STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366106	A. Building B. Wing	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gardens of Fairfax Health Care Center	9014 Cedar Ave Cleveland, OH 44106

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure an elopement was reported to the State Agency. This affected one resident (#50) of three residents reviewed for elopement. The facility census was 47.Findings include:Review of the medical record for Resident #50 revealed an admission date of 05/14/24 and a discharge date of 09/16/25. Diagnoses included emphysema, malignant neoplasm of the cecum, malignant neoplasm of the upper left female breast, and personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits. Review of the Minimum Data Set (MDS) (modified) annual assessment, dated 06/12/25, revealed Resident #50 had severely impaired cognition. The resident was independent for mobility, transfers, toileting, ambulation, upper and lower body dressing, and donning and doffing footwear. Resident #50 had no episodes of recorded wandering. Review of mood revealed she had total severity score of 13, indicating moderate depression. Review of the care plan dated 06/12/25 revealed Resident #50 was at risk for elopement as she had exit-seeking behaviors and unaware of safety needs. Interventions included a wanderguard to the right ankle and chair, redirect as needed, and follow the facility elopement policy and procedures. Review of Resident #50's physician orders revealed an order dated 07/15/25 for Resident #50 to have a wanderguard (a wearable bracelet-like device used to monitor and prevent residents at risk for wandering from leaving designated areas. It is part of a larger system which includes sensors on doors which alarm and lock the doors when a resident approaches a monitored exit) on at all times to the right ankle and an additional order to check the placement and function of the wanderguard device every shift. Review of Resident #50's Treatment Administration Record (TAR) dated 07/15/25 through 09/22/25 revealed the resident's wander guard was documented as being on at all times to the right ankle and placement and function was documented as checked daily on both day and night shifts. Review of Resident #50's elopement risk assessment dated [DATE] revealed she was an elopement risk and scored a 4.0 as she had a history of eloping and had a lack of awareness of safety needs. Listed interventions in place were the wanderguard and safety checks. Review of Resident #50's nurse progress note dated 09/14/25 at 2:30 P.M. authored by Licensed Practical Nurse (LPN) #120 revealed the nurse was alerted by Certified Nursing Assistant (CAN) #151 that Resident #50 was missing. LPN #120 and other staff began looking for Resident #50 checking all rooms and bathrooms, checking the whole facility and outside. During the search for Resident #50, the resident's daughter and the hospital administrator called the facility and stated Resident #50 was at a local hospital emergency department (ED). The facility Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON) was notified. Review of the State Agency's Certification and Licensure System (CALS) revealed no facility self-reported incident (SRI) had been submitted regarding Resident #50's elopement. An interview on 09/22/25 at 2:50 P.M. with the Administrator revealed she did not know she needed to report an elopement to the State Agency and was unaware where on the computer she was to report the incident. Review of facility policy titled Abuse, Neglect, Exploitation & Misappropriation of Resident Property, dated 11/21/16, revealed it is the facility's policy to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment of a resident, or misappropriation of resident property. Additionally, the facility should immediately report all allegations to the Administrator and to the Ohio Department of Health.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLAINCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on review of the closed medical record, interview, review of the facility's investigation, interviews with facility staff, and review of the facility policy on elopement, facility failed to ensure staff provided adequate supervision to prevent Resident #50 from leaving the facility unsupervised. This affected one resident (#50) of three residents reviewed for elopement and supervision. The facility census was 47. Findings include: Review of the closed medical record for Resident #50 revealed an admission date of 05/14/24 and a discharge date of 09/16/25. Diagnoses included emphysema, malignant neoplasm of the cecum, malignant neoplasm of the upper left female breast, and personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits. Review of the Minimum Data Set (MDS) (modified) annual assessment, dated 06/12/25, revealed Resident #50 had severely impaired cognition. The resident was independent for mobility, transfers, toileting, ambulation, upper and lower body dressing, and donning and doffing footwear. Resident #50 had no episodes of recorded wandering. Review of mood revealed she had total severity score of 13, indicating moderate depression. Review of the care plan dated 06/12/25 revealed Resident #50 was at risk for elopement as she had exit-seeking behaviors and unaware of safety needs. Interventions included a wanderguard to the right ankle and chair, redirect as needed, and follow the facility elopement policy and procedures. Review of Resident #50's physician orders revealed an order dated 07/15/25 for Resident #50 to have a wanderguard (a wearable bracelet-like device used to monitor and prevent residents at risk for wandering from leaving designated areas. It is part of a larger system which includes sensors on doors which alarm and lock the doors when a resident approaches a monitored exit) on at all times to the right ankle and an additional order to check the placement and function of the wanderguard device every shift. Review of Resident #50's Treatment Administration Record (TAR) dated 07/15/25 through 09/22/25 revealed the resident's wander guard was documented as being on at all times to the right ankle and placement and function was documented as checked daily on both day and night shifts. Review of Resident #50's elopement risk assessment dated [DATE] revealed she was an elopement risk and scored a 4.0 as she had a history of eloping and had a lack of awareness of safety needs. Listed interventions in place were the wanderguard and safety checks. Review of Resident #50's nurse progress note dated 09/14/25 at 2:30 P.M. authored by Licensed Practical Nurse (LPN) #120 revealed the nurse was alerted by Certified Nursing Assistant (CAN) #151 that Resident #50 was missing. LPN #120 and other staff began looking for Resident #50 checking all rooms and bathrooms, checking the whole facility and outside. During the search for Resident #50, the resident's daughter and the hospital administrator called the facility and stated Resident #50 was at a local hospital emergency department (ED). The facility Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON) was notified. Review of a witness statement dated 09/14/25 authored by CNA #151 revealed she was not assigned to Resident #50 but observed the resident in her wheelchair, rolling back and forth down the hallway, as she normally did. Later that morning, Resident #50 laid back down. When lunchtime came around, Resident #50 was informed it was time for lunch and stated she was not hungry. CNA #151 told her she would check back. About 1:45 P.M., she went to ask Resident #50 if she wanted to come down for church services and that's when she reported to the nurse that Resident #50 was not in her room. Review of a witness statement dated 09/14/25 authored by LPN #120 revealed she was assigned to Resident #50. Around noon, while administering a tube feeding to Resident #50's roommate, she observed Resident #50 lying in bed. After caring for the roommate, LPN #120 proceeded with passing scheduled medications and completing skilled charting at the nurse's station. Approximately 1:25 P.M., LPN #120 went on lunch break. Upon returning, a (unnamed) CNA informed her that another resident required her assistance and she provided that care. Shortly thereafter, a (unnamed) CNA informed her Resident #50 was not in her room. LPN #120 stated she immediately stopped what she was doing and initiated the facility's elopement policy. While conducting a search for Resident #50 and attempting to contact her family, the hospital called informing Resident #50 was in the emergency room (ER) requesting to be seen. LPN #120 explained to hospital staff that she did not send her and would go across the street to the ER and follow up with the resident. In addition, several attempts were made to contact Resident #50's daughter with no response. Review of a witness statement dated 09/14/25 from CNA #132 revealed he was alerted by another