STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N097003	A. BUILDING: _____ B. WING _____	R-C 04/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW ESTATES RETIREMENT COMMUNITY, INC	1630 SEWELL AVENUE COLBY, KS 67701

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{S 000}	INITIAL COMMENTS The following citations represent the findings of the 2nd licensure revisit for correction order 19-29 conducted on 4/24/19.	{S 000}		
{S3171} SS=E	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (i) The facility reported a census of 31 residents. The sample included 3 residents. Based on record review and interview the operator failed to ensure qualified staff provided health care services for 2 of 3 sampled residents (#2172 and #2044) in accordance with acceptable standards of practice regarding the need for nursing assessments related to infection/pain, clear communications with the medical care provider to ensure resident #2172 received only necessary medications and failure to follow a medical care provider's order for blood pressure monitoring (#2044). Findings included: - Record review for resident #2172 revealed a readmission date of 11/30/18 with diagnoses of chronic obstructive pulmonary disease, osteoarthritis and depression. The readmission functional capacity screen dated	{S3171}		

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

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{S3171}	Continued From page 1 11/30/18 identified the resident with intact cognition and independence with activities of daily living. He/she needed physical assistance with medications and treatments and had impaired vision. The negotiated service agreement dated 11/30/18 indicated facility staff would administer all medications and treatments for the resident as ordered by a medical care provider. The resident plan of care dated 11/30/18 directed staff the resident was independent with activities of daily living and staff should monitor for any needs. Facility staff to administer all medications and treatments per medical care provider orders. Under physical health - staff will monitor for any increased signs or symptoms (S/S) of decline in status. Review of dictation from an emergency room (ER) visit on 2/04/19 revealed instructions which included - drink plenty of fluids, ice to wrist, elevate, Augmentin (antibiotic) 875/125 milligrams twice a day for 10 days, Norco (narcotic pain reliever) ½ - 1 tab every 6 hours as needed for pain, continue home medications and follow-up with medical care provider on 2/6/19. The resident was given written prescriptions to take to the pharmacy for the antibiotic and Norco which was provided on 4/24/19 as part of the resident's record. The medical care providers orders include an order for Tramadol (a synthetic pain reliever which works in the brain like a narcotic/opioid/morphine) 50 milligrams 1 tablet by mouth every 4 hours as needed for pain. Review of the February 2019 medication	{S3171}		

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{S3171}	Continued From page 2	{S3171}		

administration record (MAR) revealed the resident received the Augmentin as ordered from 2/05/19 through 2/15/19. He/she took Tramadol frequently for the pain and occasional Norco.

Review of the nursing notes revealed on 2/04/19 the resident reported a very swollen and painful wrist, nurse evaluated and recommended an ER visit. At 12:00 PM the resident returned from ER with no fracture but had an infection with orders for an antibiotic and pain medications.
-- next note, 2/09/19 at 6:00 PM resident reports pain in right hand wanting pain medication, nurse notified pain level 6/10 Tramadol given (the note lacked an assessment by a nurse of the resident's hand).
--2/09/19 at 10:00 PM resident complained of pain in the right hand and could not sleep due to the pain with pain level 6/10 - nurse notified, and resident given a tramadol. (the note lacked an assessment by a nurse of the resident's hand).
--2/12/19 at 5:15 PM resident complains of right had pain requested a Tramadol, nurse notified ... (the note lacked an assessment by a nurse of the resident's hand).
--2/21/19 at 8:00 AM resident complains of pain in right hand and requested a Tramadol, nurse notified and Tramadol administered for pain level of 6/10 (the note lacked an assessment by a nurse of the resident's hand).

--Note nursing notes between 2/21/19 at 8:00 AM and 3/06/19 at 7:30 PM without any further mention of the resident's pain in the right hand.

On 3/06/19 at 7:30 PM certified staff E wrote - the resident had a fall by sliding off his/her walker. Resident without injury but expressed he/she had quite a bit of pain from the right hand all the way to the elbow and certified staff E told the resident

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{S3171}	Continued From page 3	{S3171}		

it was too early for more pain medication ... nurse notified (the note lacked an assessment by a nurse of the resident's hand) ... 2 - ½ tabs of Norco 5/325 were administered.
--next note 3/10/19 at 8:50 AM resident requested a Tramadol for pain in right hand, nurse notified (the note lacked an assessment by a nurse of the resident's hand). That same day at 5:30 PM the resident requested Tramadol for pain in the right hand - nurse notified (the note lacked an assessment by a nurse of the resident's hand).

Interview with licensed nurse B on 4/24/19 at 11:12 AM regarding a fax sent to the medical care provider on 3/08/19 revealed a licensed nurse on the night shift reported after a chart review he/she could not find the medical care provider's order for the Augmentin 875-125 mg from the ER visit 2/04/19 for hand infection. Administrative licensed nurse A sent the fax which read "Please sign et send back order for Amox-Clav (Augmentin generic) 875-125 mg 1 tablet by mouth twice a day for 10 days for hand infection per office visit with physician C. The physician signed the order on 3/12/19.

The record lacked any information about an office visit with physician C on or around the date of 3/08/19 for a hand infection with the only documentation of the ER visit on 2/04/19.

Review of the March 2019 MAR revealed the resident received Augmentin 875-125 mg 1 tablet by mouth twice a day for 10 days for hand infection between 3/11/19 and 3/20/19.

Review of the nursing notes revealed no entries about any S/S of a hand infection to warrant dosing of an antibiotic 3/11/19. On 3/14/19 at 2:00 PM licensed nurse D wrote resident reports pain

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{S3171}	Continued From page 4 much more in control today ... moving easier and right hand continued to be swollen but not red and warm. On 4/24/19 at 12:35 PM administrative licensed nurse A who sent and noted the fax for the Augmentin order also stated the fax was sent to get an order to cover the antibiotic administered in February 2019. He/she believed the resident only received the antibiotic in February and was not aware of the antibiotic being administered in March 2019 based on the fax sent. He/she did not know of the resident having S/S of an infection of the right hand during March 2019. He/she confirmed the record lacked nursing assessments of the resident's hand infection and continued reports of pain and the fax was not clear to the physician that the order was to cover medications given in February 2019. The operator failed to ensure qualified staff provided health care services for this resident in accordance with acceptable standards of practice regarding the need for nursing assessments related to infection/pain and clear communications with the medical care provider to ensure the resident received only necessary medications. - Record review for resident #2044 revealed an admission date of 3/01/19 with diagnoses of hypertension, edema and chronic pain. The admission functional capacity screen dated 3/01/19 indicated the resident had intact cognition, could provide self-care with supervision for bathing. He/she was able to manage his/her own medications and treatments. The negotiated service agreement dated 3/01/19	{S3171}		

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{S3171}	Continued From page 5 indicated facility staff would provide standby assistance with showers, housekeeping services weekly and provide 3 meals a day. He/she would be independent with cares and medications/treatments. The resident plan of care dated 3/01/19 identified the resident would manage his/her own medications with directions for staff to monitor residents to make sure he/she was taking the medications properly. He/she could manage treatments independently with directions for staff to monitor for any signs or symptoms (S/S) of need for assistance. Under the physical health section - directions to staff to monitor for any S/S of pain or hypertension issues. A faxed communication with the medical care provider sent on 4/03/19 reported the resident's emergency room (ER) visit on 4/01/19 for blood pressure (BP) over 200 ... (info about concerns with self-administering medications and lack of refills on his/her BP medication). The medical care provider responded on 4/04/19 with please continue prior medications but add Lisinopril 10 milligrams (mg) daily. Please continue to monitor his/her BP at least 1 time per day. Review of the nursing notes revealed the following: -- 4/01/19 at 4:40 PM resident was sent to the ER with S/S of dizziness and BP of 220/120 resident transported by ambulance. At 10:30 PM that day, the resident returned from the hospital ... with new orders to start Lisinopril 10 milligrams by mouth starting on 4/02/19 and follow-up with the doctor in 2 weeks. -- 4/04/19 at 5:00 PM received communication back from family member to monitor the BP 1 times a day and continue to self-administer	{S3171}		

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{S3171}	Continued From page 6 his/her own medications. -- None of the nursing notes dated 4/02/19, 4/03/19, 4/4/19 and 4/09/19 reflect monitoring of the resident's BP. Interview with administrative licensed nurse A on 4/24/19 at 12:45 PM confirmed the record lacked any evidence of monitoring the resident's BP daily as ordered by a medical care provider. The operator failed to ensure licensed nurses met standards of care by a failure to monitor this resident's BP as ordered by a medical care provider.	{S3171}		