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	05/06/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to access, monitor, and intervene for a change in condition for 1 (#1) of 3 sampled residents reviewed for quality of care.The administrator identified 50 residents who resided in the facility. Findings:A quarterly assessment, dated 11/17/25, showed Resident #1 was originally admitted on [DATE] with diagnoses which included stroke, congestive heart failure, hemiplegia and diabetes mellitus type II. The assessment showed Resident #1 was severely impaired in cognition and had unclear speech. The assessment showed Resident #1 required substantial assistance with all activities of daily living. There were no nurse progress notes documented for Resident #1 between 02/03/26 and 02/09/26.A treatment administration record for Resident #1, dated 02/09/26 at 7:44 a.m., showed the resident's finger stick blood sugar was 209.A blood pressure and pulse summary for Resident #1, dated 02/09/26 at 10:37 a.m., showed the resident's blood pressure was 130/84 and heart rate was 93 beats per minute.A staff schedule, dated 02/09/26, showed LPN #2 was responsible for Resident #1's care. No documentation was found in Resident #1's medical record showing LPN #2 had provided care to the resident on 02/09/26.A nurse progress note, dated 02/09/26 at 7:45 p.m., showed LPN #1 found Resident #1 lethargic and not responding to verbal or tactile stimuli. Resident #1's finger stick blood sugar was 334, their blood pressure was 108/57, and their pulse was 111. Resident #1 was sent to the emergency room for evaluation and treatment. A Change in Condition policy, revised 03/01/26, read in part, The facility shall promptly identify and respond to any change in a resident's condition. Changes in condition shall be assessed immediately, reported to the physician, reported to the resident's representative, documented thoroughly, and care planned appropriately. On 05/04/26 at 1:36 p.m., family member #1 stated they were notified Resident #1 was admitted to the hospital with a UTI after they were found unresponsive. Family member #1 stated Resident #1's mind wasn't there and the family had watched their health slowly decline. Family member #1 stated they believed Resident #1 had a small stroke while in the hospital. Family member #1 stated they were informed by an unidentified staff member that Resident #1 had not been checked on in four hours and nobody knew how long Resident #1 had been unresponsive.On 05/04/26 at 2:02 p.m., family member #2 stated they spoke to one of the nurses at the hospital and was informed the resident was septic from a UTI. On 05/04/26 at 2:40 p.m., the EMT stated on 02/09/26, they were dispatched for an unresponsive patient. The EMT stated when they arrived, shortly after 8:00 p.m., they observed LPN #1 getting out of their car and smoking a cigarette. The EMT stated when they entered Resident #1's room they observed Resident #1 lying flat on their back, alone in their room, barely breathing, and white as a ghost. The EMT stated they initially thought Resident #1 was dead. The EMT stated three staff members were observed at the nurse's station. The EMT stated CMA #1 told them Resident #1 had been like that since at least 4:00 p.m. The EMT stated LPN #1 told the EMTs they had arrived at 6:00 p.m. and had just assessed Resident #1. The EMT stated Resident #1 was one of their regulars.On 05/04/26 at 3:26 p.m., CMA #1 stated they arrived on shift at 3:00 p.m. CMA #1 stated between 4:00 p.m. and 5:00 p.m., they tried to assist Resident #1 with eating, but Resident #1 only managed to eat a couple bites because they kept gagging. CMA #1 stated Resident #1 did not answer or talk to them which was abnormal. CMA #1 (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated they notified LPN #2 about their observations, but LPN #2 was new at the time and never laid eyes on [Resident #1]. CMA #1 stated they told LPN #1 about what was going on and asked LPN #1 to go lay eyes on [Resident #1]. CMA #1 stated LPN #1 informed them they would after they completed the evening blood sugar checks. CMA #1 stated LPN #1 called EMS after their observation and asked CMA #1 for a pulse oximeter to allow them to check Resident #1's oxygen levels. CMA #1 stated LPN #1 ran to their car looking for a pulse oximeter, and that was when the EMTs arrived. CMA #1 stated LPN #1 did not have time to smoke a cigarette in the short amount of time they went to their car to look for the pulse oximeter. CMA #1 stated the EMT was yelling at [LPN #1] about why no one was with [Resident #1]. CMA #1 stated I think the nurses should have acted like it was more important. CMA #1 stated when they last saw Resident #1 for the dinner meal, they were not unresponsive, but they were not responding appropriately. CMA #1 stated they did not know the facility protocol for leaving residents alone when they are preparing to be transferred to the hospital.On 05/04/26 at 3:58 p.m., CNA #1 stated when they fed lunch to Resident #1 on 02/09/26. CNA #1 stated the resident only took a couple of bites and was letting food roll out of their mouth. CNA #1 stated they notified LPN #2 Resident #1 was not eating.On 05/04/26 at 5:06 p.m., the ADON stated they were made aware Resident #1 was acting differently on 02/09/26. The ADON stated they went to speak with Resident #1 at approximately 1:00 p.m., and Resident #1 stated they were fine. The ADON stated documentation should have been completed about Resident #1's decline throughout the day. The ADON stated LPN #2 was the nurse responsible for Resident #1 and the ADON assumed LPN #2 was going to document Resident 1's condition. The ADON stated they did not know when Resident #1's decline began because the administration did not have a procedure in place to verify if charting was being completed or monitoring for resident changes in condition. The ADON stated an assessment should have been conducted right after a change in condition was identified. The ADON stated it should not have taken the nurse almost two hours to assess Resident #1 after the change in condition was identified.On 05/04/26 at 5:16 p.m., LPN #2 stated at the time of the incident, they were still new and Resident #1 was already naturally declining. LPN #2 stated they were notified around 4:00 p.m. that Resident #1 was not acting right. LPN #2 stated they assessed Resident #1's vital signs but did not recognize any change in condition from the previous day. LPN #2 stated they did not feel their assessment needed to be documented because there was nothing out of the ordinary and Resident #1 was stable. LPN #2 stated Resident #1 had not been eating well in the last few days. LPN #2 stated they did not feel Resident #1's condition warranted a call to the physician because they did not identify a change in condition.On 05/04/26 at 6:02 p.m., LPN #1 stated they arrived at work around 6:00 p.m. and received report. LPN #2 stated they had not been notified about any concerns with Resident #1. LPN #1 stated they reviewed documentation and started completing blood sugar checks. LPN #2 stated when they checked Resident #1's blood sugar at approximately 7:45 p.m., they noticed Resident #1 was not acting right. LPN #1 stated Resident #1 had an increased pulse rate, low blood pressure, and was pale which indicated something was wrong. LPN #1 stated they went to their car to look for a pulse oximeter after they called EMS. LPN #1 stated the EMT kept asking how long Resident #1 had been unresponsive. LPN #1 stated they had a two-hour time frame to check on their residents. LPN #1 stated they called and gave report to the hospital. LPN #1 stated after they identified Resident #1's change in condition, they were notified by CMA #1 that concerns about Resident #1's change in condition were raised earlier during the previous shift. LPN #1 stated they did not feel the situation was dire enough to have someone sit with Resident #1. They stated they didn't really have time to go chase somebody down. LPN #1 stated Resident #1's breathing was normal. LPN #1 stated they were aware of Resident #1's history of UTI's and that Resident #1 did not like liquids because they had to be thickened. LPN #1 stated I did not stop for a smoke break; I wasn't out there for more than a few seconds to look for a pulse oximeter. On 05/06/26 at 12:37 p.m., the director of nursing stated We are trying to educate the staff on how to appropriately chart and make sure observations are charted.