

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/26/2024
NAME OF PROVIDER OR SUPPLIER  Fairfield Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  420 Moody St Fairfield, TX 75840	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>47855</p> <p>Based on observation, interview, and record review, the facility failed to ensure all allegations of abuse are reported immediately, but not later than 2 hours after the allegation is made, to the Administrator of the facility and to HHSC for one (Resident #4) of five residents reviewed for abuse.</p> <p>The facility staff failed to immediately report an allegation of abuse to the Administrator and to HHSC as required when Resident #4 was struck in the face by Resident #3 on 08/20/2024 at 8:30 p.m</p> <p>This failure could place residents at risk for unreported allegations of abuse.</p> <p>Findings included:</p> <p>Record review of the facility EHR reflected nurses note dated 08/20/24 at 8:30p.m. stated that Resident #3 struck Resident #4 in the face at 8:30 p.m. on 08/20/24. The facility staff was present in the area and intervened. The residents were separated and assessed for injuries. Resident #3 was placed on 1:1 supervision by staff. Resident #4 was monitored as part of the assessment. The facility Administrator was not made aware of the incident until a 6:45 a.m. on 08/21/2024. The report was made at that time.</p> <p>Record review of Resident #3 MDS record reflected a current BIMS score of 5, indicating severe impairment, and the following partial diagnosis Unspecified Dementia, Major Depressive Disorder, Alzheimer's Disease and Bipolar Disorder.</p> <p>Record review of resident #4 MDS record reflected a current BIMS of 0 indicating severe impairment and partial diagnosis including Cerebral Infarction, Depression, Adjustment Disorder, and Aphasia.</p> <p>Interview with Resident#3 09/24/2024 at 1:30 p.m. Resident observed in bed eyes open, no marks or bruises were observed. Resident did not respond to questions.</p> <p>Interview with Resident #4 on 09/24/2024 at 2:30 p.m. Resident #4 was observed sitting in the common area where the incident occurred. Resident #4 was sitting in a wheelchair watching television. Resident #4 acknowledged the surveyor's presence but did not speak when spoken to. Resident #4 motioned for the surveyor to come closer but did not speak in an understandable manner. Resident#4 was observed with no visible marks or bruising.</p> <p>(continued on next page)</p>

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with RN A on 09/24/24 at 3:15 p.m. RN A stated she is aware of the incident involving Resident #4. She stated it happened on the other side of the building. RN A stated that she had provided care for Resident #3 before. Resident #3 was known to be aggressive with staff, but RN A stated she is unaware of any issues with other residents. RN A stated that they had to complete an in-service regarding reporting incidents to Administrator who is the Abuse Coordinator. She stated that all incidents of abuse or neglect must be reported immediately to the Administrator. She stated that residents could be negatively impacted by abuse and neglect. Injuries may be unnoticed or the abuse or neglect it could continue to happen.</p> <p>In an interview on 9/24/2024 at 3:40 p.m. with CNA C. CNA C stated that Resident #3 was resistive to care and at times could be aggressive to staff. She would come after staff in her wheelchair. CNA C stated she had never observed Resident #3 being aggressive with the other residents. She stated that neither of residents seemed to be bothered or upset by the incident. She stated that she completed the in-service for reporting abuse to the Administrator.</p> <p>In an interview with LVN B on 09/25/2024 at 11:25 am. LVN B stated that she primarily cares for Resident #1 she stated that she has no issues with her behaviors as she will just spend a little more time with her. She stated that there were no previous issues with Resident #3 and Resident #4. She stated that after the incident they had in-service for Abuse Neglect, Reporting and Residents Rights. She stated that staff must inform the Administrator of any suspected abuse immediately and she must report it to the State. She stated that they must protect the residents from any abuse or neglect whether it be staff, other residents or outside family or others.</p> <p>In an interview on 9/25/2024 at 3:25 with the DON. The DON stated that the Administrator found out about the incident when she was reviewing the overnight reports. She stated that the Administrator reported the incident to the HHSC desk immediately on 08/21/2024 at 6:45 a.m. She stated after the report was made, they spoke to the staff involved the ADON and LVN D about reporting and they found that LVN D did not call either of them. She then told them she informed the ADON. She stated that they conferenced both the ADON and LVN D. She stated at that point they in-serviced the whole building on when to report incidents of abuse and neglect to, that being both the DON and the Administrator. She stated that she conducted the in-service for staff on abuse, neglect and resident rights, the Administrator completed the in-service for reporting abuse neglect.</p> <p>Record review of the provider investigation dated 08/29/2024 reflected that LVN D stated that she did inform the Administrator, DON, and ADON. Both LVN D and ADON were provided with 1 on 1 in-service with the self-reporting protocol.</p> <p>Review of in-service records reflected that all staff completed the resident's rights in-service conducted by the Administrator on 08/21/2024. The abuse and neglect in-service were conducted by DON and completed by all staff on 08/21/2024. The self-reporting protocol/Ad Hoc QAPI resident to resident physical aggression in-service was conducted by the Administrator and completed by all staff on 08/21/2024.</p>		