STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N066003	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW NURSING & RESIDENTIAL LIVING	808 N 8TH STREET , SENECA, Kansas, 66538

(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) COMPLETION DATE
S0000	INITIAL COMMENTS The following citations represent the findings of a Health Licensure Resurvey at the above named facility on 11/4/25.	S0000		
S3081 SS = D	Functional Capacity Screen Reassessment CFR(s): 26-41-201 (c) (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 LICENSURE REQUIREMENT is NOT MET as evidenced by: KAR 26-41-201 (c) (2) The facility reported a census of six residents, with three residents included in the sample. Based on interview and record review, the operator failed to ensure designated staff completed a "Functional Capacity Screen" (FCS) for Residents (R) 1 and R3 when they had a change of condition. Findings included: The facility reported a census of six residents, with three residents included in the sample. Based on the interview and record review, the operator failed to ensure designated staff completed a "Functional Capacity Screen" (FCS) for Residents (R) 1 and R3 when they had a change of condition. Findings included: - Record review for R1 revealed an admission date of 03/26/25 with a diagnoses of anxiety and depression.	S3081		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N066003	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW NURSING & RESIDENTIAL LIVING	808 N 8TH STREET , SENECA, Kansas, 66538

(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) COMPLETION DATE
S3081 SS = D	Continued from page 1 Review of R1's chart revealed the change of condition FCS, dated 09/24/25, was not completed; staff documented over the admission information for dressing, toileting, transfer, walk/mobility, and eating. The “Nurses Note,” dated 09/22/25 at 01:41 PM, documented R1 was sent to the emergency room (ER) for an x-ray of her lower back, and the x-ray showed R1 had a compression fracture in her lumbar (consisting of the five bones (vertebrae) in your lower back) region of her back. On 11/04/25 at 10:31 AM, Administrative Nurse D verified staff had not completed a new FCS when the resident had a change in condition. Administrative Nurse D stated Administrative Nurse E was responsible for completing R1’s FCS form, and she should not document over the prior FCS; she should complete a new one.. - Record review for R3 revealed an admission date of 03/26/25 with a diagnosis of anxiety and depression. The “Progress Notes,” dated 10/01/25, documented R3 received an extended Vancomycin (an antibiotic medication used to treat bacterial infections due to a recent diagnosis of Clostridium difficile (C-diff: contagious bacteria characterized by foul-smelling, frequent loose bowel movements). Review of R3's chart revealed the change of condition FCS, dated 10/01/25, was not completed; staff documented over the admission information for dressing, toileting, transfer, walk/mobility, and eating. On 11/04/25 at 10:31 AM, Administrative Nurse D verified staff had not completed a new FCS when the resident had a change in condition. Administrative Nurse D stated Administrative Nurse E was responsible for completing R3’s FCS form, and she should not document over the prior FCS; she should complete a new one. The facility’s “Assisted Living (AL) FCS,” reviewed in 2025, documented designated facility staff would conduct a screening to determine each resident’s functional capacity according to the following requirements: A. The screen would be assessed at the time of admission, quarterly, with any significant change, and would be completed at least once every 365 days.	S3081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N066003	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW NURSING & RESIDENTIAL LIVING	808 N 8TH STREET , SENECA, Kansas, 66538

(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) COMPLETION DATE
S3081 SS = D	Continued from page 2 B. Following any significant change in condition. C. At least quarterly if the resident received assistance with eating from a paid nutrition assistant. The operator failed to ensure designated staff completed an FCS for R1 and R3 upon a change of condition.	S3081		