STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265856	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair View Health Care Center	1714 W 16th Street Sedalia, MO 65301

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on observation, interview and record review, facility staff failed to develop a comprehensive person-centered baseline care plan to meet the resident's medical, nursing, mental and psychosocial needs for one resident (Resident #1) out of two sampled residents. The facility's census was 52. 1. Review of the facility's Baseline Care Plan Policy, dated 5/18/24, showed the baseline care plan will be developed in 48 hours of a resident's admission. It should include the minimum healthcare information necessary to properly care for a resident. The admitting nurse, or supervising nurse on duty, shall gather infoamtion form the admission physical assessment, hospital transfer information, physicain orders, and discussion with teh residnt and resident representative. A supervising nurse shall verify within 48 hours that a baseline care plan has been developed. 2. Review of Resident #1's Entry Minimum Datat Set (MDS), a federally mandated assessment tool, dated 3/27/25, showed the resident admitted to the facility 3/27/25. Review of the resident's clinical admission assessment, dated 3/28/25, showed staff assessed the resident as follows: -Severe cognitive impairment; -Diagnosis of acute respiratory failure, tracheostomy status, angelman syndrome (a genetic disorder causing developmental disabilities and nerve-related symptoms), and encounter screening for autism; -Tracheostomy; -Urinary catheter; Review showed it did not contain documentation related to gastrostomy tube. Review of the resident's baseline care plan, dated 3/27/25, did not contain staff direction in regard to resident's tracheostomy, gastrostomy tube, or urinary catheter. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair View Health Care Center	1714 W 16th Street Sedalia, MO 65301

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/25 at 12:16 P.M., the Director of Nursing (DON) said the MDS cordinator was responsible for baseline careplans, but they do not have a MDS cordinator right now so he/she has been responsible for completing them. The DON said he/she would expect to see the resident's tracheostomy, gastrostomy tube, and urinary catheter addressed on the baseline care plan. He/she said it wasn't put on the baseline care plan because she didn't do it. The DON said he/she is trying to work on care plans as he/she can. During an interview on 4/4/25 at 12:24 P.M., Licensed Practical Nurse (LPN) D said nurses have access to care plans and can update them if needed. LPN D said he/she is unsure of who is responsible for baseline care plans or for checking them. He/She said a resident should have a baseline care plan within 48 hours and would expect a resident's tracheostomy, gastrostomy tube, and urinary catheter to be addressed on the baseline care plan. During an interview on 4/4/25 at 2:45 P.M., LPN A said he/she has access to the care plans but is not sure how to access them as he/she has only been working part time. He/She said a resident should have a baseline care plan within 48 hours of admission and would expect for the resident's tracheostomy, gastrostomy tube, and urinary catheter to be addressed in the baseline care plan. He/She does not know who is responsible for completing the baseline care plan and thinks the DON would be responsible for making sure they were completed by staff. During an interview on 4/4/25 at 2:54 P.M., the adminsitrator said baseline care plans are to be comleted within 48 hours of the residents admission and the nursing staff is responsible. The DON is responsible for making sure the baseline care plans are completed. MO00252016

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NAME OF PROVIDER OR SUPPLIER Fair View Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1714 W 16th Street Sedalia, MO 65301	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to meet professional standards when staff did not obtain orders for a urinary catheter (flexible tube used to drain the bladder when someone cannot urinate on their own), catheter care, for a tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe), tracheosyomy care, and did not obtain orders for a Gastrostomy (a surgical procedure creating an opening through the abdominal wall into the stomach, allowing for the insertion of a gastrostomy tube for feeding) tube, Gastrostomy tube flushes, or Gastrostomy tube care for one resident (Resident #1) out of five sampled residents. The facility census was 52. 1. Review of the facility's admission process, assignment of primary diagnosis policy, dated 12/1/22, showed a licensed or registered nurse will ensure all admission paperwork including physician orders, medications, diet orders, laboratory orders are obtained and followed. Review of the facility's Medication order policy, dated 5/18/24, showed written transfer orders staff are to implement a transfer order without further validation, if it is signed and dated by the resident's current attending physician, unless the order is unclear or incomplete, or the date signed is different from the date of admission. If the order is unsigned, or signed by another physician, or the date is other than the date of admission, the receiving nurse should verify the order witht the current attending physicina before medications are adminsitered. The nurse should document verification on the admission order record by enter the time, date, and signature. 2. Review of Resident #1's Entry Minimum Data Set (MDS), a federally mandated assessment tool, date 3/27/25, showed the resident was admitted on [DATE]. Review of the resident's Clinical admission assessment, dated 3/28/25, showed staff assessed the resident as follows: -Severe cognitive impairment; -Diagnoses of acute respiratory failure, tracheostomy status, angelman syndrome (a genetic disorder causing developmental disabilities and nerve-related symptoms), and encounter screening for autism; -Tracheostomy; -Urinary catheter. Review showed it did not contain documentation related to gastrostomy tube. Review of the resident's baseline care plan, dated 3/27/25, showed staff assessed the resident at risk for impaired communication, had limited physical mobility and requires one to two assist at time, and at risk for falls. Staff were instructed to provide gentle range of motion as tolerated with daily care, provide supportive care, assistance with mobility as needed, and document assistance as needed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Order Sheet (POS), dated March 2025, showed it did not contain orders for the resident's tracheostomy, tracheostomy care, catheter, catheter care, gastrostomy tube, gastrostomy tube care, or gasttrostomy tube flushes. During an interview on 4/2/25 at 1:15 P.M., Licensed Practical Nurse (LPN) A said the resident is a new admission and has not been at the facility long. He/She said the resident has a tracheostomy, urinary catheter, and gastrostomy tube. LPN A said he/she was not aware there were not orders in the system for the resident's tracheostomy, catheter, or gastrostomy tube. LPN A said he/she knew how to care for the resident because of caring for residents with same tubes in the past and his/her nursing knowlegde. He/She said the charge nurse is responsible for entering in orders on new admissions and the Director of Nursing (DON) is resposible to make sure they are put in correctly. During an interview on 4/2/25 at 2:15 P.M., LPN D said the charge nurse is responsible to put orders in on a new admission. He/She said the nurses are receiving training on how to do this. LPN D said he/she put some of the resident's orders in but is not sure of the process from start to finish. He/She said the DON would be responsible for making sure all the information was in correctly. LPN D said he/she is not very familiar with the resident, but would expect there to be orders for the resident's tracheostomy, urinary catheter, gastrostomy tube, and cares for all of those listed on the physician's orders. LPN D said he/she was not aware the orders were not in the system and said he/she knew what care to provide through his/her nursing knowledge. During an interview on 4/2/25 at 3:50 P.M., the DON said he/she was not aware the orders were not in the system. He/She said they used to have a corporate person who helped with admissions. He/She said the charge nurses will be responsible for putting in orders for new admissions and he/she is responsible for making sure they are put in correctly. He/She said the orders were not put in due to a lack of knowledge on the nurses part. Nurses are currently in training. During an interview on 4/4/25 at 2:54 P.M., the administrator said the nursing staff are responsible for putting in orders for new admissions and the DON is responsible for making sure the nurses complete this task. MO00252016