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 _____	03/13/2023

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 an abbreviated survey for complaint #178654 at the above named facility conducted on 03/13/23.	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101 (f) (1) (B) The facility reported a census of 29 residents. The sample included 1 closed record review resident. Based on record review and interview for cognitively impaired Resident (R)1, Operator/Certified Medication Aide (CMA) A failed to ensure no resident was subjected to neglect when Operator/CMA A failed to provide or coordinate services reasonably necessary to ensure the resident's safety and well-being and to avoid harm when R1 was confused, eloped from the facility on 03/04/23, with facility staff unaware of her elopement until law enforcement notified the facility. Per video footage reviewed with Operator/CMA A on 03/13/23, R1 exited the southeast door of the facility on 03/04/23 at	S3026		

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

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S3026	Continued From page 1	S3026		

04:22:24 PM near a two lane street and walked to the (grocery store) across the parking lot. R1 left the facility without staff knowledge and was found at the (grocery store) by a citizen who called the police department. R1 was returned to the facility by staff at 05:43 PM. Making R1 unaccounted for by the facility for 1 hour and 20 minutes. This failure placed the resident in immediate jeopardy for harm, injury, or death.

Findings included:

- R1's medical record revealed she admitted to the facility on 06/20/17 with diagnoses of dementia, anxiety and right pubic fracture.

The "Functional Capacity Screen" (FCS) dated 06/10/22 recorded the resident was independent with dressing, toileting, transfer, and eating; required physical assistance with bathing, walking, mobility, and was unable to perform management of medications and treatments. The FCS recorded R1 had impaired memory/recall. The FCS further recorded R1 was occasionally incontinent of urine, was usually understandable/understood and was at risk for falls and unsteadiness. R1 used a walker. The FCS was signed by Licensed Nurse (LN) B, dated 06/10/22.

R1's record lacked a FCS completed upon significant change in status after elopement on 03/04/23.

The "Negotiated Service Agreement" (NSA) dated 06/10/22 recorded R1 received the following services from facility staff: bathing assistance three times per week and as needed,

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S3026	Continued From page 2 dressing and undressing assistance daily as needed, transfer assistance as needed, supervision of mobility as needed, reminders and queuing for meals and activities and management of medications. The NSA failed to identify interventions to address R1's impaired memory/recall and problem/risk for falls and unsteadiness. The NSA lacked signatures of R1 and her legal representative or family member. The NSA lacked the review and revision upon significant change in condition when R1 eloped from the facility on 03/04/23. The "Resident Plan of Care" dated 06/10/22 recorded R1 required standby assistance with bathing up to three times per week, standby assistance with dressing, standby assistance with walking, independent with toileting, transfer, and eating and facility staff were to manage medications and treatments. R1 used a walker. The "Resident Plan of Care" recorded R1 was alert and knew location, but did not know day, year, or president and further recorded, "Her Dementia is increasing slightly but this may be due to testing positive for COVID and the pain from the fracture." The "Resident Plan of Care" failed to identify interventions to address resident's impaired memory/recall and problem/risk for falls and unsteadiness. The "Resident Plan of Care" failed to address interventions after 03/04/23 elopement.	S3026		

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S3026	Continued From page 3 R1's medical record lacked an elopement risk assessment completed. By review of R1's "Nurse's Notes" in the medical record revealed no documentation from facility staff since 12/30/22. The notes lacked documentation related to the elopement on 03/04/23. R1's medical record revealed no assessment completed by a licensed nurse after returning to the facility after an elopement from facility on 03/04/23. Review of the undated "Hourly Checks [R1]" recorded staff signed their initials verifying hourly checks from 11:00 PM to 06:00 AM , eight hourly checks total recorded. R1's record lacked any further documentation of hourly checks when the resident's daughter was not with the resident after her return to the facility on 03/04/23 at 05:43 PM until R1's discharge from the facility on 03/10/23. [Town name] Police Department Supplemental Narrative Report recorded, "Case #23-0154: On 03/04/23 ...At approximately 05:10 PM I was dispatched to Dillons (food store) in reference to a elderly female that appeared confused ... [R1] stated she could not find her car or keys to her vehicle ...[R1] appeared confused on who she was supposed to meet at Dillons ...I drove to [facility name] and contacted [CMA C]. [CMA C] stated that she had been looking for [R1] since approximately 05:00 PM. I advised [CMA C] that [R1] was located over at Dillons under the awning ...The other employee drove a van over	S3026		

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S3026	Continued From page 4	S3026		

to Dillons and escorted [R1] back to [facility name]."

CMA C's signed statement dated 03/04/23 recorded, "[R1] wandered around the facility all afternoon today. At 04:00 PM she was sitting on the hearth of the fireplace when I started down B hall to pass medications. She was still there when I headed down D hall to pass medications around 04:10 PM. When I came out of [resident's room] and headed back to the medication room, I heard a door slam. I turned to see who it was but saw no one. I went to make sure [resident's name] was still in her room. I finished passing medications ...I noticed [R1] wasn't at the fireplace or at her seat at the table between 04:45 PM and 04:50 PM ... Thinking [R1] had gone back to her room, I helped get everyone served. By 05:10 PM [R1] still wasn't out, so I went to get her. [R1] wasn't in her room. I checked the hallways and apartments ...checked front room, library, and front awning. Called [Operator/CMA A] checked hall bathrooms, checked library again. I hadn't been off the phone long when a police [officer] came in asking if a [R1] lived here. [Dietary Staff D] went to get her."

Operator/CMA A's notarized witness statement dated 03/13/23 recorded, "Hallways- On camera 12 [on 03/04/23] at approximately 04:17:23 PM [R1] is going down hallway D. [R1] continues down the hallway and the camera switches to camera 11 at 04:18:36 PM [on 03/04/23]. [R1] continues to head south down hallway D with her 4-wheeled walker ... She goes out of first door to garage area door at 04:20:54 PM [on 03/04/23] and attempts to open that door ... Once [R1]

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S3026	Continued From page 5 figures out she cannot open that door, she walks over to the southeast door, which is at 04:22:24 PM [on 03/04/23]. She does take her walker with her. The last time the "medical staff" had any contact with [R1] was at 04:06:59 PM [on 03/04/23]. The last time "non-medical staff" had any contact with [R1] was at 04:15:18 PM [on 03/04/23]. At 04:08:46 PM [on 03/04/23] [CMA C] went to [resident's room]. She came back out at 04:09:59 PM [on 03/04/23] and then entered [resident's room] at 04:09:58 PM [on 03/04/23]. She left [resident's room] at 04:16:20 [on 03/04/23]. She then goes to [resident's room] at 04:16:32 PM [on 03/04/23], [CMA C] misses [R1] walking down the hallway. [CMA C] walks out of [resident's room], [CMA C] does look south as she's leaving the apartment. As she walks down the hallway at 04:20:21 PM [on 03/04/23] she looks to the south as the door shuts. [On 03/04/23] 05:43 PM, [Dietary Staff D] walks in with [R1] ... At 05:35 PM [on 03/04/23], I [Operator/CMA A] spoke with [CMA C] and told her to document and to put in place that hourly checks will need to be done when daughter leaves the facility until placement of [R1]." Interview on 03/13/23 at 10:30 AM with CMA E confirmed R1 was pleasantly confused. CMA E further confirmed no documentation of hourly checks completed on R1 after elopement on 03/04/23. Interview on 03/13/23 at 11:40 AM with Operator/CMA A confirmed R1 was confused and unable to leave facility alone. Operator/CMA A further confirmed at the time of elopement there was 1 certified staff on duty and 1 dietary staff on duty.	S3026		

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S3026	Continued From page 6 Interview on 03/13/23 at 12:46 PM with Operator/CMA A confirmed the NSA was not updated after 03/04/23 elopement and further confirmed there was no documentation in R1's medical record related to elopement on 03/04/23. Phone interview on 03/13/23 at 11:20 AM with R1's family member stated R1 was confused and further stated R1 discharged from the facility on 03/10/23 to a secured memory care unit. Phone interview on 03/14/23 at 10:30 AM with CMA C stated she last saw R1 between 04:00 and 04:30 PM on 03/04/23. The immediate jeopardy was removed on 03/10/23 when R1 discharged from the facility to a secured memory care unit. Operator/CMA A failed to ensure no resident was subjected to neglect when Operator/CMA A failed to provide or coordinate services reasonably necessary to ensure the resident's safety and well-being and to avoid harm when R1 eloped from the facility on 03/04/23. This failure placed the resident in immediate jeopardy for harm, injury, or death. Abatement plan obtained on 03/13/23 at 04:04 PM, which recorded, "Address any resident who may leave the facility unattended in state of confusion. All residents will be assessed by the MMI scale within 14 days. If potential confused state is scaled, facility will contact family and physician and redo plans in place. Administrator will educate staff the importance of checking pagers when they are signaling. Administrator	S3026		

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S3026	Continued From page 7 will educate employees on how to check each door when pager is signaled for that particular door that is signaling. Each employee will demonstrate the correct way on how to check the signal when it goes off on the pager. This is for plan of action for potential elopement residents in the future. Facility will have new pager system in place within 90 days, until that time, "all" staff will carry pagers and will be trained on how to check the system immediately. The overhead signal system will be kept on until further notice when new system is put in place." Printed, signed, dated and timed by Operator/CMA A.	S3026		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201 (c) (2) The census equaled 29 residents. The sample included 1 closed record review resident. Based on record review and interview for 1 of 1 closed record review resident (R)1, Operator/Certified Medication Aide (CMA) A failed to ensure	S3081		

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S3081	Continued From page 8	S3081		

designated facility staff conducted a screening following any significant change in condition when R1 eloped from the facility as defined in K.A.R. 26-39-100.

Findings included:

- R1's medical record revealed she admitted to the facility on 06/20/17 with diagnoses of dementia, anxiety and right pubic fracture.

The "Functional Capacity Screen" (FCS) dated 06/10/22 recorded the resident was independent with dressing, toileting, transfer, and eating; required physical assistance with bathing, walking, mobility, and was unable to perform management of medications and treatments. The FCS recorded R1 had impaired memory/recall. The FCS further recorded R1 was occasionally incontinent of urine, was usually understandable/understood and was at risk for falls and unsteadiness. R1 used a walker. The FCS was signed by Licensed Nurse (LN) B, dated 06/10/22.

R1's record lacked a FCS completed upon significant change in status after elopement on 03/04/23.

The "Negotiated Service Agreement" (NSA) dated 06/10/22 recorded R1 received the following services from facility staff: bathing assistance three times per week and as needed, dressing and undressing assistance daily as needed, transfer assistance as needed, supervision of mobility as needed, reminders and queuing for meals and activities and management of medications.

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S3081	Continued From page 9 The "Resident Plan of Care" dated 06/10/22 recorded R1 required standby assistance with bathing up to three times per week, standby assistance with dressing, standby assistance with walking, independent with toileting, transfer, and eating and facility staff were to manage medications and treatments. R1 used a walker. The "Resident Plan of Care" recorded R1 was alert and knew location, but did not know day, year, or president and further recorded, "Her Dementia is increasing slightly but this may be due to testing positive for COVID and the pain from the fracture." Electronic interview on 03/14/23 at 02:55 PM with Operator/CMA A confirmed R1's record lacked a FCS completed after elopement on 03/04/23. Operator/CMA A failed to ensure designated facility staff conduct a screening following any significant change in condition when R1 eloped from the facility as defined in K.A.R. 26-39-100.	S3081		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and	S3092		

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S3092	Continued From page 10 (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (d) (2) The census equaled 29 residents. The sample included 1 closed record review resident. Based on record review and interview for 1 of 1 sampled resident (R)1, Operator/Certified Medication Aide (CMA) A failed to ensure the review, and if necessary, revision of the negotiated service agreement following any significant change in condition when R1 eloped from the facility, as defined in K.A.R. 26-39-100. Findings included: - R1's medical record revealed she admitted to the facility on 06/20/17 with diagnoses of dementia, anxiety and right pubic fracture. The "Functional Capacity Screen" (FCS) dated 06/10/22 recorded the resident was independent with dressing, toileting, transfer, and eating; required physical assistance with bathing, walking, mobility, and was unable to perform management of medications and treatments. The FCS recorded R1 had impaired memory/recall. The FCS further recorded R1 was occasionally incontinent of urine, was usually understandable/understood and was at risk for falls and unsteadiness. R1 used a walker. The	S3092		

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S3092	Continued From page 11 FCS was signed by Licensed Nurse (LN) B, dated 06/10/22. The "Negotiated Service Agreement" (NSA) dated 06/10/22 recorded R1 received the following services from facility staff: bathing assistance three times per week and as needed, dressing and undressing assistance daily as needed, transfer assistance as needed, supervision of mobility as needed, reminders and queuing for meals and activities and management of medications. The NSA failed to identify interventions to address R1's impaired memory/recall and problem/risk for falls and unsteadiness. The NSA lacked signatures of R1 and her legal representative or family member. The NSA lacked the review and revision upon significant change in condition when R1 eloped from the facility on 03/04/23. The "Resident Plan of Care" dated 06/10/22 recorded R1 required standby assistance with bathing up to three times per week, standby assistance with dressing, standby assistance with walking, independent with toileting, transfer, and eating and facility staff were to manage medications and treatments. R1 used a walker. The "Resident Plan of Care" recorded R1 was alert and knew location, but did not know day, year, or president and further recorded, "Her Dementia is increasing slightly but this may be due to testing positive for COVID and the pain from the fracture."	S3092		

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S3092	Continued From page 12 Operator/CMA A's notarized witness statement dated 03/13/23 recorded, "[On 03/04/23] ...At 05:35 PM, I [Operator/CMA A] spoke with [CMA C] and told her to document and to put in place that hourly checks will need to be done when daughter leaves the facility until placement of [R1]." Interview on 03/13/23 at 12:46 PM with Operator/CMA A confirmed NSA not updated for R1 after elopement on 03/04/23 to reflect interventions put in place to prevent elopement from reoccurring. Operator/CMA A failed to ensure the review, and if necessary, revision of the negotiated service agreement following any significant change in condition when R1 eloped from the facility, as defined in K.A.R. 26-39-100.	S3092		
S3101 SS=D	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 29 residents. The sample included 1 closed record review resident. Based	S3101		

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S3101	Continued From page 13	S3101		

on record review and interview for 1 closed record review Resident (R)1, 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:

- R1's medical record revealed she admitted to the facility on 06/20/17 with diagnoses of dementia, anxiety and right pubic fracture.

The "Functional Capacity Screen" (FCS) dated 06/10/22 recorded the resident was independent with dressing, toileting, transfer, and eating; required physical assistance with bathing, walking, mobility, and was unable to perform management of medications and treatments. The FCS recorded R1 had impaired memory/recall. The FCS further recorded R1 was occasionally incontinent of urine, was usually understandable/understood and was at risk for falls and unsteadiness. R1 used a walker. The FCS was signed by Licensed Nurse (LN) B, dated 06/10/22.

The NSA dated 06/10/22 recorded R1 received the following services from facility staff: bathing assistance three times per week and as needed, dressing and undressing assistance daily as needed, transfer assistance as needed, supervision of mobility as needed, reminders and queuing for meals and activities and management of medications.

The "Resident Plan of Care" dated 06/10/22 recorded R1 required standby assistance with

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 _____	03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3101	Continued From page 14 bathing up to three times per week, standby assistance with dressing, standby assistance with walking, independent with toileting, transfer, and eating and facility staff were to manage medications and treatments. R1 used a walker. The "Resident Plan of Care" recorded R1 was alert and knew location, but did not know day, year, or president and further recorded, "Her dementia is increasing slightly but this may be due to testing positive for COVID and the pain from the fracture." The NSA lacked signatures of R1 and her legal representative or family member. Electronic interview on 03/14/23 at 02:55 PM with Operator/CMA A confirmed R1's current negotiated service agreement dated 06/10/22 lacked signatures of R1 and any legal representatives or family members. Operator/CMA A failed to ensure each individual involved in the development of the NSA signed the agreement.	S3101		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by:	S3261		

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S3261	Continued From page 15 KAR 26-41-105 (f) (11) The census totaled 29 residents. The sample included 1 closed record review resident. Based on record review and interview for 1 closed record review Resident(R)1, Operator/ Certified Medication Aide (CMA) A failed to ensure documentation of all incidents, and indications of illness or injury including date, time of occurrence, action taken and results of the action when R1 eloped from the facility. Findings included: - R1's medical record revealed she admitted to the facility on 06/20/17 with diagnoses of dementia, anxiety and right pubic fracture. The "Functional Capacity Screen" (FCS) dated 06/10/22 recorded the resident was independent with dressing, toileting, transfer, and eating; required physical assistance with bathing, walking, mobility, and was unable to perform management of medications and treatments. The FCS recorded R1 had impaired memory/recall. The FCS further recorded R1 was occasionally incontinent of urine, was usually understandable/understood and was at risk for falls and unsteadiness. R1 used a walker. The FCS was signed by Licensed Nurse (LN) B, dated 06/10/22. The "Negotiated Service Agreement" (NSA) dated 06/10/22 recorded R1 received the following services from facility staff: bathing assistance three times per week and as needed, dressing and undressing assistance daily as needed, transfer assistance as needed,	S3261		

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S3261	Continued From page 16	S3261		

supervision of mobility as needed, reminders and queuing for meals and activities and management of medications.

The "Resident Plan of Care" dated 06/10/22 recorded R1 required standby assistance with bathing up to three times per week, standby assistance with dressing, standby assistance with walking, independent with toileting, transfer, and eating and facility staff were to manage medications and treatments. R1 used a walker. The "Resident Plan of Care" recorded R1 was alert and knew location, but did not know day, year, or president and further recorded, "Her dementia is increasing slightly but this may be due to testing positive for COVID and the pain from the fracture."

By review of R1's "Nurse's Notes" in the medical record revealed no documentation from facility staff since 12/30/22. The notes lacked documentation related to the elopement on 03/04/23.

R1's medical record revealed no assessment completed by a licensed nurse after returning to the facility after an elopement from facility on 03/04/23.

Interview on 03/13/23 at 01:00 PM with Operator/CMA A confirmed R1's record lacked documentation related to elopement on 03/04/23 and further recorded record lacked documentation of nurse assessment upon return to facility on 03/04/23 after elopement to assess for illness or injury.

Operator/CMA A failed to ensure designated staff

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S3261	Continued From page 17 documented all incidents, symptoms, and other indications of illness including the date and time of occurrence, action taken, and results of the action when R1 eloped from the facility.	S3261		