STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676123	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairfield Nursing & Rehabilitation Center	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)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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
	676123	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairfield Nursing & Rehabilitation Center	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)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the resident has the right to be informed of, and participate in, his or her treatment including the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers for 1 of 5 (Resident #1) reviewed for resident rights. The facility failed to ensure Resident #1 was sent out to the hospital when Resident #1 complained of pain in her lower back on 07/17/2025. This failure could place residents at risk of their rights to have their medical needs met . Findings include:A record review of Resident #1's face sheet, dated 07/26/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1's diagnoses which included unspecified dementia (memory loss), major depressive disorder (sadness), diabetes (too much sugar in the blood) and hypertension (high blood pressure). A record review of Resident #1's Quarterly MDS assessment, dated 06/23/2025, reflected the resident had a BIMS score of 8, which indicated moderate cognitive impairment. A record review of Resident #1's progress note, dated 07/17/2025 written by LVN A at 10:39 AM, reflected Patient c/o increased pain to her lower back. UA was obtained early this AM and sent to the lab R/T malodorous (smelling very unpleasant) urine. Patient lower pubic area is distended and firm to palpitation. IN and OUT cath performed using sterile supplies and sterile technique. Once urine returned a small amount of blood returned an no more urine noted. Bladder appears to be having spasms during procedure. Cath. Removed and MD was contacted. Patient stated that she wants to go to ER at this time. She remains Afebrile (free from fever) and has received PRN medications for pain. MD gave verbal order for Rocephin 1GM now, and he will come visit patient and check bladder for retention. LVN A, charge nurse contacted RP for patient. She is aware of plan of care at this time and agrees. Care ongoing. During an interview with Resident #1's RP on 07/26/2025 at 10:35 AM, the RP stated LVN A did not send Resident # 1 to the hospital on [DATE], when Resident # 1 requested to go to the hospital when she had experienced pain in the lower back. Resident #1's RP stated LVN A did collect a sample of urine and Resident #1 received pain medication, but the LVN A should had sent Resident #1 out to the hospital when she requested to go. The RP stated when LVN A did not send Resident #1 out to the hospital per her request her medical needs would not have been addressed. The RP stated Resident #1 was no longer at the facility as she transferred her to another facility on 07/22/2025. During an interview with LVN A on 07/26/2025 at 1:27 PM, LVN A stated on 07/17/2025, can't recall the time around 11:00 AM to 12:00 PM, she went in to check on Resident # 1 and she told her that her lower back was hurting, and she wanted to go to the hospital. LVN A asked Resident #1 if she could help her with anything before sending her out and she said okay and she was fine. LVN A stated she assessed Resident #1 and she did not fail to send Resident #1 out to the hospital because she wanted to see what she could do before Resident # 1 would be sent out. LVN A stated she knew it was expected to send Resident #1 out per her request, but she assessed Resident # 1 and also had contacted Resident # 1's RP. LVN A stated not sending Resident #1 out when she requested, Resident #1's medical needs may have not been met. During an interview with the DON on 07/28/2025 at 4:12 PM, the DON stated it was expected for LVN A to send Resident #1 to the hospital per her request. The DON stated when residents were not sent out to the hospital when they requested their medical need would not have been met. During an interview with the ADM on 07/28/2025 at 4:28 PM, the ADM stated it was expected for LVN A to have sent Resident #1 when she requested to be sent out to the hospital on [DATE] when she experienced lower back pain. The ADM stated if Resident #1 was not sent out when she requested her needs would not have been met. Record review of facility's policy titled Resident Rights, dated 11/28/2016, reflected The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676123	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairfield Nursing & Rehabilitation Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete and accurately documented for 1 of 5 residents (Resident #1) for complete and accurate records. The facility failed to ensure Resident #1's weight was documented in PCC for July 2025. This failure could place residents at risk for the possibility of not verifying the needed care and services to meet their needs. Findings include:A record review of Resident #1's face sheet, dated 07/26/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1's had diagnoses which included unspecified dementia (memory loss), major depressive disorder (sadness), diabetes (too much sugar in the blood) and hypertension (high blood pressure) A record review of Resident #1's Quarterly MDS assessment, dated 06/23/2025, reflected the resident had a BIMS score of 8, which indicated moderate cognitive impairment. A record review of Resident #1's weight in PCC for July 2025 did not reflect a weight for Resident #1. During an interview with the ADON on 07/28/2025 at 3:48 PM, the ADON stated she was responsible for placing and making sure Resident #1's weight, taken on 07/08/2025, was documented in PCC. The ADON stated Resident #1's weight was 148 pounds, and she failed to enter it in PCC and when she realized Resident # 1's weight did not get entered was when Resident #1 discharged on 07/19/2025. The ADON states she knew how important it was to document the weights in PCC and without the weights documented, the system would not be able to flag any weight loss or gains.During an interview with the DON on 07/28/2025 at 4:12 PM, the DON stated it was expected for the ADON to document Resident #1's July weight by 07/10/2025. The DON stated if it was not documented it did not happen. The DON stated if the weight was not documented in the system, it would not trigger weight loss or gain to identify if interventions needed to be set in place.During an interview with the ADM on 07/28/2025 at 4:28 PM, the ADM stated it was expected for the ADON to have documented Resident #1's weight in PCC by 07/10/2025. The ADM stated it was important for the July 2025 weight to be entered to make sure there was not any weight loss or gains. The ADM stated when weights were not documented in PCC, staff would not be able to identify weight loss or gain to be able to put an intervention in place Record review of the facility's, undated, policy titled documentation reflected Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident and or soft resident file. It may include observations, investigations, and communications of the resident involving care and treatments. It has legal requirements regarding accuracy and completeness legibility and timing. Special forms on the clinical record are utilized in nursing documentation, such as assessment, care plan, nursing progress notes, flow sheets, medication sheets, incident reports, and summary sheets (daily, weekly, monthly, discharge). Documentation also occurs in the clinical software Point Click Care (PCC). All documentation and clinical records are confidential and can be released with signed permission of the resident legal representative.