline, pat dry, apply Betadine (antiseptic) every shift and leave open to air two times a day for wound care.The TAR for July 2025 did not show any wound care completed for the left great toe as of 07/17/25. On 07/17/2025 at 1:34 p.m., Resident #4 stated no treatment was being done on their toe. On 07/17/2025 at 1:42 p.m. ADON #1 stated the order had been put in incorrectly and was triggering a task on the TAR. ADON #1 stated the wound care treatment was not being completed as ordered. On 07/17/2025 at 2:12 p.m., the DON stated the wound care had not been completed as ordered. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375467 | A. Building<br>B. Wing | 07/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fairfax Behavioral Health & Memory Care Community | 282 County Road 6300<br>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 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>Based on observation, record review, and interview, the facility failed to follow the menu for 2 of 2 meal services observed.The administrator reported 48 residents received meals from the kitchen.Findings:On 07/16/25 at 11:28 a.m., cook #1 was observed to plate one portion of meatloaf, one scoop of mixed vegetables, one scoop of au gratin potatoes, and one brownie.On 07/16/25 at 11:45 a.m., cook #1 was observed to plate a pureed diet plate with one scoop of pureed meatloaf, one portion of pureed corn, one portion of pureed bowtie pasta, and one portion of banana pudding.No bread was served with either meal.A spring/summer menu, dated 07/16/25, showed the menu for the day was meatloaf, au gratin potatoes, vegetable blend of the day, bread of choice, and dessert of the day.On 07/16/25 at 11:50 a.m., cook #2 stated they use frozen pureed food, and they tried to keep the pureed menu similar to the regular menu.On 07/17/25 at 1:51 p.m., the DM stated they had forgotten to prepare bread for the lunch service on 07/16/25. They stated the pureed meal served on 07/16/25 did not follow the menu. The DM stated that instead of using the frozen pureed meals they could have pureed the meal they had prepared, but they did not. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375467 | A. Building<br>B. Wing | 07/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fairfax Behavioral Health & Memory Care Community | 282 County Road 6300<br>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 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Based on observation and interview, the facility failed to ensure food served from the kitchen was palatable and served at an appetizing temperature.The administrator reported 48 residents received meals from the kitchen.Findings:On 07/16/25 at 12:47 p.m., a test tray was delivered. The food was observed to not be hot, the meatloaf was dry and bland, the mixed vegetables were soggy, the potatoes were not well seasoned, and the brownie was undercooked. No bread was served with the meal.A quarterly assessment, dated 06/18/25, showed Res #7 had a BIMS score (a test of cognitive function) of 15, indicative of intact cognition. A quarterly assessment, dated 07/09/25, showed Res #55 had a BIMS score (a test of cognitive function) of 15, indicative of intact cognition.On 07/15/25 at 10:09 a.m., Res #7 stated the food was not hot when served in the room and it sometimes did not taste appealing.On 07/15/25 at 10:50 a.m., Res #55 stated the food was not good.On 07/15/25 at 3:30 p.m., during a resident council meeting, some residents in attendance voiced concerns regarding temperature and palatability of the food.On 07/17/25 at 1:51 p.m., the DM stated the facility tried to serve hot palatable food. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375467 | A. Building<br>B. Wing | 07/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fairfax Behavioral Health & Memory Care Community | 282 County Road 6300<br>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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation and interview, the facility failed to ensure lids to bulk containers were not broken and beard guards were worn in the kitchen.The administrator reported 48 residents received meals from the kitchen.Findings:On 07/15/25 at 10:35 a.m., an initial tour of the kitchen was conducted. Dietary Aide #1 was observed washing dishes without wearing a beard guard. A bulk sugar container with a broken lid was also observed.On 07/17/25 at 1:51 p.m., the DM stated staff should wear hair restraints while in the kitchen, and the broken lid for the bulk sugar container should have been replaced. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375467 | A. Building<br>B. Wing | 07/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fairfax Behavioral Health & Memory Care Community | 282 County Road 6300<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure EBP were in place during wound care for 1 (#55) of 1 sampled resident reviewed for wound care.The Administrator reported one resident received routine wound care.Findings:On 07/17/25 at 9:30 a.m., ADON #1 was observed providing wound care to Res #55. ADON #1 was not observed to be wearing a gown. No signage was observed indicating Res #55 was on EBP.A facility policy titled Enhanced Barrier Precautions (EBP) Policy and Procedure, dated 11/01/23, read in part, [NAME] Behavioral Health & Memory Care Community shall implement Enhanced Barrier Precautions (EBP) for all residents known to be colonized or infected with MDROs [Multidrug-Resistant Organisms] and in accordance with CDC [Centers for Disease Control] guidance. This includes the use of personal protective equipment (PPE) for certain resident care activities even when residents are not in isolation or on contact precautions.An admission record, dated 04/08/25, showed Res #55 had diagnosis which included diabetes mellitus with foot ulcer.A quarterly assessment, dated 07/09/25, showed Res #55 had a BIMS score (a test for cognitive function) of 15 which was indicative of intact cognition. A physician's order, dated 07/16/25, read in part, WOUND CARE - Cleanse left great toe with NS [normal saline], pat dry, apply medihoney [gel wound and burn dressing] and dry dressing daily and PRN [as needed].On 07/15/25 at 1:00 p.m., Res #55 stated staff did not wear gowns while providing wound care.On 07/16/25 at 9:45 a.m., ADON #1 stated they did not use EBP during wound care.On 07/21/25 at 2:50 p.m., the acting DON stated they were not aware of the requirement to use EBP during wound care. |