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	02/12/2026

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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, interview, review of meal times, and review of the dining room checklist, the facility failed to maintain effective communication and processes to ensure a timely meal service and ensure adequate portions of the main entree were available. This had the potential to effect all residents receiving meals from the kitchen. The facility identified one Resident (#7) as receiving nothing by mouth (NPO) who did not receive meals from the facility kitchen. The facility census was 61.Findings include: Observations on 02/11/26 of the lunch meal service revealed service began at 11:55 A.M. in the main kitchen area to serve residents who would be eating in their room. The menu included meatloaf, corn, and mashed potatoes. There were three insulated carts delivered. Following delivery of the carts, [NAME] #804 loaded trays of food from the steamtable into a heated cart and took the cart to the second floor servery at 12:34 P.M. [NAME] #804 unloaded trays onto another steamtable and began to take temperatures of each food item. There was a large spill of creamed corn on the floor which required clean up before meal service could continue. [NAME] #804 had forgotten the tray of meatloaf on the steam table in the main kitchen. There was no noted communication method with the main kitchen such as a walkie talkie or phone in the servery. [NAME] #804 asked a dietary aide who was assisting in the dining room to return to the main kitchen and retrieve the meatloaf. The dietary aide returned with the meatloaf. [NAME] #804 then realized there was only one plate available for serving in the plate warmer. [NAME] #804 again asked the dietary aide to return to the kitchen to retrieve plates. At 12:55 P.M., [NAME] #804 was able to serve the first plate to residents in the dining room. A puree diet served in bowls was ordered and [NAME] #804 did not have enough bowls in the servery. [NAME] #804 requested the dietary aide return to the main kitchen to retrieve bowls. Three hamburgers were requested from the alternate menu, however, [NAME] #804 had not brought hamburgers from the main kitchen. [NAME] #804 requested Dietary Manager (DM) #868 return to the kitchen to retrieve hamburgers for three alternate requests. Continued observation revealed [NAME] #804 had run out of the main entree of meatloaf. [NAME] #804 was unable to continue serving as the hamburgers had not arrived and she had run out of the main entree. [NAME] #804 and the dining room servers remained at the second floor servery waiting for the return of DM #868. At 1:24 P.M., [NAME] #838 brought up three hamburgers for the ordered alternates. At 1:31 P.M., DM #868 returned with additional hamburgers to substitute for main entree meatloaf. Following service in the dining room, there were four additional room trays. There was no meatloaf available for two residents which were served hamburgers as a substitute. The lunch meal service was completed at 1:42 P.M. There was not a method of communication with the main kitchen located in the servery. There was not a method of cleaning and sanitizing dishes located in the servery.Interview on 02/11/26 at 2:01 P.M. with DM #868 revealed she had worked at the facility for approximately one year. DM #868 stated there were only 30 residents when she started due to ongoing renovations. DM #868 stated the renovations were completed in October 2025 and they had been steadily gaining census. DM #868 stated they had been working on a process to serve room trays and the dining room. DM #868 stated the process was trial and error and she had to make several revisions in the process to date. DM #868 confirmed the current process was to serve (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	residents who wished to eat in their room first from the main kitchen, then transfer the food to the servery on the second floor to serve the dining room. DM #868 confirmed there was not a method to clean and sanitize dishes in the second floor servery so all dishes had to be returned to the main kitchen after each meal. DM #868 confirmed there was no plates or bowls available at the start of the lunch meal service on 02/11/26. DM #868 confirmed there was not a current method of communication between the servery and the main kitchen such as a phone or handheld radio. DM #868 confirmed [NAME] #804 had run out of meatloaf as [NAME] #804 had used the preparation sheets for the wrong census. DM #868 indicated the preparation sheets were from the previous menu cycle which did not account for the increased census.Review of facility meal times undated revealed lunch was served from 11:45 A.M. to 12:30 P.M. It was noted meal times could vary by 15 minutes. Lunch was to be served to the 100 hallway at 11:45 A.M., to the 200 hallway at 12:00 P.M., to the 300 hallway at 12:15 P.M., and to the main dining room at 12:30 P.M.Review of Dining Room Set Up Checklist for lunch dated 02/10/26 revealed stocking plates and bowls to the servery was not included.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and facility policy review, the facility failed to ensure Resident #49's allegation of missing funds was reported to the State Agency. This affected one resident (Resident #49) out of three residents reviewed for misappropriation. The facility census was 61.Findings include: Review of Resident #49's medical record revealed an admission date of 01/19/26 and diagnoses included cerebral infarction due to embolism of the left vertebral artery, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, and vascular dementia.Review of Resident #49's care plan dated 01/20/26 included Resident #49 required maximal assistance with ADL's (Activity of Daily Living)'s and might be at risk of developing complications associated with decreased ADL self-care performance related to decreased mobility, CVA with hemiparesis and dementia. Resident #49 would have his ADL needs met through his next review date. Interventions included Resident #49 required total care for grooming including nails, shaving, and hair.Review of Resident #49's admission Minimum Data Set (MDS) assessment dated [DATE] included Resident #49 had moderate cognitive impairment. Resident #49 had impairment on one side of the upper extremity and no impairment of the lower extremities, and used a wheelchair. Resident #49 was dependent for toileting hygiene, bathing, and dressing. Resident #49 required partial to moderate assistance for personal hygiene. Resident #49 did not reject care during the seven-day assessment look-back period.Review of Resident #49's progress notes dated 01/29/26 at 11:14 P.M. included Resident #49 asked staff to use his debit card to order food, and was informed that the staff could not use his card to order food. Resident #49's son and daughter were unable to be contacted, and the nurse notified the Supervisor regarding Resident #49's request. While giving report, Resident #49 activated his call light and told an aide someone stole his card and his money. The nurse and the on-coming nurse talked to Resident #49 and were told his card wasn't stolen but it was his money totaling $8000.00 that was stolen. Resident #49 showed the nurse his debit card, declined to have the card locked in the nurses cart, and wanted the police called about his missing $8000.00. Review of Resident #49's progress notes dated 01/30/26 at 6:39 A.M. revealed Resident #49 called the police and the police came tot he facility and interviewed him. Resident #49 continued to state he was missing $8,000.00 off his bank card. The police advised Resident #49 to call his bank and they opened a theft report on his behalf. Review of Resident #49's late entry progress note dated 01/30/26 at 10:15 A.M. included a follow up investigation was completed regarding Resident #49's concern related to missing funds. Resident #49 stated he was not accusing staff or the facility of taking his money and explained that he believed his bank account was compromised. Resident #49 reported that after several attempts to order food by phone his debit card was declined which prompted concern for possible account fraud. Resident #49 and Business Office Manager (BOM) #811 contacted the bank and his account activity was reviewed. Resident #49 never had a balance of 8000.00 in his account and recent transactions were reviewed for potential fraud. The bank locked Resident #49's debit card and advised Resident #49 a replacement card would be issued. Resident #49 confirmed he provided authorization for the facility to debit his account for patient liability payments. Resident #49 voiced no concerns regarding facility billing or staff involvement. The police came to the facility for a follow up visit and spoke with Resident #49 and BOM #811 and were told everything was taken care of with the bank and Resident #49 had no concerns. The police stated they would note the report as closed with no further action requested from the facility. Staff were re-educated regarding abuse prevention, reporting requirements, and proper handling of resident concerns. Resident #49 was provided a lockbox for his debit card which would be used once the replacement debit card was received. Observation on 02/10/26 at 8:38 A.M. of Resident #49 revealed he was lying in bed with the head of his bed elevated. Resident #49 stated he was unhappy at the facility and did not like the food. A (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	breakfast tray was on his bedside table and was untouched except for a small bite out of a piece of toast. When asked if he told anyone he was unhappy at the facility Resident #49 stated he did not know what they knew, they stole my money and the police came twice.Interview on 02/10/26 at 3:49 P.M. with the Administrator revealed Resident #49 stated he was missing $8000.00. The Administrator stated she knew Resident #49 from other facilities and how much money he received monthly and he could not have had $8000.00 in his account. The Administrator stated before he was admitted to the facility he paid his patient liability and that was how she knew how much money he had in his account. The Administrator stated she contacted Resident #49's bank to inquire about the missing funds and Social Services Director (SSD) #810, BOM #811 and Resident #49 were present for the conversation. The bank staff confirmed Resident #49's account was hacked and the stolen money was refunded to his account. Resident #49 needed to go to the bank so he could update his address in person and then the bank would send a replacement debit card. The Administrator stated it was more of an identity theft and that was why she did not report the incident to the State Agency. The Administrator confirmed Resident #49's debit card was compromised and he had out of town charges on his debit card totaling $504.48. Resident #49 was not liable for the charges and his debit card was refunded the money. The Administrator indicated Resident #49 needed to go to the bank in person to change his address and then a new card would be mailed. The Administrator stated the facility did not consider it abuse because Resident #49 was not accusing anyone at the facility of stealing his money, it was a cyber attack and she did not think since she knew what happened that an SRI (Self-Reported Incident) needed initiated. Observation on 02/11/26 at 2:02 P.M. revealed Resident #49 was out of the facility and Licensed Practical Nurse (LPN) #802 stated SSD #819 accompanied him to the bank.Interview on 02/11/26 at 3:37 P.M. of SSD #819 confirmed she took Resident #49 to the bank and he said some of the charges on his account were not his. Resident #49 changed his address from the previous facility he resided in to the facility and his replacement card would be mailed within seven to ten days. SSD #819 stated she did not know details about Resident #49's missing money.Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property dated 11/21/16 included it was the facility policy to investigate all alleged violations involving Abuse, Neglect, Exploitation, Mistreatment of a resident, or Misappropriation of Resident Property, including Injuries of Unknown Source. Additionally the facility should immediately report all such allegations to the Administrator and the State Agency. In cases where a crime was suspected staff should also report the same to local law enforcement. Misappropriation of Resident Property was the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. In response to allegations of abuse, neglect, exploitation or mistreatment the facility must ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation or resident property, are reported immediately, but not later than two hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the Administrator or designee of the facility and to other officials, including the State Survey Agency in accordance with State law.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility policy review, the facility failed to ensure residents who were dependent on care received the appropriate assistance. This affected three Residents (#5, #21, and #49) of four residents reviewed for activities of daily living (ADL) assistance. The facility census was 61.Findings include: 1. Review of the medical record for Resident #21 revealed an admission date of 08/16/22 and diagnoses included metabolic encephalopathy, diabetes mellitus, chronic obstructive pulmonary disease, and altered mental status. Review of plan of care dated 01/20/25 revealed Resident #21 may require assistance with ADLs due to cognitive impairment and disease process. Interventions included provide assistance with bathing and grooming which included nail care, shaving, and hair care. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #21 had a moderate cognitive impairment and was dependent on staff for ADLs including bathing and personal hygiene. Review of bathing forms from 01/07/26 to 02/07/26 revealed Resident #21 received a shower twice per week on Wednesdays and Saturdays. Resident #21 was last documented to have received assistance with shaving on 01/17/26. Observation on 02/10/26 at 10:05 A.M. revealed Resident #21 had hair growth on her chin which appeared to be between one eighth and a quarter of an inch in length. Observation on 02/11/26 at 9:12 A.M. revealed Resident #21 was in her wheelchair returning from the dining room on the second floor. Resident #21 continued to have facial hair on her chin. Interview on 02/11/26 at 2:20 P.M. with Certified Nursing Assistant (CNA) #800 revealed residents received shaving assistance on shower days. CNA #800 stated Resident #21 did not refuse care. CNA #800 observed Resident #21 and confirmed Resident #21 had facial hair growth. CNA #800 offered Resident #21 shaving assistance and Resident #21 agreed to receive shaving assistance. CNA #800 stated Resident #21 was due to have a shower that day and would provide shaving care during shower assistance. 2. Review of Resident #49's medical record revealed an admission date of 01/19/26 and diagnoses included cerebral infarction due to embolism of the left vertebral artery, hemiplegia and hemiparesis following cerebral infarction (CVA) affecting the right dominant side, and vascular dementia. Review of Resident #49's care plan dated 01/20/26 included Resident #49 required maximal assistance with ADLs and might be at risk of developing complications associated with decreased ADL self-care performance related to decreased mobility, CVA with hemiparesis, and dementia. Resident #49 would have his ADL needs met through his next review date. Interventions included Resident #49 required total care for grooming including nails, shaving, and hair. Review of Resident #49's admission MDS assessment dated [DATE] included Resident #49 had a moderate cognitive impairment. Resident #49 had impairment on one side of the upper extremity and no impairment of the lower extremities, and used a wheelchair. Resident #49 was dependent for toileting hygiene, bathing, and dressing. Resident #49 required partial to moderate assistance for (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	personal hygiene. Resident #49 did not reject care during the seven-day assessment look-back period. Review of Resident #49's shower sheets dated 02/04/26 revealed Resident #49 was given a bed bath but refused to be shaved. There was no evidence on 02/04/26 an additional attempt was made to shave Resident #49. Review of Resident #49's shower sheet dated 02/07/26 revealed there was no evidence Resident #49 was shaved, encouraged to be shaved, or refused to be shaved. Observation on 02/10/26 at 11:11 A.M. of Resident #49 revealed he was lying in bed and a scruffy, scraggly beard could be seen with the hair about three quarters of an inch long. Resident #49 stated he would like to have his beard shaved, but no one had shaved his beard or offered to shave it for him. Interview on 02/10/26 at 2:56 P.M. of CNA #851 confirmed Resident #49 needed to be shaved and the hair of his beard was about three-quarters of an inch long. CNA #851 stated she had been off work for three days and was not at the facility to shave Resident #49. CNA #851 stated depending on who the aide was, Resident #49's care might or might not be done. CNA #851 indicated she was preparing to shave Resident #49 now. CNA #851 stated if Resident #49 needed care, she gave the care needed. Interview on 02/11/26 at 1:45 P.M. of CNA #807 revealed sometimes Resident #49 did not want to have his care provided when she offered, but if she went back to his room in about 15 minutes he was fine and would allow the care to be completed. CNA #807 stated Resident #49 allowed her to shave him and cut his fingernails. Interview on 02/11/26 at 2:13 P.M. of CNA #851 revealed Resident #49 allowed her to shave him on 02/10/26 and there were no issues. Interview on 02/11/26 at 2:41 P.M. of CNA #805 revealed Resident #49 required total care, he fed himself but needed help with everything else. CNA #805 indicated Resident #49 sometimes needed a lot of convincing to allow him to provide showers. CNA #805 stated shaving and nail care were provided as needed. CNA #805 revealed he worked on Saturday 02/07/26, Resident #49 was in his resident care assignment and he wanted a bed bath. CNA #805 confirmed he did not shave Resident #49 on 02/07/26 and there was no specific reason he was not shaved other than it was a busy day. 3. Review of the medical record for Resident #5 revealed he was admitted to the facility on [DATE] with diagnoses that included hypertensive heart disease without heart failure, hyperlipidemia, retention of urine, and dementia. Review of the MDS assessment dated [DATE] revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 11 that indicated he was alert and oriented with cognition impairment. Review of the MDS assessment revealed Resident #5 was dependent on staff for ADLs. Review of the physician orders dated 08/19/25 revealed an order for transfers via mechanical lift with assistance of two. Review of the care plan dated 05/02/23 revealed Resident #5 required assistance with ADLs and was at risk for alteration in elimination, completely incontinent of bladder and frequently incontinent of bowel with interventions that included provide incontinence care as needed. Interview and observation on 02/09/26 at 8:16 P.M. revealed Resident #5 seated in his wheelchair next to the right side of his bed, adjacent to the door. Upon entering Resident #5's, a strong odor (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	consistent with urine was noted and was present in the immediate vicinity of the resident. Resident #5 stated staff don't check on me. I need help getting in and out of bed and help going to the bathroom. When I press the call light, they tell me not to press it, and they'll get to me when they can. Observation revealed Resident #5's call light was activated. Observation on 02/09/26 at 8:22 A.M. revealed multiple staff on the unit, near the nursing station. No staff was observed rounding the unit or assisting Resident #5 with his care. Interview and observation on 02/11/26 at 8:15 A.M. revealed Resident #5 seated on the edge of his bed, undressed from the waist down attempting to get dressed. Resident #5 stated I've been stuck in bed all morning and the staff is not worried about me. I didn't do anything wrong. Resident #5 revealed he informed Licensed Practical Nurse (LPN) #802 he wanted to get dressed and out of bed before his breakfast tray arrived. Resident #5 revealed he did not like eating his meals in his night clothes. Interview on 02/11/26 at 8:17 A.M. with LPN #802 revealed Resident #5 was dependent on staff for ADLs. LPN #802 revealed there were two CNAs assigned to assist on Resident #5's unit. LPN #802 revealed she informed CNA #805 of Resident #5's request and continued with the medication pass. Observation on 02/11/26 at 8:25 A.M. revealed LPN #802 entered Resident #5's room and exited a short time after. LPN #802 was then seen approaching CNA #805 and informed him that Resident #5 wanted to get cleaned up, dressed, and in his wheelchair to eat his breakfast. CNA #805 was observed entering Resident #5's room with a breakfast tray and exited the room without the breakfast tray. Interview on 02/11/26 at 8:30 A.M. with CNA #805 revealed breakfast trays had to be delivered before care could be provided to ensure all residents received their meals. CNA #805 revealed Resident #5 would be provided care after tray pass and when another CNA was present due to needing a 2-person assist. Review of the facility document titled Bathing: Bed Bath revised April 2002, revealed the facility had a policy in place to ensure residents receive clean, comfortable care that produced a sense of well-being. Review of the document revealed the facility did not implement the policy. Review of the facility policy titled Bathing: Bed Bath revised 04/2002 included the purpose was to provide cleanliness and comfort, to produce a sense of well-being, to stimulate circulation and relaxation and observe the condition of the resident.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility policy, the facility failed to ensure Resident #60's dialysis access site was immediately monitored upon her return to the facility from dialysis for bleeding and other complications. This affected one resident (#60) out of two residents reviewed for dialysis. The facility census was 61.Findings include: Review of Resident #60's medical record revealed an admission date of 12/25/25 and diagnoses included end stage renal disease (ESRD), type two diabetes mellitus with hypoglycemia, polyneuropathy and dependence on renal dialysis.Review of Resident #60's care plan dated 12/27/25 included Resident #60 was at risk for complications due to hemodialysis treatments three times weekly for ESRD. Resident #60 would receive hemodialysis treatments as scheduled with monitoring of disease process. Interventions included dialysis treatments were every Tuesday, Thursday and Saturday; monitor right upper chest tunneled dialysis catheter every shift and notify the physician of abnormalities. There was no evidence of an intervention to immediately monitor Resident #60's dialysis access site when she returned from dialysis for bleeding and other complications.Review of Resident #60's admission Minimum Data Set assessment dated [DATE] included Resident #60 was cognitively intact. Resident #60 had no impairment of the upper extremities and impairment on one side of the lower extremities and used a wheelchair. Resident #60 required supervision or touching assistance for toileting and personal hygiene, partial to moderate assistance with bathing, and substantial to maximal assistance for lower body dressing. Resident #60 required dialysis.Review of Resident #60's progress notes and assessments tab dated 01/12/26 through 02/04/26 did not reveal evidence Resident #60 was monitored immediately upon her return from dialysis including her dialysis access site.Review of Resident #60's Medication Administration Record and Treatment Administration Record dated 01/23/26 through 02/04/26 revealed Resident #60's right upper chest tunneled dialysis catheter was checked every shift. There no times documented, and a check mark was used, indicating the check was completed two times a day, sometime during the day shift and sometime during the night shift. Review of Resident #60's progress notes dated 02/04/26 at 9:09 P.M. revealed Resident #60 was transported to the ER for fluid overload.Interview on 02/11/26 at 9:42 A.M. of Licensed Practical Nurse (LPN) #802 revealed Resident #60 was non compliant with her diet and ate anything she wanted and that probably contributed to her hospital admission for fluid overload. LPN #802 stated Resident #60 had dialysis on Tuesdays, Thursdays and Saturdays. LPN #802 indicated she was not working when Resident #60 was admitted to the hospital for fluid overload, but a few days before that she had a stuffy nose, her appetite was poor, and STAT labs and a chest x-ray were ordered. LPN #802 stated when Resident #60 returned from dialysis her Dialysis Communication Form was placed in her dialysis binder and post dialysis vital signs were documented at the dialysis center. LPN #802 stated vital signs and Resident #60's access port did not need to be checked when she returned from dialysis because they were done at the dialysis center post dialysis. LPN #802 indicated she just found out there was a tab for dialysis assessment in the electronic record and she would be using it going forward. Interview on 02/11/26 at 12:15 P.M. of the Director of Nursing (DON) revealed a communication form was sent to the dialysis center with Resident #60 on her dialysis days. The DON stated the nurses documented vital signs and noted any concerns on the communication form before Resident #60 was transported to the dialysis center. The DON indicated the dialysis facility completed pre-dialysis and post-dialysis vital signs, medications administered during dialysis, and pertinent comments before Resident #60 was sent back to the facility. The DON stated the nurses should check vital signs and complete an assessment when Resident #60 returned from dialysis and the assessment should be in the progress notes. The DON indicated she would check Resident #60's medical record for evaluations completed when Resident #60 returned from dialysis including monitoring of Resident #60's dialysis access site. Interview on 02/11/26 at 2:30 P.M. of the DON (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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	revealed Resident #60 had her right upper chest tunneled dialysis catheter checked twice a day by the nurses. The DON confirmed there was no evidence Resident #60's dialysis catheter was monitored immediately upon her return from dialysis, the check twice a day could be anytime during the shift and could be hours after Resident #60 returned from dialysis. The DON stated Resident #60's blood pressure and pulse were checked three times a day in the morning, at lunch and at dinner.Review of the facility policy titled Dialysis Management dated 10/11/18 included the facility would assess, monitor for complications and provide adequate intervention in the management of those receiving hemodialysis based on physician orders and plan of care. The following might be included on the resident's plan of care including the resident's target pre and post weights, vital signs, or other monitoring required during the provision of the dialysis treatment.

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	02/12/2026

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

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review and staff interview, the facility failed to ensure pharmacy recommendations approved by the physician were implemented in a timely manner. This affected one resident (#4) of five residents reviewed for pharmacy reviews. The facility census was 61.Findings include: Review of the medical record for Resident #4 revealed she was admitted to the facility on [DATE] with diagnoses of atrial fibrillation, schizophrenia, and type 2 diabetes mellitus with hyperglycemia.Review of the facility document titled Pharmacist Medication Regimen Review (MRR) dated 04/24/25 and 06/23/25 revealed Resident #4's medical records were reviewed and the consultant Pharmacist recorded the Medication Review Results referenced to see recommendations. Review of the facility document titled Note to Attending Physician/Prescriber (APP) dated 04/24/25 and 06/23/25 revealed the consultant Pharmacist made recommendations on both dates for laboratory testing, including Valproic Acid Level (VALs) and Liver Function Test (LFTs) to be completed. Both recommendates were signed by a physician as agree with the recommendations for Resident #4 to have the [NAME] and LFT laboratory testing completed. Review of the National Institute of Health (NIH) via www.nih.gov revealed LFTs included alanine transaminase (ALT), aspartate transaminase (AST), alkaline phosphatase (ALP), gamma-glutamyl transferase (GGT), serum bilirubin, prothrombin time (PT), the international normalized ratio (INR), total protein and albumin.Review of the laboratory drawings dated 10/08/24 through 08/13/25 revealed Resident #4 had laboratory draws for VALs, but lacked draws for LFTs. Continued review of the laboratory drawings dated 10/08/24 through 08/13/25 revealed Resident #4 did not have laboratory drawings for LFTs until 08/13/25, approximately four months after the initial request and two months after the second request. Review of the physician orders revealed no current, completed or discontinued orders for laboratory draws related to Resident #4's LFTs.Interview on 02/12/26 at 3:15 P.M. with the Director of Nursing (DON) confirmed and verified the above findings at the time of the interview.