STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375467	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairfax Behavioral Health & Memory Care Community	282 County Road 6300 Fairfax, OK 74637

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to update care plan interventions after falls for 1 (#2) of 3 sampled residents reviewed for care plan interventions.The DON identified 48 residents resided in the facility. Findings:On 02/03/26 at 1:33 p.m., Resident #2 was observed walking up and down halls with CNA #5. The resident was unsteady on their feet and required hands on assistance to walk. CNA #5 attempted to redirect the resident several times to sit in their specialized wheelchair without success. On 02/03/26 at 2:47 p.m., Resident #2 was observed sitting in their chair while CNA #5 was talking to them.On 02/03/26 at 3:01 p.m., a sign posted in Resident #2's room, read in part, Use call light when needed.On 02/04/26 at 9:48 a.m., Resident #2 was observed walking up and down halls with CNA #5.A document titled Policy: Resident Falls and Prevention, dated 08/01/25, read in part, Interventions will be reflected in the resident's care plan and reviewed regularly .Update the care plan with revised or additional interventions.A care plan, dated 08/20/25, showed Resident #2 was at risk for falls related to weakness, impaired mobility, abnormal gait, and balance.An admission assessment, dated 08/28/25, showed Resident #2 was admitted to the facility on [DATE] with a diagnosis of non-Alzheimer's dementia. The assessment showed Resident #2 required supervision or touching assistance to walk 10 feet or more. The assessment showed Resident #2 had no history of falls.A review of the care plan showed a post fall intervention was added on 11/02/25 to provide frequent checks while they were in their room. The care plan had no additional interventions beyond 11/02/25.An incident note, dated 12/26/25, showed Resident #2 had a witnessed fall without injury. Interventions documented were to apply non-slip socks and obtain proper fitting shoes.An incident note, dated 01/01/26, showed Resident #2 had an unwitnessed fall which resulted in a skin tear to their right elbow. No interventions were documented.An incident note, dated 01/18/26, showed Resident #2 had an unwitnessed fall. No injuries or interventions were documented.An untitled document, dated 01/20/26, showed Resident #2 was seen in the emergency department for a fall. The document showed Resident #2 sustained a laceration of the face which was repaired by tissue glue. Resident #2 also sustained a bruise to the face and unspecified knee.An incident note, dated 01/21/26, showed Resident #2 was being monitored post fall. The note showed Resident #2 had bruising and swelling to their right eye.An incident note, dated 01/22/26, showed Resident #2 had an unwitnessed fall and the skin tear to their right elbow reopened. No interventions were documented.An incident note, dated 01/24/26, showed Resident #2 had an unwitnessed fall. No injuries or interventions were documented.An incident note, dated 01/28/26, showed Resident #2 had three unwitnessed falls. No injuries or interventions were documented.An incident note, dated 01/29/26, showed Resident #2 had an unwitnessed fall at 2:45 p.m. No injuries were documented. An intervention in place was to place resident in non-slip socks.An incident note, dated 01/29/26, showed Resident #2 had an unwitnessed fall at 4:33 p.m. with a skin tear and bruising to their right elbow. Intervention in place was (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
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to start Buspar (an anti-anxiety medication) 5mg twice daily for agitation.On 02/03/26, at 2:48 p.m., CNA #5 stated as a fall intervention a staff member would be with them around the clock. CNA #5 stated when Resident #2 became anxious or agitated, they would give snacks or treats as a distraction. CNA #5 was asked how they knew these were the interventions in place. They stated it was in the resident's electronic health record.On 02/03/26 at 2:59 p.m., LPN #5 stated fall interventions in place for Resident #2 were to take them to their room after meals, frequent toileting, non- slip socks, and use their chair when needed. LPN #5 was asked how they knew these were the interventions in place. They stated the interventions were posted in resident rooms, charts, or care plans.On 02/03/26 at 3:03 p.m., the DON stated care plans were reviewed and updated quarterly or with new physician orders and after every fall. The DON was asked to show interventions for Resident #2's falls after 11/02/25. They stated they could not show the interventions because they were not on the care plan. The DON was asked how staff knew what interventions were in place for residents. They stated progress notes in the electronic health record reflected the interventions. They were asked if the CNAs could see the progress notes. They stated, No, they can't. They receive the interventions verbally from the nurses.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, record review, and interview, the facility failed to ensure staff transferred a resident in a safe manner to prevent injury for 1 (#6) of 2 sampled residents reviewed for safe transfers.The DON identified 48 residents resided in the facility. Findings:On 02/03/26 at 1:14 p.m., Resident #6 was observed sitting in a wheelchair in their room with their left arm wrapped in an ace wrap and secured in an immobilized arm sling.A facility policy titled Policy and Procedure Resident Transfer and Safe Patient Handling, dated 11/01/23, read in part, It is the policy to ensure all resident transfers are performed using proper body mechanics, approved transfer techniques, and appropriate equipment in order to prevent injury to residents and staff and to promote resident dignity and mobility.A care plan for Resident #6, dated 10/02/25, showed the resident required moderate to maximum assistance of two staff members for toileting and incontinent care.An incident note for Resident #6, dated 11/30/25, showed the resident had a fall and was lowered to the bathroom floor by staff. The incident note showed Resident #6 was crying that their left wrist was hurt.A mobile x-ray report for Resident #6, dated 11/30/25, showed the resident had an x-ray taken of their left arm which showed an acute distal left arm fracture.A radiology results note for Resident #6, dated 11/30/25 showed resident was sent to the hospital for their left arm to be stabilized.A quarterly assessment for Resident #6, dated 01/08/26, showed the resident had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making, and required substantial maximum assistance with transfers. The assessment showed the resident had one fall with major injury. A progress note for Resident #6, dated 01/09/26, showed a CNA reported to a nurse they had heard a pop while assisting Resident #6 in the shower.A mobile x -ray report for Resident #6, dated 01/10/26, showed the resident had an acute distal fracture of the left humerus.A progress note for Resident #6, dated 01/10/26, showed was sent to the hospital for stabilization of the arm.On 02/03/26 at 1:15 p.m., Resident #6 stated they broke their wrist while CMA#1 was assisting them to the bathroom. Resident #6 stated they told CMA #1 they needed two people for assistance. Resident #6 stated they broke their left arm when two aides transferred them under their arm pits to get into a shower chair.On 02/03/26 at 3:18 p.m., CNA #1 stated they transferred residents by placing their forearms under the residents' arms. On 02/04/26 at 9:15 a.m., LPN #2 stated on 01/09/26 two CNAs transferred Resident #6 under the resident's arms. They stated the CNAs where transferring Resident #6 to a shower chair when they heard the resident's left shoulder pop.On 02/04/26 at 10:14 a.m., CNA #3 stated when they had attempted to transfer Resident #6 to a shower chair on 01/09/26, they transferred by putting their arms under the resident's arms. CNA #3 stated they heard a pop in Resident #6's left shoulder.On 02/05/26 at 10:32 a.m., CMA #1 stated they utilized a one-person transfer for Resident #6 on 11/30/25. They stated Resident #6 started to fall and used their left hand to break the fall. CMA #1 stated they did not know Resident #6 was a two-person transfer. On 02/05/26 at 11:49 a.m., the DON stated staff were to use gait belts and to not lift residents under their arms.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure adequate supervision to prevent elopement for 1 (#2) of 2 sampled residents reviewed for elopements.The DON identified 48 residents resided in the facility.Findings:On 02/03/26 at 1:33 p.m., Resident #2 was observed walking up and down halls with CNA #5. They were unsteady on their feet and required hands on assistance to walk. CNA #5 attempted to redirect resident several times to sit in their broda chair without success. On 02/03/26 at 2:47 p.m., Resident #2 was observed sitting in their chair while CNA #5 was talking to them.On 02/04/26 at 9:48 a.m., Resident #2 was observed walking up and down halls with CNA #5.On 02/04/26 at 11:10 a.m., the park where Resident #2 was found during their elopement was observed to be approximately 50 yards from the facility's back door and on the other side of a small hill.A Policy and Procedure: Resident Elopement Prevention and Response, dated 11/01/23, read in part, It is the policy to protect residents from elopement.An admission assessment, dated 08/28/25, showed Resident #2 was admitted to the facility on [DATE] with diagnoses which included non-Alzheimer's dementia, delirium due to known psychological condition, and anxiety disorder. The assessment showed Resident #2 had a BIMS of 3, which indicated Resident #2 had severe cognitive dysfunction, and had a history of wandering. A care plan, dated 08/21/25, showed Resident #2 was an elopement risk. Interventions for risk of elopement were to provide structured activities and offer diversions.An Incident Report, dated 10/04/25, showed Resident #2 was noticed to be missing from the facility on 10/04/25 at 2:59 p.m. The resident was located by staff at a nearby park shortly after 3:11 p.m. and was visibly anxious.An incident note, dated 10/04/25, read in part, Order for Hydroxyzine (an anti-anxiety medication) 25mg PO [by mouth] every 6 hours for 48 hours then reassess with primary care provider. Resident continues on every 30 minute checks.A MAR dated October 2025 showed Resident #2 was given eight doses of Hydroxyzine 25mg every six hours for 48 hours and then it was discontinued due to anxiety resolution.A document titled, In-Service Educational Program, dated 10/04/25, showed all staff were educated regarding elopement prevention and procedures and an elopement drill was completed.A document titled, 30 Minute Check Log [Resident #2], dated 10/04/25 showed Resident #2 was placed on 30 minute visual checks by staff until 10/24/25.A document titled, Quality Assurance and Performance Improvement Committee Meeting, dated 10/27/25, showed quality assurance committee members met to discuss elopement prevention and response monitoring.An undated task created in Resident #2's electronic health record showed they are to be one-on-one with a staff member at all waking times.A review of time punches from 10/04/25 showed eight direct care staff were working at the time of Resident #2's elopement.On 02/03/26 at 2:48 p.m., CNA #5 stated interventions in place to prevent elopement for Resident #2 was that someone was with them, they give treats and snacks or something to fidget with to keep Resident #2 distracted.On 02/03/26 at 2:53 p.m., LPN #1 stated interventions in place to prevent elopement for Resident #2 was that a member of staff was to be with them during waking hours. They stated distraction with activity and toileting as needed were also interventions. LPN #1 stated the facility changed the code on the door and only staff had the code for entering and exiting.On 02/03/26 at 3:12 p.m., the DON was asked about Resident #2's elopement. They stated Resident #2 was off premises for approximately 12 minutes, found at the nearby park, and uninjured. They stated Resident #2 was then prescribed Hydroxyzine and placed on 30 minute visual checks. The DON stated an elopement drill and all staff in-service regarding elopement prevention and response was held.On 02/05/26 at 11:03 a.m., CNA #6 stated a staff member is with Resident #2 at all times except while sleeping and still on 30 minute visual checks while sleeping. CNA #6 stated residents at risk for elopement were (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discussed during ongoing in-services and no one had the door code except employees. CNA #6 stated staff was educated to check exit doors when near them, keep residents engaged in activity, and check all residents at least hourly.On 02/05/26 at 11:07 a.m., the dietary manager stated Resident #1 had a staff member with them at all times. They stated the facility door code changed and only staff had codes for entering and exiting. The dietary manager stated they had received an in-service training to prevent elopements and as part of that training they check exit doors whenever they were near them.