

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Fairview Fellowship Home for Senior Citizens, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 605 East State Road Fairview, OK 73737	

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 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Fairview Fellowship Home for Senior Citizens, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 605 East State Road Fairview, OK 73737	
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 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, record review, and interview, the facility failed to ensure a medication order for an anti-anxiety medication was entered accurately and an anti-anxiety medication was administered following physician orders for 1 (#8) of 3 sampled residents reviewed for medication administration. The DON identified 72 residents received medications from the facility. Findings: On 10/13/25 at 1:36 p.m., Resident #8 was observed ambulating independently in the common area on the memory care unit. Resident #8's admission record, dated 08/30/24, showed they were admitted with diagnoses which included unspecified dementia and generalized anxiety disorder. Resident #8's quarterly MDS assessment, dated 09/11/25, showed their cognition was severely impaired with BIMS score of 04. The assessment showed Resident #8 was prescribed anti-anxiety medication during the look back period. A facility policy titled PCU059-Medication Discrepancies and Adverse Reactions, dated 03/2025, read in part, Medication Discrepancy: An inappropriate or incorrect medication prescribed for, dispensed for, or given to a resident. It is also an omission of an ordered medication due to a prescribing, dispensing, or administering error. Resident #8's medication administration record, dated 09/2025, showed Resident #8 received hydroxyzine 25 mg TID from 09/26/25 through 09/29/25. The medication administration record showed Resident #8 received 4 additional doses of hydroxyzine not ordered by the treating physician from 09/26/25 through 09/29/25. Resident #8's Medication Regimen Review form, dated 09/23/25, showed the pharmacist consultant reviewed Resident #8's medications and requested the physician consider a gradual dose reduction of the prescribed hydroxyzine 25 mg (anti-anxiety medication) for anxiety TID. The form showed the physician ordered to reduce the hydroxyzine 25 mg to BID on 09/24/25. Resident #8's physician recap order summary, dated 10/13/25, read in part, a. Hydroxyzine HCl oral tablet 25 mg (Hydroxyzine HCl) Give 25 mg by mouth three times a day for increase anxiety, agitation, and restlessness related to GENERALIZED ANXIETY DISORDER. Order date -09/02/24, Start date -09/02/24 - end date 09/25/25. b. Hydroxyzine HCl oral tablet 25 mg (Hydroxyzine HCl) Give 25 mg by mouth two times a day for increase anxiety, agitation, and restlessness related to GENERALIZED ANXIETY DISORDER. Order date- 09/25/25, Start date -09/25/25 - end date 09/25/25.; .c. Hydroxyzine HCl oral tablet 25 mg (Hydroxyzine HCl) Give 25 mg by mouth three times a day for increase anxiety, agitation, and restlessness related to GENERALIZED ANXIETY DISORDER. order date- 09/25/25, Start date -09/26/25 - end date 09/29/25. d. Hydroxyzine HCl oral tablet 25 mg (Hydroxyzine HCl) Give 25 mg by mouth three times a day for increase anxiety, agitation, and restlessness related to GENERALIZED ANXIETY DISORDER. order date- 09/25/25, Start date -09/30/25 - end date 10/08/25. The facility's form titled Employee Counseling Form, dated 10/01/25, showed LPN #1 put an order for hydroxyzine TID. The form read in part, Resident hydroxyzine decreased to BID. ask for clarify from PCP and Dr. Confirmed BID, order written TID. When questioned, said Dr. really meant TID despite Dr. confirming BID to decrease to assess need. Changed treatment and med orders without doctors' orders. On 10/09/25 at 12:05 p.m., the administrator stated LPN #1 put the wrong order in for Resident #8 on 09/25/25 for hydroxyzine 25 mg TID when the physician reduced the dose after a GDR review on 09/24/25 to hydroxyzine 25 mg BID. The administrator stated the order was put in on 09/25/25 for hydroxyzine 25 mg BID after the GDR request by the physician. The administrator stated LPN #1 called the physician and verified the order as BID but LPN #1 put the order in as TID which was not what the physician had ordered. The administrator stated LPN #1 was an agency staff and was not allowed to return to the facility due to the error. On 10/09/25 at 4:10 p.m., RN #1 stated there was an order to reduce Resident #8's hydroxyzine 25 mg TID to BID on 09/24/25. RN #1 stated the DON changed Resident #8's orders to hydroxyzine 25 mg BID on 09/25/25. RN #1 stated on 09/29/25, they checked Resident #8's orders and saw LPN #1 changed Resident #8's orders on 09/25/25 around 7:00 p.m., to hydroxyzine 25 mg TID after the DON had changed the order on 09/25/25 earlier in the day. RN #1 stated they had the medication aide hold the medication and verified with the physician the order for Resident #8's hydroxyzine was not correct and should have been hydroxyzine 25 mg BID. RN #1 stated LPN #1 told them they knew the doctor meant TID and not BID so that was why LPN #1 entered the order as TID. RN #1 stated Resident #8 received 4 additional doses of Hydroxyzine 25 mg from 09/25/25 through 09/29/25 due to LPN #1 putting in the wrong dose order in Resident #8's orders. On 10/13/25 at 3:35 p.m., LPN #1 stated there was a medication review for Resident #8 and the medication aides asked them to change the orders back to TID. LPN #1 stated they changed the order for hydroxyzine 25 mg BID to TID without verifying the order was correct. LPN #1 stated they put the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Fairview Fellowship Home for Senior Citizens, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 605 East State Road Fairview, OK 73737	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Fairview Fellowship Home for Senior Citizens, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 605 East State Road Fairview, OK 73737	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review and interview, the facility failed to ensure professional accepted standards of quality were met related to a physician's order being entered accurately for 1 (#8) of 3 sampled residents reviewed for unnecessary medications. The DON identified 72 residents were administered medications from the facility. Findings: The facility's policy titled PCU059-Medication Discrepancies and Adverse Reactions, dated 03/2025, read in part, Medication Discrepancy: An inappropriate or incorrect medication prescribed for, dispensed for, or given to a resident. It is also an omission of an ordered medication due to a prescribing, dispensing, or administering error. On 10/13/25 at 1:36 p.m., Resident #8 was observed ambulating independently in the common area on the memory care unit. Resident #8's admission record, dated 08/30/24, showed they were admitted with diagnoses which included unspecified dementia and generalized anxiety disorder. Resident #8's quarterly MDS assessment, dated 09/11/25, showed their cognition was severely impaired with BIMS score of 04. The assessment showed Resident #8 was prescribed anti-anxiety medication during the look back period. Resident #8's medication administration record, dated 09/2025, showed Resident #8 received hydroxyzine 25 mg TID from 09/26/25 through 09/29/25. The medication administration record showed Resident #8 received four additional doses of hydroxyzine not ordered by the treating physician from 09/26/25 through 09/29/25. Resident #8's Medication Regimen Review form, dated 09/23/25, showed the pharmacist consultant reviewed Resident #8's medications and requested the physician consider a GDR of the prescribed hydroxyzine 25 mg (anti-anxiety medication) for anxiety TID. The form showed the physician ordered to reduce the hydroxyzine 25 mg to BID on 09/24/25. Resident #8's physician recap order summary, dated 10/13/25, read in part, a. Hydroxyzine HCl oral tablet 25 mg (Hydroxyzine HCl) Give 25 mg by mouth three times a day for increase anxiety, agitation, and restlessness related to GENERALIZED ANXIETY DISORDER. Order date -09/02/24, Start date -09/02/24 - end date 09/25/25. b. Hydroxyzine HCl oral tablet 25 mg (Hydroxyzine HCl) Give 25 mg by mouth two times a day for increase anxiety, agitation, and restlessness related to GENERALIZED ANXIETY DISORDER. Order date- 09/25/25, Start date -09/25/25 - end date 09/25/25. c. Hydroxyzine HCl oral tablet 25 mg (Hydroxyzine HCl) Give 25 mg by mouth three times a day for increase anxiety, agitation, and restlessness related to GENERALIZED ANXIETY DISORDER. order date- 09/25/25, Start date -09/26/25 - end date 09/29/25. d. Hydroxyzine HCl oral tablet 25 mg (Hydroxyzine HCl) Give 25 mg by mouth three times a day for increase anxiety, agitation, and restlessness related to GENERALIZED ANXIETY DISORDER. order date- 09/25/25, Start date -09/30/25 - end date 10/08/25. A facility form titled Employee Counseling Form, dated 10/01/25, showed LPN #1 put an order for hydroxyzine TID. The form read in part, Resident hydroxyzine decreased to BID. ask for clarify from PCP and Dr. Confirmed BID, order written TID. When questioned, said Dr. really meant TID despite Dr. confirming BID to decrease to assess need. Changed treatment and med orders without doctors' orders. On 10/09/25 at 12:05 p.m., the administrator stated LPN #1 put the wrong order in for Resident #8 on 09/25/25 for hydroxyzine 25 mg TID when the physician reduced the dose after a GDR review on 09/24/25 to hydroxyzine 25 mg BID. The administrator stated the order was put in on 09/25/25 for hydroxyzine 25 mg BID after the GDR request by the physician. The administrator stated LPN #1 called the physician and verified the order as BID but LPN #1 put the order in as TID which was not what the physician had ordered. The administrator stated LPN #1 was an agency staff and was not allowed to return to the facility due to the error. On 10/09/25 at 4:10 p.m., RN #1 stated there was an order to reduce Resident #8's hydroxyzine 25 mg TID to BID on 09/24/25. RN #1 stated the DON changed Resident #8's orders to hydroxyzine 25 mg BID on 09/25/25. RN #1 stated on 09/29/25, they checked Resident #8's orders and saw LPN #1 changed Resident #8's orders on 09/25/25 around 7:00 p.m. to hydroxyzine 25 mg TID after the DON had changed the order on 09/25/25 earlier in the day. RN #1 stated they had the med aide hold the medication and verified with the physician the order for Resident #8's hydroxyzine was not correct and should have been hydroxyzine 25 mg BID. RN #1 stated LPN #1 told them they knew the doctor meant TID and not BID so that was why LPN #1 entered the order as TID. RN #1 stated Resident #8 received 4 additional doses of Hydroxyzine 25 mg from 09/25/25 through 09/29/25 due to LPN #1 putting in the wrong dose order in Resident #8's orders. On 10/13/25 at 3:35 p.m., LPN #1 stated there was a medication review for Resident #8 and the medication aides asked them to change the orders back to TID. LPN #1 stated they changed the order for hydroxyzine 25 mg BID to TID without verifying the order was correct. LPN #1 stated they put the order in as hydroxyzine 25 mg TID when it should have been BID. On 10/14/25 at 1:46 p.m. the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Fairview Fellowship Home for Senior Citizens, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 605 East State Road Fairview, OK 73737	

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 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Fairview Fellowship Home for Senior Citizens, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 605 East State Road Fairview, OK 73737	
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 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, record review, and interview, the facility failed to ensure medication orders for a psychotropic medication were correct to prevent unnecessary medication administered after a gradual dose reduction for 1 (#8) of 3 sampled residents reviewed for unnecessary medications. The DON identified 72 residents were administered medications from the facility. Findings: A facility policy titled PCU059-Medication Discrepancies and Adverse Reactions, dated 03/2025, read in part, Medication Discrepancy: An inappropriate or incorrect medication prescribed for, dispensed for, or given to a resident. It is also an omission of an ordered medication due to a prescribing, dispensing, or administering error. On 10/13/25 at 1:36 p.m., Resident #8 was observed ambulating independently in the common area on the memory care unit. Resident #8's admission record, dated 08/30/24, showed they were admitted with diagnoses which included unspecified dementia and generalized anxiety disorder. Resident #8's quarterly MDS assessment, dated 09/11/25, showed their cognition was severely impaired with BIMS score of 04. The assessment showed Resident #8 was prescribed anti-anxiety medication during the look back period. Resident #8's Medication Regimen Review form, dated 09/23/25, showed the pharmacist consultant reviewed Resident #8's medications and requested the physician consider a GDR of the prescribed hydroxyzine 25 mg (anti-anxiety medication) for anxiety TID. The form showed the physician ordered to reduce the hydroxyzine 25 mg to BID on 09/24/25. Resident #8's physician recap order summary read in part, a. Hydroxyzine HCl oral tablet 25 mg (Hydroxyzine HCl) Give 25 mg by mouth three times a day for increase anxiety, agitation, and restlessness related to GENERALIZED ANXIETY DISORDER. Order date -09/02/24, Start date -09/02/24 - end date 09/25/25. b. Hydroxyzine HCl oral tablet 25 mg (Hydroxyzine HCl) Give 25 mg by mouth two times a day for increase anxiety, agitation, and restlessness related to GENERALIZED ANXIETY DISORDER. Order date- 09/25/25, Start date -09/25/25 - end date 09/25/25. c. Hydroxyzine HCl oral tablet 25 mg (Hydroxyzine HCl) Give 25 mg by mouth three times a day for increase anxiety, agitation, and restlessness related to GENERALIZED ANXIETY DISORDER. order date- 09/25/25, Start date -09/26/25 - end date 09/29/25. d. Hydroxyzine HCl oral tablet 25 mg (Hydroxyzine HCl) Give 25 mg by mouth three times a day for increase anxiety, agitation, and restlessness related to GENERALIZED ANXIETY DISORDER. order date- 09/25/25, Start date -09/30/25 - end date 10/08/25. Resident #8's medication administration record, dated 09/2025, showed Resident #8 received hydroxyzine 25 mg TID from 09/26/25 through 09/29/25. The medication administration record showed Resident #8 received 4 additional doses of hydroxyzine not ordered by the treating physician from 09/26/25 through 09/29/25. A facility form titled Employee Counseling Form, dated 10/01/25, showed LPN #1 put an order for hydroxyzine TID. The form read in part, Resident hydroxyzine decreased to BID. ask for clarify from PCP and Dr. Confirmed BID, order written TID. When questioned, said Dr. really meant TID despite Dr. confirming BID to decrease to assess need. Changed treatment and med orders without doctors' orders. On 10/09/25 at 12:05 p.m., the administrator stated LPN #1 put the wrong order in for Resident #8 on 09/25/25 for hydroxyzine 25 mg TID when the physician reduced the dose after a GDR review on 09/24/25 to hydroxyzine 25 mg BID. The administrator stated the order was put in on 09/25/25 for hydroxyzine 25 mg BID after the GDR request by the physician. The administrator stated LPN #1 called the physician and verified the order as BID but LPN #1 put the order in as TID which was not what the physician had ordered. The administrator stated LPN #1 was an agency staff and was not allowed to return to the facility due to the error. On 10/09/25 at 4:10 p.m., RN #1 stated there was an order to reduce Resident #8's hydroxyzine 25 mg TID to BID on 09/24/25. RN #1 stated the DON changed Resident #8's orders to hydroxyzine 25 mg BID on 09/25/25. RN #1 stated on 09/29/25, they checked Resident #8's orders and saw LPN #1 changed Resident #8's orders on 09/25/25 around 7:00 p.m., to hydroxyzine 25 mg TID after the DON had changed the order on 09/25/25 earlier in the day. RN #1 stated they had the medication aide hold the medication and verified with the physician the order for Resident #8's hydroxyzine was not correct and should have been hydroxyzine 25 mg BID. RN #1 stated LPN #1 told them they knew the doctor meant TID and not BID so that was why LPN #1 entered the order as TID. RN #1 stated Resident #8 received 4 additional doses of Hydroxyzine 25 mg from 09/25/25 through 09/29/25 due to LPN #1 putting in the wrong dose order in Resident #8's orders. On 10/13/25 at 3:35 p.m., LPN #1 stated there was a medication review for Resident #8 and the medication aides asked them to change the orders back to TID. LPN #1 stated they changed the order for hydroxyzine 25 mg BID to TID without verifying the order was correct. LPN #1 stated they put the order in as hydroxyzine 25 mg TID when it should have</p>		