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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaints (#174075, #171735, #171695, #170471, #170459, #170295, #165392) at the above named assisted living facility conducted on 11/14/22 and 11/15/22.	S 000		
S3101 SS=E	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (h) The census equaled 31 residents. The sample included 3 residents and 1 closed record review resident. Based on record review and interview for 3 Residents (R)1, R2 and R3, Operator/Certified Medication Aide (CMA) A failed to ensure each individual involved in the development of the negotiated service agreement (NSA) signed the agreement. Findings included: - Record review for R1 revealed he admitted on 09/04/21 with diagnoses of cerebral vascular accident (CVA) and diabetes mellitus. R1's "Functional Capacity Screen" (FCS) dated	S3101		

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
	N097003	A. BUILDING: _____ B. WING _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3101	Continued From page 1 03/22/22 recorded the resident as independent with eating, required supervision with transfer and walk/mobility and required physical assistance with bathing, dressing, toileting and was unable to perform management of medications and treatments. R1 was frequently incontinent, had impaired memory/recall and usually understood communication. The resident's current NSA dated 09/04/22 recorded facility staff would provide the following personal care services: bathing, supervision of mobility as needed, management of medications and medical treatments and management of bladder incontinence. The NSA failed to identify services provided for dressing and diabetic management. The "Resident Plan of Care" dated 03/22/22 recorded resident as independent for toileting and eating, stand by assistance required for bathing, dressing and transfer, assistance required for walk/mobility and facility staff to provide medication administration per physician order. The "Resident Plan of Care" recorded R1 as alert and oriented. NSA lacked signatures of the individuals involved in the development of the agreement including R1 and any legal representatives or family members. - Record review for R2 revealed she admitted on 12/17/20 with diagnoses of hypertension, hyperlipidemia, and constipation. R2's "Functional Capacity Screen" (FCS) dated 02/16/22 recorded the resident as independent	S3101		

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3101	Continued From page 2	S3101		

with eating and management of treatments, required supervision with bathing, dressing, toileting, transfer and walk/mobility and was unable to perform management of medications. R2 was frequently incontinent, had short term memory impairment, usually understood communication and was at risk for falls.

The resident's current NSA dated 01/19/22 recorded facility staff would provide the following personal care services: bathing and management of bladder incontinence. The NSA recorded R2 provided supervision for mobility and management of medications and medical treatments. The NSA failed to identify services provided for dressing.

The "Resident Plan of Care" dated 12/01/21 recorded resident as independent for transfers, stand by assist for bathing, dressing and toileting and facility staff to handle all medication administrations per physician order. The "Resident Plan of Care" recorded R2 as alert and oriented.

NSA lacked signatures of the individuals involved in the development of the agreement including R2 and any legal representatives or family members.

- Record review for R3 revealed she admitted on 09/14/18 with diagnoses of diabetes mellitus, chronic kidney disease and hypertension.

R3's "Functional Capacity Screen" (FCS) dated 02/20/22 recorded the resident as independent with bathing, dressing, toileting, transfer, walk/mobility, eating and management of

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3101	Continued From page 3 medications and treatments. R3 had short term memory impairment, memory/recall impairment and impaired decision making. The resident's current NSA dated 01/01/22 recorded facility staff would provide the following personal care services: bathing, supervision of mobility, management of medications and medical treatments and stand by assistance as needed for management of bladder incontinence. The NSA failed to identify services provided for dressing. The "Resident Plan of Care" dated 12/01/21 recorded resident as independent for bathing, dressing, toileting, transfers, walk/mobility and management of medications. The "Resident Plan of Care" recorded R3 as alert and oriented. NSA lacked signatures of the individuals involved in the development of the agreement including R3 and any legal representatives or family members. Interview on 11/15/22 at 10:21 AM with Operator/CMA A confirmed R1, R2 and R3's current negotiated service agreements lacked signatures. Operator/CMA A failed to ensure each individual involved in the development of the NSA signed the agreement.	S3101		
S3166 SS=D	26-41-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or	S3166		

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3166	Continued From page 4 medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (e) The census equaled 31 residents. The sample included 3 residents and 1 closed record review resident. Based on record review and interview for 1 Resident (R)1 requiring "accuchecks" (blood sugar monitoring with a glucometer), a nursing procedure not included in the medication aide curriculum, Operator/Certified Medication Aide (CMA) A failed to ensure the licensed nurse delegated the procedure to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. Findings included: - Record review for R1 revealed he admitted on 09/04/21 with diagnoses of cerebral vascular accident (CVA) and diabetes mellitus. R1's "Functional Capacity Screen" (FCS) dated 03/22/22 recorded the resident was unable to perform management of medications and treatments. The resident's "Negotiated Service Agreement" (NSA) dated 09/04/22 recorded facility staff would provide management of medications and medical treatments. The NSA failed to identify	S3166		

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3166	Continued From page 5 services provided for diabetic management. The "Resident Plan of Care" dated 03/22/22 recorded facility staff to provide medication administration per physician order and failed to identify diabetic management. Observation on 11/14/22 at 11:54 AM in R1's room revealed CMA B obtain accucheck on R1. Review of sampled personnel records on 11/14/22 recorded the following CMA's recently hired, competency exams for accuchecks were requested. CMA B, hire date 03/02/22 CMA C, hire date 09/16/22 On 11/14/22, requested accucheck delegation for CMAs from Operator/CMA A. Interview on 11/15/22 at 08:40 AM with Operator/CMA A confirmed unable to locate competency checkoffs for accuchecks on CMA B. Interview on 11/15/22 at 10:25 AM with Operator/CMA A confirmed unable to locate competency checkoffs for accuchecks on CMA C. For residents requiring "accuchecks", a nursing procedure not included in the medication aide curriculum, Operator/CMA A failed to ensure the licensed nurse delegated the procedure to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	S3166		

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 6	S3171		
S3171 SS=D	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 census equaled 31 residents. The sample included 3 residents and 1 closed record review resident. Based on observation, interview and record review, Operator/Certified Medication Aide (CMA) A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services in accordance with acceptable standards of practice for the use of bed assistive devices, which met the needs of 2 of 3 sampled Residents (R)1 and R2. Findings included: - The "Resident Roster" obtained on 11/14/22 identified three residents as having a bed rail. Record review for R1 revealed he admitted on 09/04/21 with diagnoses of cerebral vascular accident (CVA) and diabetes mellitus. R1's "Functional Capacity Screen" (FCS) dated 03/22/22 recorded the resident as independent with eating, required supervision with transfer and walk/mobility and required physical assistance with bathing, dressing, toileting and	S3171		

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 7	S3171		

unable to perform management of medications and treatments. R1 was frequently incontinent, had impaired memory/recall and usually understood communication.

The resident's current NSA dated 09/04/22 recorded facility staff would provide the following personal care services: bathing, supervision of mobility as needed, management of medications and medical treatments and management of bladder incontinence. The NSA failed to identify services provided for dressing and diabetic management. The NSA failed to identify a bed assistive device used for safe transfers.

The "Resident Plan of Care" dated 03/22/22 recorded resident as independent for toileting and eating, stand by assistance for bathing, dressing and transfer, assistance required for walk/mobility and facility staff to provide medication administration per physician order. The "Resident Plan of Care" recorded R1 was alert and oriented.

Record review lacked an annual assessment of the resident to confirm the device was not a restraint, an annual assessment of the resident to determine the purpose of the bedrail/assistive device and the resident's ability to safely use the device and an annual assessment of the bedrail/assistive device to ensure the device was securely attached to the bed or bedframe and posed no risk for entrapment.

Observation on 11/14/22 at 11:14 AM in R1's room revealed an unsecured bed assistive device to the left side of his bed.

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 8 Interview on 11/15/22 at 10:23 AM with Operator/CMA A confirmed safety checks and bed assistive device assessments for R1 had not been completed. Operator/CMA A stated she was unaware R1 had a bed assistive device. - Record review for R2 revealed she admitted on 12/17/20 with diagnoses of hypertension, hyperlipidemia, and constipation. R1's "Functional Capacity Screen" (FCS) dated 02/16/22 recorded the resident as independent with eating and management of treatments, required supervision with bathing, dressing, toileting, transfer and walk/mobility and was unable to perform management of medications. R2 was frequently incontinent, had short term memory impairment, usually understood communication and was at risk for falls. The resident's current NSA dated 01/19/22 recorded facility staff would provide the following personal care services: bathing and management of bladder incontinence. The NSA recorded R2 provided supervision of mobility and management of medications and medical treatments. The NSA failed to identify services provided for dressing. The NSA failed to identify a bed assistive device used for safe transfers. The "Resident Plan of Care" dated 12/01/21 recorded resident as independent for transfers, stand by assist for bathing, dressing and toileting and facility staff to handle all medication administrations per physician order. The "Resident Plan of Care" recorded R2 as alert and oriented.	S3171		

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 9 Record review lacked an annual assessment of the resident to confirm the device was not a restraint, an annual assessment of the resident to determine the purpose of the bedrail/assistive device and the resident's ability to safely use the device, and an annual assessment of the bedrail/assistive device to ensure the device was securely attached to the bed or bedframe and posed no risk for entrapment. Observation on 11/14/22 at 07:34 PM in R2's room revealed a bed assistive device to the right side of her bed. R2 stated she used the bed rail to get out of bed. Interview on 11/14/22 at 07:49 PM with Operator/CMA A confirmed safety checks and bed assistive device assessments for R2 had not been completed. Operator/CMA A stated she was unaware R2 had a bed assistive device. The FDA (food and drug administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows: Zone 1 within the rail should measure less than 4 and 3/4 inches Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches. Operator/CMA A failed to ensure a licensed	S3171		

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 10 nurse provided or coordinated the provision of necessary health care services which met the needs of R1 and R2 regarding use of a bed assistive device.	S3171		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d) (2) The census equaled 31 residents. The sample included 3 residents and 1 closed record review resident. Based on record review and interview for 1 Resident (R)1, Operator/Certified Medication Aide (CMA) A failed to ensure all medications and treatments were administered in	S3200		

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3200	Continued From page 11 accordance with professional standards of practice by ensuring medication aides did not administer medications through the parenteral route. Findings included: - Record review for R1 revealed he admitted on 09/04/21 with diagnoses of cerebral vascular accident (CVA) and diabetes mellitus. R1's "Functional Capacity Screen" (FCS) dated 03/22/22 recorded the resident was unable to perform management of medications and treatments. The resident's "Negotiated Service Agreement" (NSA) dated 09/04/22 recorded facility staff would provide management of medications and medical treatments. The NSA failed to identify services provided for diabetic management. The "Resident Plan of Care" dated 03/22/22 recorded facility staff to provide medication administration per physician order and failed to identify diabetic management. Signed physician order dated 08/08/22 recorded "Humalog [insulin] sliding scale dose before meals." Signed physician order dated 08/01/22 recorded, "Lantus [insulin] 23 units subcutaneously at bedtime." Written statement obtained on 11/14/22 at 11:52 AM from CMA B recorded, "when giving [R1] his insulin we always dial it for him. Sometimes he	S3200		

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3200	Continued From page 12	S3200		

injects it, sometimes we do it for him. The reason we do it for him is because of his weakness. I was trained by [CMA G] and upon training she told that sometimes we have to do his insulin for him. When being trained at this facility I was aware that we were able to do it for him due to his weakness. At the time I was unaware that CMA's aren't allowed to inject insulin. Again, I was trained to do it that way so that's how I would do it due to him not being able to sometimes and nobody else there."

Written statement obtained on 11/14/22 at 06:41 PM from CMA C recorded, "When being trained [Operator/CMA A and CMA G] told me that I could administer insulin to resident [R1] if he is too weak or if he does not want to. [R1] has never been too weak to do on his own but asks me to do it because he does not like doing it himself."

Interview on 11/14/22 at 11:14 AM with R1 in his room stated staff inject his insulin at times when he feels weak.

Signed abatement plan obtained on 11/14/22 at 07:55 PM from Operator/CMA A recorded, "When [R1] is too weak to give himself his insulin, staff will call [R1's outside caretaker] in [name of town], KS that will come in and administer the insulin for him."

Facility "Medication Administration Policy" recorded, "If Fairview Estates Retirement Community is responsible for the administration of a resident's medications, the administrator shall ensure that all medications and biologicals are administered to that resident in accordance

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3200	Continued From page 13 with a medical care provider's written order." Policy further stated, "Medication aides shall not administer medication through the parenteral route." Operator/CMA A failed to ensure all medications and treatments were administered in accordance with professional standards of practice by ensuring medication aides did not administer medications through the parenteral route.	S3200		
S3202 SS=D	26-41-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(4) The facility reported a census of 31 residents. The sample included 3 residents and 1 closed record review resident. Based on record review and interview for 1 of 3 sampled Residents (R)1, Operator/Certified Medication Aide (CMA) A failed to ensure the licensed nurse delegated nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto when medication aides dialed insulin pens for the residents without an assessment for competency by a licensed nurse.	S3202		

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3202	Continued From page 14 Findings included: - Record review for R1 revealed he admitted on 09/04/21 with diagnoses of cerebral vascular accident (CVA) and diabetes mellitus. R1's "Functional Capacity Screen" (FCS) dated 03/22/22 recorded the resident was unable to perform management of medications and treatments. The resident's "Negotiated Service Agreement" (NSA) dated 09/04/22 recorded facility staff would provide management of medications and medical treatments. The NSA failed to identify services provided for diabetic management. The "Resident Plan of Care" dated 03/22/22 recorded facility staff to provide medication administration per physician order and failed to identify diabetic management. The "Resident Roster" obtained on 11/14/22 from CMA B identified two residents as receiving insulin by injection. Competency checkoffs requested for CMAs to dial insulin pens. Interview on 11/15/22 at 08:40 AM with Operator/CMA A confirmed unable to locate competency checkoffs for dialing insulin pens on CMA B. Interview on 11/15/22 at 10:25 AM with Operator/CMA A confirmed unable to locate competency checkoffs for dialing insulin pens on	S3202		

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3202	Continued From page 15 CMA C. Operator/CMA A failed to ensure the licensed nurse delegated nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto when medication aides dialed insulin pens for the residents without an assessment for competency by a licensed nurse.	S3202		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g) (3) The census equaled 31 residents. The sample included 3 residents and 1 closed record review resident. Based on observation and interview for 2 resident (R)1, R2 and 8 non-sampled resident	S3211		

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3211	Continued From page 16 (R)5, R6, R7, R8, R9, R10, R11 and R12, Operator/Certified Medication Aide (CMA) A failed to ensure licensed nurses or pharmacists placed the full name of the resident on each package of the residents over the counter medication. Findings included: - Observation on 11/14/22 at 10:29 AM with CMA B revealed two locked medication carts in the medication room of the facility. CMA B confirmed the following over the counter medications were noted without first and last names: For R1 the cart contained one bottle of Metamucil (fiber supplement), For R2 the cart contained one bottle of Calcium, For R5 the cart continued one bottle of Guaifenesin Extended-Release (expectorant) and one bottle of Complete Multivitamins, For R6 the cart contained one bottle Mylanta (antacid) and one container of Salonpas Lidocaine 4% pain relieving patches, For R7 the cart contained one bottle of Acidophilus (probiotic), one bottle of Aspirin (non-steroidal anti-inflammatory drug), one bottle of Tylenol (pain reliever/fever reducer), one bottle of Vitamin D3 and one bottle of Melatonin (sleep support), For R8 the cart contained one box and tube of Lubricant Eye Drops, For R9 the cart contained one bottle of Tylenol Arthritis, one bottle of Aspirin and one bottle of Lutein (eye supplement), For R10 the cart contained one bottle of Calcium, one bottle of Multivitamins, one bottle of Tylenol,	S3211		

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3211	Continued From page 17 one bottle of AREDS 2 (eye vitamin) and one bottle of Aleve (non-steroidal anti-inflammatory drug), For R11 the cart contained one bottle of Tylenol, one bottle of AREDS, one bottle of Melatonin and one bottle of Ibuprofen (non-steroidal anti-inflammatory drug), For R12 the cart contained one bottle of Melatonin, one bottle of Anti-Diarrheal + Anti-Gas. Interview on 11/14/22 at 06:13 PM with Operator/CMA A confirmed over the counter medications are to be labeled with full name. Operator/CMA A failed to ensure licensed nurses or pharmacists placed the full name of residents on each package of the residents over the counter medication.	S3211		
S3229 SS=D	26-41-205 (l) (4) Medication Regimen Review Self Administration (l) (4) The administrator or operator, or the designee, shall offer each resident who self-administers medication a medication regimen review to be conducted by a licensed pharmacist at least quarterly and each time a resident experiences a significant change in condition. A licensed nurse shall document the resident ' s decision in the resident ' s clinical record. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (l) (4)	S3229		

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3229	Continued From page 18 The census equaled 31 residents. The sampled included 3 residents and 1 closed record review resident. Based on record review and interview, the facility failed to ensure a licensed pharmacist conducted a quarterly medication regimen review for 1 Resident (R)3 when she self-administered her medications and further failed to document R3's decision in the clinical record. Findings included: - Record review for R3 revealed she admitted on 09/14/18 with diagnoses of diabetes mellitus, chronic kidney disease and hypertension. R3's "Functional Capacity Screen" (FCS) dated 02/20/22 recorded the resident as independent with management of medications and treatments. The resident's current "Negotiated Service Agreement" dated 01/01/22 recorded facility staff would provide the following personal care services: management of medications and medical treatments. The "Resident Plan of Care" dated 12/01/21 recorded resident as independent for management of medications. Review of R3's "Medication Regimen Reviews" lacked evidence reviews were completed for the resident. Interview on 11/15/22 at 08:49 AM with Operator/ Certified Medication Aide (CMA) A confirmed she was unable to locate quarterly medication regimen reviews by a pharmacist for R3.	S3229		

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3229	Continued From page 19 "Drug Regimen Review Accept/Decline Form" obtained on 11/16/22 from Operator/CMA A recorded R3 declined the quarterly regimen review on 09/14/18. Form lacked quarterly performance since 09/14/18. Facility's "Medication Management" policy (no date) recorded, "The administrator of Community RN shall offer each resident who self-administers medication a medication regimen review to be conducted by a licensed pharmacist at least quarterly and each time a resident experience a significant change in condition. The Community RN shall document the resident's decision in the resident's clinical record." The facility failed to ensure a licensed pharmacist conducted a quarterly medication regimen review for 1 Resident (R)3 when she self-administered her medications and further failed to document R3's decision in the clinical record.	S3229		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and	S3280		

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3280	Continued From page 20 (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104 (d) (3) (4) The census equaled 31 residents. The sample included 3 residents, 1 closed record review resident and review of 5 employee records. Based on record review and interview, Operator/Certified Medication Aide (CMA) A failed to ensure disaster and emergency preparedness by ensuring the performance of quarterly review of the facility's entire "Emergency Management Plan" with staff and residents and an annual emergency drill with staff and residents to include an evacuation of the residents to a secure location. Findings included: - Review of the facility "Emergency Management Plan" revealed the plan contained procedures to manage potential emergencies and disasters including fire, flood, severe weather, tornado, explosion, natural gas leak, lack of electrical, or water service, and missing residents. Review on 11/14/22 of the facility's quarterly reviews of the emergency management plan with residents revealed the following reviews with residents: 04/26/22 and 08/22/22.	S3280		

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3280	Continued From page 21 The facility failed to provide documentation regarding emergency management plan reviews with residents for the first quarter of 2022. The facility failed to provide documentation regarding emergency management plan reviews with staff for the first, second and thirds quarters of 2022. Interview on 11/15/22 at 09:47 AM with Operator/CMA A stated unable to locate reviews with staff for the first, second and thirds quarters of 2022, the first quarter of 2022 with residents and a full evacuation of the residents to a secure location. Operator/CMA A failed to ensure disaster and emergency preparedness by the failure to ensure the performance of quarterly reviews of the facility's entire emergency plan with staff and residents and an annual emergency drill with staff and residents to include an evacuation of the residents to a secure location.	S3280		
S3298 SS=E	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough	S3298		

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3298	Continued From page 22 to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206 (d) (1) The census equaled 31 residents. Based on record review, observation, and interview for all residents living in the facility and receiving meal services Operator/ Certified Medication Aide (CMA) A failed to ensure the facility staff served food at the proper temperature. Findings included: - During the initial tour on 11/14/22, facility food temperature monitoring logs were requested, and Dietary Staff E failed to provide food temperature monitoring logs. On 11/14/22 at 04:07 PM, Operator/CMA A provided food temperature monitoring logs for October 2022 and November 2022, which were located in her office. Record lacked breakfast, lunch, and supper food temperatures for the following dates: 10/02/22, 10/11/22, 10/12/22, 10/16/22, 11/01/22 and 11/06/22.	S3298		

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3298	Continued From page 23 Interview on 11/14/22 at 04:07 PM with Operator/CMA A confirmed the facility was missing food temperature monitoring logs for breakfast, lunch and supper on 10/02/22, 10/11/22, 10/12/22, 10/16/22, 11/01/22 and 11/06/22. Interview on 11/14/22 at 03:28 PM with Resident (R)13 stated the food is not always warm. Interview on 11/14/22 at 05:00 PM in dining room with R14 had complaints of temperature of vegetable soup served for supper meal. Kansas Department of Agriculture Food Safety guidelines records hot food must be maintained at a temperature of 135 degrees Fahrenheit or above, cold foods at 41 degrees Fahrenheit or below. Facility's "Food Storage and Preparation Policy" (no date) recorded, "All meat, fish, and poultry will be properly cooked before being served." For all residents of the facility, Operator/CMA A failed to ensure facility staff served food at the proper temperature.	S3298		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving.	S3299		

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3299	Continued From page 24 This REQUIREMENT is not met as evidenced by: KAR 26-41-206 (e) The census equaled 31 residents. The sample included 3 residents and 1 closed record review resident. Based on record review, interview, and observation for all residents receiving meal services, Operator/Certified Medication Aide (CMA) A failed to ensure the facility staff stored all food under safe and sanitary conditions. Findings included: - Observation during the initial tour on 11/14/22 at 10:11 AM revealed a kitchen. Observation of the kitchen cabinets revealed the following foods, which were not sealed or dated: two bags of sweet cornbread muffin mix, four bags of gravy mix, one bag of brownie mix, one container of baking powder with foil covering the top, one container of breadcrumbs with no lid, one bag of cheese sauce mix, two bags of marshmallows (one dated 02/09), one bag of low sugar no bake cheesecake mix, one bag of butterscotch baking chips and two bags of cornbread stuffing mix. Observation of the kitchen cabinet revealed a container of table salt with a medication cup inside. Observation of the refrigerator revealed the following foods, which were not sealed, labeled, or dated: one block of cheese, one drink pitcher containing ketchup, one container of premade	S3299		

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3299	Continued From page 25 frosting, one stick of butter, two bags of shredded cheese and one bowl containing cheesecake. Observation of the freezer revealed the following foods, which were not sealed or dated: one bag of onion rings and one bag of chicken. Observation of the pantry revealed the following foods, which were not sealed or dated: one bag of potato chips. Observation on 11/14/22 at 12:20 PM revealed 29 residents at dining room table eating supper time meal provided by facility. Certified Nurse Aide (CNA) D stated all residents received meal services by the facility. Facility's "Food Storage and Preparation Policy" (no date) recorded, "[Facility name] shall store, prepare, display, serve, or transport food and drink in a manner to prevent it from contamination. Perishable food shall be covered ...All repackaged, potentially hazardous food shall be labeled and dated." For all residents receiving meal services, Operator/CMA A failed to ensure the facility staff stored all food under safe and sanitary conditions.	S3299		
S3310 SS=E	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer	S3310		

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3310	Continued From page 26 infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: KAR 26-41-207 (c) The census totaled 31 residents. The sample included 3 residents, 1 closed record review resident and review of 5 newly hired employees. Based on record review and interview for 5 Staff (Certified Medication Aide (CMA) B, CMA C, Certified Nurse Aide (CNA) D, Non-Certified Staff E and Non-Certified Staff F), the facility failed to ensure compliance with the State Agency's tuberculosis (TB) guidelines. Findings included: - CMA B's "Employee Record" revealed a hire date of 03/02/22. CMA B's record lacked evidence of completion of TB testing and a TB questionnaire upon hire. CMA C's "Employee Record" revealed a hire date of 09/16/22. CMA C's record lacked evidence of completion of TB testing and a TB questionnaire upon hire.	S3310		

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 _____	11/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3310	Continued From page 27 CNA D "Employee Record" revealed a hire date of 04/21/22. CNA D's record lacked evidence of completion of TB testing and a TB questionnaire upon hire. Non-Certified Staff E's "Employee Record" revealed a hire date of 09/24/22. Non-Certified Staff E's record lacked evidence of completion of TB testing and a TB questionnaire upon hire. Non-Certified Staff F's "Employee Record" revealed a hire date of 12/10/21. Non-Certified Staff F's record lacked evidence of TB testing and completion of a TB questionnaire upon hire. Non-Certified Staff F's first step TB test and TB questionnaire were completed on 03/02/22, approximately 12 weeks after being hired by the facility. Record lacked evidence of second step of TB testing. Interview on 11/15/22 at 10:14 AM with Operator/CMA A confirmed TB testing and TB questionnaires were not completed upon hire on CMA B, CMA C, Non-Certified Staff E and Non-Certified Staff F. The facility failed to follow the State Agency's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105, which had the potential to affect all residents.	S3310		