

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/09/2026
NAME OF PROVIDER OR SUPPLIER The Gardens of Fairfax Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, review of dialysis center documentation, review of an Emergency Medical Services (EMS) run sheet, interview and review of the facility policy, the facility failed to provide adequate amounts of oxygen to ensure safe breathing. This affected one resident (Resident #60) of one resident requiring oxygen on outside appointments. Facility census was 58. Findings include: Review of Resident #60's closed medical record revealed an admission date of 01/30/26 with diagnoses including end stage renal disease, reduced mobility, insomnia, hypertension, paraplegia, acute and chronic respiratory failure with hypoxia, type two diabetes and unspecified psychosis. Resident #60 discharged to home on [DATE]. Review of Resident #60's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #60 was cognitively intact, did not ambulate, used oxygen and received dialysis services. Review of Resident #60's physician's orders revealed an order dated 02/02/26 for dialysis Mondays, Wednesdays and Fridays at [NAME] Shaker with an on time of 11:45 A.M. and an off time of 3:30 P.M. as well as an order dated 02/10/26 for oxygen at five liters via nasal cannula (NC) continuous. Review of a plan of care initiated 02/15/26 revealed Resident #60 required oxygen related to chronic respiratory disease and listed interventions including medications as ordered and observe for signs/symptoms of dyspnea (labored respirations, low oxygen saturation, use of accessory muscles, cyanosis, change in mental status or tachypnea). Review of a dialysis treatment report for Resident #60 dated 02/18/26 revealed treatment was completed from 12:37 P.M. to 3:35 P.M. Review of a progress note dated 02/18/26 at 5:39 P.M. and authored by Licensed Practical Nurse (LPN) #141 revealed at 5:29 P.M. [NAME] called this nurse and stated Resident #60's transportation was delayed to bring him back to the facility. They also stated Resident #60 ran out of the oxygen from the tank that was sent with him and that they did not have any emergency oxygen tanks to send with Resident #60 so they would have to send him to the emergency room (ER). This nurse asked nurse at [NAME] to assess Resident #60's oxygen to see what his measurements were. Nurse stated Resident #60 was at 96 (percent) with two liters via NC and dropped to 80 (percent) without oxygen and was in distress. This nurse also spoke with transportation to see if they could wait for the Assistant Director of Nursing (ADON) to bring a back up oxygen tank and transport hung up on this nurse. [NAME] nurse called back and this nurse informed her that if Resident #60 is in distress then to just send him to the ER. Review of an EMS run report dated 02/18/26 revealed a call placed at 5:39 P.M. for Resident #60 at the dialysis center. EMS arrived at the office on 02/18/26 at 5:46 P.M. Assessment completed on 02/18/26 at 6:05 P.M. revealed Resident #60 had a 97% oxygen saturation from supplemental oxygen. EMS arrived on scene and found Resident #60 sitting in his wheelchair in the lobby of the dialysis center. Resident #60's nurse states that he is not having a medical emergency. Resident #60 is oxygen dependent and is always on oxygen at three liters per minute (3lpm). Resident #60's portable oxygen tank ran out of oxygen while waiting for his ride to get there. The dialysis staff put Resident #60 on their own oxygen concentrator at 3lpm and called his nursing home. The nurse at the nursing home stated that there was no way for them to bring him a replacement oxygen tank; dialysis staff told them that Resident #60 cannot stay at dialysis all night and his ride was not willing to wait and did not have portable (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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