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	04/22/2026

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 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to ensure the admission policy did not require the resident and/or responsible party to waive facility liability for loss or damage to personal belongings for two residents (Resident #39, and #51) out of three residents. The census was 53.1. Review of the facility's Skilled Nursing Facility Resident Agreement, undated, showed the facility under no circumstances will be held responsible for or have any liability of any nature whatsoever for loss or damage to valuables, personal property or money brought to facility. It is further agreed that no deductions or credits shall be taken from any amount due or owing to facility as a result of any loss suffered or damage done by residents to personal property. 2. Review of Resident #39's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 03/12/26, showed staff documented the resident admitted to the facility on [DATE]. Review of the resident's Resident Handbook, signed and dated 12/16/24, showed the facility under no circumstances will be held responsible for or have any liability of any nature whatsoever for loss or damage to valuables, personal property or money brought to facility. It is further agreed that no deductions or credits shall be taken from any amount due or owing to facility as a result of any loss suffered or damage done by residents to personal property. 3. Review of Resident #51's Quarterly MDS, dated [DATE], showed staff documented the resident admitted to the facility on [DATE]. Review of the resident's Resident Handbook signed and dated 12/03/25, showed the facility under no circumstances will be held responsible for or have any liability of any nature whatsoever for loss or damage to valuables, personal property or money brought to facility. It is further agreed that no deductions or credits shall be taken from any amount due or owing to facility as a result of any loss suffered or damage done by residents to personal property. 4. During an interview on 04/22/26 at 4:07 P.M., the Director of Nursing (DON) said he/she is new and has not completed an admission contract with any residents since he/she started. He/She said he/she is not familiar with the policy and was not aware of what it said. During an interview on 04/22/26 at 4:16 P.M., the corporate DON said the admissions agreement is created on the corporate level and not a document that he/she participates in creating. He/She said because the document is created on that level and used at other facilities, he/she believed the information to be appropriate, and was not aware that it did not meet regulatory requirements. During an interview on 04/22/26 at 4:52 P.M., the Administrator said the admissions agreement is a (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265856	A. Building B. Wing	04/22/2026

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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 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	standard contract the facility uses. He/She said he/she was just made aware of the wording in the agreement about loss and/or damage to resident property. He/She said he/she believes that statement is not agreeable to regulation.

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	265856	A. Building B. Wing	04/22/2026

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility staff failed to designate a person to serve as the Director of Food and Nutrition Services (DFNS) with the appropriate qualifications, when the facility did not employ a qualified dietitian or other clinically qualified nutrition professional full-time. This failure has the potential to affect all residents. The facility census was 53.1. Review of the facility's Dietary Manager (DM) job description, dated 2023, showed the DM must meet State requirements for food service managers or dietary managers, and also meet one of the following qualification requirements: - Certification as a DM;- Certification as a food service manager;- Has similar national certification for food service management and safety from a national certifying body;- Has an associate's or higher degree in food service management and or in hospitality, if the course of study includes food service or restaurant management, from an accredited institution of higher learning;- Has two or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than 10/01/23, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving. Review of the DM personnel records showed a hire date for the DFNS position as 03/12/26. The record did not contain documentation of prior experience as a DFNS in a nursing facility and certification or other education required for the DFNS position. During an interview on 04/22/26 at 1:36 P.M., the DM said he/she became the DM in mid-March 2026 and he/she did not have a degree or certification related to food service management and had not previously worked as a DM. The DM said the facility's consultant registered dietician (RD) only works part-time and the facility did not have any other clinically qualified nutritional staff employed full-time. During an interview on 04/22/26 at 2:33 P.M., the administrator said the DM had been the DM since March 2026, he/she did not know of the qualifications that the DFNS had to meet by regulation and did not know the DM did not meet the qualifications. The administrator said the facility's RD only works part-time and was not aware of any other clinically qualified nutritional staff employed full-time working at the facility.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to maintain the walk-in freezer in a manner to prevent potential food contamination. This failure has the potential to affect all residents. The facility census was 53.1. Review of the facility policies provided showed they did not contain a policy related to maintenance of the walk-in freezer. Observation on 04/19/26 at 10:24 A.M., showed the walk-in freezer door unable to fully seal shut. Observation showed a thick frost accumulation on the freezer walls, evaporator coil cabinet and on most of the food stored inside the freezer. Observation also showed a thick layer of ice on the front and back of the evaporator coil cabinet and on the floor inside the freezer. Observation on 04/20/16 at 10:18 A.M., showed the walk-in freezer door unable to fully seal shut. Observation showed thick frost on most of the stored food items, on the freezer walls, and on the evaporator coil cabinet inside the freezer. Observation showed a thick layer of ice on the freezer floor, on the side of the freezer door, and on the front and back of the evaporator coil cabinet in the freezer. During an interview on 04/21/26 at 3:00 P.M., the maintenance director said he/she began employment at the facility approximately three weeks ago and had just been made aware of the issue with the freezer door not fully sealing. During an interview on 04/22/26 at 12:39 P.M., the dietary manager (DM) said he/she began his/her employment at the facility approximately eight months ago and the door to the walk-in freezer not being able to fully seal shut was already an issue when he/she started and it had never been fixed. The DM said the accumulation of frost and ice within the freezer has gradually gotten worse over the last eight months and he/she knows it is a problem. The DM said he/she reported the walk-in freezer door issue to the previous maintenance director multiple times, but the previous maintenance director never addressed the issue and stopped working at the facility approximately a month ago. During an interview on 04/22/26 at 2:33 P.M., the administrator said he/she did not know about the condition of the walk-in freezer until last week. The administrator said he/she thought the freezer door seal was supposed to be replaced last week and did not know the seal had not been replaced. The administrator said he/she did not know how long the walk-in freezer door had been unable to fully seal shut and did not know how much frost and ice had built up in the walk-in freezer and on the evaporator coil cabinet.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, facility staff failed to electronically submit to Centers for Medicare and Medicaid Services (CMS), a complete and accurate direct care staffing information to the Payroll Based Journal (PBJ) data for the first and second quarter of 2025. The facility census was 53.1.Review of the facility's Registered Nurse (RN) policy, revised 04/30/24, showed the facility is responsible for submitting timely and accurate staffing data through the CMS PBJ system. 2. Review of the facility's CMS PBJ Staffing Data Report, dated April 17, 2026, did not contain a report for the first and second quarter of 2025. 3. During an interview on 04/22/2026 at 4:07 P.M., the Director of Nursing (DON) said their corporate office is responsible for reporting staffing information to the PBJ. He/She said he/she was not aware the PBJ wasn't reported correctly for 2025. During an interview on 04/22/2026 at 4:52 P.M., the Administrator said he/she was not aware there were issues with the PBJ being reported. He/She said their corporate office handles the final submission to PBJ. During an interview on 4/29/26 at 12:57 P.M., the Regional Human Resource Director said the facility Human Resource Director (HR) keeps a calendar and collects the hours worked information. He/She said that information is then sent to him/her quarterly. He/She said he/she then takes that information, compares it to their system, creates the file to submit to CMS. He/She just took over this position in November 2025 and was not aware of the previous person's process. He/She said he/she knows the importance of submitting to CMS and ensures timely processing.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to use appropriate infection control procedures to prevent the spread of bacteria or other infectious causing contaminants when staff failed to ensure the two-step purified protein derivative (PPD), a skin test for Tuberculosis (TB) (a potentially serious infectious bacterial disease that mainly affects the lungs) was completed and on file in accordance with the facility policy for five employees (Dietary Aide M, Licensed Practical Nurse (LPN) N, [NAME] O, Certified Medication Technician (CMT) P, and Registered Nurse (RN) E out of 10 employee files reviewed. Staff failed to ensure all residents were screened for TB when staff failed to ensure a two-step PPD and/or annual PPD tests were completed and documented per the facility policy for four residents (Resident #3, #10, #26, and #35) of five sampled residents. Facility staff failed to develop and implement complete policies and procedures for the inspection, testing and maintenance of the facility's water systems to inhibit the growth of waterborne pathogens and reduce the risk of an outbreak of Legionnaire's Disease, a serious type of pneumonia (lung infection) caused by Legionella bacteria. This failure has the potential for the failure of staff to identify and mitigate the presence of waterborne pathogens, which places all facility occupants at risk of exposure which could lead to illness. The facility census was 53.1.Review of the facility's Tuberculosis Testing policy, revised 06/29/23, showed: -Upon hire, a new employee will receive a 2 step PPD skin test. Each employee will also have an annual 1 step TB test to ensure that any possible infections can be triggered proactively to prevent further spread. -Upon admission and readmission, each resident will receive a 2 step PPD skin test as ordered by the physician. Each resident will also have an annual 1 step TB test as ordered by the physician to ensure that any possible infections can be triggered proactively to prevent further spread. If the resident has not been hospitalized for the year, they will receive a signs and symptoms checklist to monitor for communicable diseases. -All TB test and chest x-rays records will be kept on file in the according areas (employee files and resident records). 2. Review of Dietary Aide M's employee file showed: -Hire date of 03/04/26; -First step TB skin test administered on 03/09/26, read date of 03/11/26; -Second step TB administered on 03/23/26, read date of 03/25/26; -Staff documented they administered the first TB test after the date of hire. 3. Review of LPN N's employee file showed: -Hire date of 03/30/26; -First step TB skin test administered on 04/04/26, read date of 04/06/26; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Second step TB administered on 04/18/26, the date of 04/20/26; -Staff documented they administered the first TB test after the date of hire. 4. Review of [NAME] O's employee file showed: -Hire date of 11/11/25; -First step TB skin test administered on 03/22/26, read date of 03/24/26; -Second step TB administered on 04/04/26, read date was 04/06/26; -Staff documented they administered the first TB test after the date of hire. 5. Review of CMT P's employee file showed: -Hire date of 03/14/25; -First step TB skin test administered on 03/01/26, read date of 03/03/26; -Staff did not document the resident received a second-step TB test. 6. Review of RN E's employee file showed: -Hire date of 09/16/25; -First step TB skin test administered on 09/08/25, the record did not contain a date read; -Second step TB administered on 9/18/25, the record did not contain a date read. 7. During an interview on 04/22/2026 at 4:07 P.M., the Director of Nursing (DON) said the human resource manager is responsible to ensure staff TB'S are complete. The DON said he/she's been here a month and unsure why the staff TBs were not complete. He/She said nursing staff give TB tests. During an interview on 04/22/26 at 5:09 P.M., the Administrator said there is a two-part process when new staff's hired. The Business Office Manager (BOM) is responsible for ensuring the information is provided to the DON and ensure the TB step is provided. The Administrator was not aware some new hire TB tests were not administered appropriately. During a phone interview on 05/05/26 at 1:00 P.M., the BOM schedules staff to get their TB tests three days before staff start. He/She said when the first step is completed, he/she places the first step near the nurse's station. The BOM said if the new hire staff miss their tests, it is due to no shows or nurses did not give the tests. He/She is responsible for ensuring tests are complete before contact with residents. 8. Review of Resident #3's medical record showed: -admitted on [DATE]; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The record did not contain documentation the resident received the first or second step TB tests. 9. Review of Resident #10's medical record showed: -admitted on [DATE]; -The record did not contain documentation the resident received the first or second step TB tests. 10. Review of Resident #26's medical record showed: -admitted on [DATE]; -The record did not contain documentation the resident received the first or second step TB tests. 11. Review of Resident #35's medical record showed: -admitted on [DATE]; -The record did not contain documentation the resident received the first or second step TB tests. 12. During an interview on 04/22/26 at 4:40, the Corporate Director of Nursing said residents are expected to have the first step TB test upon admission, and the second step within 14 days after, he/she said they believe the issue is that the information isn't flowing over in the Electronic Medical Record (EMR) system to trigger staff to do the tests. During an interview on 04/22/26 at 4:45 P.M., the Administrator said the DON is ultimately responsible for making sure resident TBs are done, and there has been a lot of change over with the DON position and that might be why it was not done. 13.Review of the Centers for Medicare and Medicaid Services (CMS), QSO-17-30, dated 06/02/17 and revised 07/06/18, showed: -CMS expects Medicare and Medicare/Medicaid certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems.-Facilities must have water management plans and documentation that, at a minimum, ensure each facility:--Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system;--Develops and implements a water management program that considers the ASHRAE industry standard and the CDC toolkit;--Specifies testing protocols and acceptable ranges for control measures and document the results of testing and corrective actions taken when control limits are not maintained;--Maintains compliance with other applicable Federal, State and local requirements; --Note: CMS does not require water cultures for Legionella or other opportunistic water borne pathogens. Testing protocols are at the discretion of the provider. Review of the facility's policy titled, Legionella and Legionnaires' Disease Prevention, undated, showed the facility shall operate potable water systems in a manner that reduces the risk of Legionella growth and Legionnaires' disease by: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Maintaining potable water systems in a clean condition and free of excessive sediment and debris; - Controlling hot and cold water temperatures to reduce conditions favorable to Legionella growth; - Minimizing water age and stagnation throughout the system; - Maintaining a measurable disinfectant residual where feasible; - Identify and correct dead legs, low-flow, and low-use conditions; - Performing routine flushing, cleaning, maintenance, and monitoring; - Documenting all monitoring, maintenance, corrective actions, and response measures; - Maintaining documentation of the facility's water system descriptions and maps and annual risk assessments and policy reviews. - This policy shall be reviewed at least annually and revised as needed. Observations on 04/21/26 during the Life Safety Code tour showed the facility equipped with a cooling tower, multiple ice machines and multiple water sources throughout the facility. Observations showed all water sources were not in regular use. Review of the facility's Water Management Program showed the documentation did not contain: -A facility specific risk assessment; -Identification of dead legs, low-flow, and low-use conditions;-Documentation of routine flushing, cleaning, maintenance, and monitoring of water sources. During an interview on 04/22/26 at 10:32 A.M., the regional maintenance director said maintenance staff and facility administration are responsible to develop and implement the water management program. The director said he/she thought the facility had completed a facility specific risk assessment that identified how water was distributed throughout the building and identified risk areas, but he/she could not locate it. The director said the current maintenance director had only worked at the facility for approximately three weeks and he/she does not have documentation of routine flushes, cleaning, maintenance, or monitoring of the facility's water system. The director said the facility is expected to maintain documentation of the facility risk assessment and of routine flushes, cleaning, maintenance, and monitoring of water sources. During an interview on 04/22/26 at 2:33 P.M., the administrator said maintenance staff is responsible for implementing the facility's water management program. The administrator said he/she thought the facility had a risk assessment that showed a diagram of how water is distributed throughout the building and identified areas of risk, but he/she could not locate it. The administrator said he/she expects maintenance staff to perform and document any necessary routine monitoring, maintenance, and cleaning of the facility's water sources and he/she could not provide documentation to show any actions taken by maintenance staff.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to review and revise the plan of care for four residents (Resident #4, # 5, #10, and #22) out of 16 sampled residents. The facility census was 53.1. Review of the Facility's Comprehensive Care Plan Policy, revised 10/31/24, showed the care planning process will include an assessment of the resident's strengths and needs, and cultural preferences in developing goals of care. The Care plans will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS), a federally mandated assessment tool, assessment. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. 2. Review of Resident #4's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Upper and lower extremity impairment on both sides; -Dependent on staff for eating, toileting, shower/bathe, and personal hygiene; -Diagnosis of Cerebral Palsy and Quadriplegia. Review of the Physician Order Sheets (POS), dated April 2026, showed an order to wear bilateral resting hand splints as tolerated during the day. Review of the residents' care plan, dated 04/2026, showed the plan did not address the residents' contractures or interventions. Observation on 04/19/26 at 12:10 P.M., showed the resident in his/her specialized medical wheelchair in the dining room with both hands contracted without interventions place. Observation on 04/20/26 at 12:125 P.M., showed the resident in his/her specialized medical wheelchair in the dining room with both hands contracted without interventions place. Observation on 04/21/26 at 4:00 P.M., showed the resident in his/her bed with both hands contracted without interventions place. Observation on 04/22/26 at 11:00 A.M., showed the resident in his/her bed with both hands contracted without interventions place. 3. Review of Resident #5's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Upper extremity impairment to one side; -Substantial/maximal assistance with toileting hygiene, and shower/bathe; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Moderate assistance with upper body dressing and personal hygiene. Review of the resident's POS, dated April 2026, showed an order for a left upper body brace. Review of the resident's care plan, dated 02/27/26, showed the plan did not address the residents' contracture. Observation on 04/19/26 at 11:36 A.M., showed the resident in his/her wheelchair with left hand contracted without interventions place. Observation on 04/20/26 at 11:20 A.M., showed the resident in his/her wheelchair with left hand contracted without interventions place. Observation on 04/21/26 at 10:25 A.M., showed the resident in his/her wheelchair with left hand contracted without interventions place. Observation on 04/22/26 at 12:25 P.M., showed the resident in his/her wheelchair with left hand contracted without interventions place. 4. Review of Resident #10's annual MDS, dated [DATE], showed staff assessed the resident needs/wants assistance to communicate with doctors and health care staff. Review of resident's Nursing Progress Notes, dated 04/16/26, 04/18/26 and 04/21/26, showed the resident went to medical appointments outside of the facility. Review of the resident's care plan, dated 01/28/26, showed the plan did not reflect the resident's need/want for communication assistance during his/her medical appointments. During an interview on 04/21/26 at 10:40 A.M., the resident said he/she goes to his appointment without communication assistance. The resident said his preference is to have someone with him when he/she attends. During an interview on 04/21/26 at 10:30 A.M., Certified Medication Technician (CMT) J said he/she is unsure if the facility sends communication assistance with the resident. CMT said when the resident is at the facility, he/she assists in communication per the resident's request. During an interview on 04/22/26 at 2:00 P.M., social worker K said there is a med tech at the facility he/she utilizes when communicating with the resident. He/She believes the resident needs communication assistance for each shift to ensure his/her needs are known but he/she does not believe he/she has that at all times. 5. Review of Resident #22's annual MDS, dated [DATE], showed: -Severely impaired cognition; -Upper extremity impairment on both sides; -Dependent of staff for toileting, eating, shower/bathe, on/off footwear, and dressing; (continued on next page)

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	265856	A. Building B. Wing	04/22/2026

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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnosis of cerebral palsy. Review of the resident's care plan, dated 2/16/26, showed the plan did not direct staff to use ace wraps for edema and did not address new interventions for edema. Review of the resident's POS, dated April 2026, showed an order for the resident's bilateral lower legs to be ace wrapped daily for edema. Observation on 04/20/26 at 1:39 P.M., showed the resident in his/her wheelchair with swollen bilateral lower legs. The resident did not have bilateral ace wraps on his/her legs. Observation on 04/21/26 at 2:42 P.M., showed the resident in his/her wheelchair with swollen bilateral lower legs. The resident did not have bilateral ace wraps on his/her legs. Observation on 04/22/26 at 1:22 P.M., showed the resident in his/her wheelchair with swollen bilateral lower legs. The resident did not have bilateral ace wraps on his/her legs. 6. During an interview on 04/22/26 at 4:35 P.M., the Director of Nursing (DON) said he/she would expect resident contractures with interventions such as braces and splits to be on the care plan. The DON said language restrictions should be care planned. During an interview on 04/22/26 at 4:40 P.M., the Administrator said care plans should be personalized to each resident's needs and preferences. He/She said they would expect interventions and language restrictions to be on a care plan.

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	265856	A. Building B. Wing	04/22/2026

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility staff failed to provide the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week. The facility census was 53.1.Review of the Facility's RN policy, revised 4/30/24, showed the facility will utilize the services of a RN for at least eight consecutive hours per day, seven days a week. 2. Review of the facility's RN staff schedule, dated January 2026, showed the facility did not have an RN in the building on: -Saturday, 01/03/26; -Sunday, 01/04/26; -Saturday, 01/17/26; -Sunday, 01/18/26; -Saturday, 01/31/26. 3. Review of the facility's RN staff schedule, dated February 2026, showed the facility did not have an RN in the building on: -Sunday, 02/01/26; -Saturday, 02/14/26; -Sunday, 02/15/26; -Saturday, 02/28/26; -Sunday, 02/29/26. 4. Review of the facility's RN staff schedule, dated March 2026, showed the facility did not have an RN in the building on: -Sunday, 03/14/26; -Saturday, 03/15/26; -Saturday, 03/28/26; -Sunday, 03/29/26. 5. Review of the facility's RN staff schedule, dated March 2026, showed the facility did not have an RN in the building on Saturday 04/11/26 and Sunday 04/12/26. 6. During an interview on 04/22/26 at 4:07 P.M., the Director of Nursing (DON) said the facility is (continued on next page)

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	265856	A. Building B. Wing	04/22/2026

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	required to have an RN in the building seven days a week for eight consecutive hours a day. He/She said he/she thought they had an RN rotating every other weekend to cover and was not aware there was not an RN scheduled some weekends. He/She said if there are holes for RN coverage the corporate DON and himself/herself cover the shift. During an interview on 04/22/26 at 4:52 P.M., the Administrator said the facility should have an RN on everyday shift, 8 hours consecutively. He/She said he/she had some concerns with RN coverage, and they have been recruiting RN's. He/She said RN coverage has been an issue, and they are working on. He/She said the DON and corporate DON cover shift when needed. He/She said their DON and corporate DON do not clock in to track the RN hours in the building.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review, facility staff failed to ensure four Nurse Aide's (NA) (NA A, NA B, NA C and NA D) of four completed the nurse aide training program within four months of his/her employment in the facility. The census was 53.1.Review of the facility's policies showed staff did not provide a policy that directed staff on NA qualifications. 2. Review of NA A's Certified Nurse Aid (CNA) report showed a hire date of 09/15/25. The report did not contain documentation NA A completed a nurse aide training program. 3. Review of NA B's CNA report showed a hire date of 08/23/25. The report did not contain documentation NA B completed a nurse aide training program. During an interview on 04/22/26 at 10:51 A.M., NA B said he/she started in August of 2025 and has never worked in any other department. He/She said he/she started classes a few months ago. He/She said before he/she started classes there were issues with not having an instructor. He/She said he/she has completed classes but has not set up any testing dates. 4. Review of NA C's CNA report showed a hire date of 03/06/23. The report did not contain documentation NA C completed a nurse aide training program. 5. Review of NA D's CNA report showed a hire date of 11/21/25. The report did not contain documentation NA D completed a nurse aide training program. During an interview on 04/22/26 at 11:08 A.M., NA D said he/she has worked at the facility for four to five months and before that he/she worked at another one of their homes for seven months as an NA. He/She said he/she completed the classes but has not set up a time to take the test. 6. During an interview on 04/22/26 at 4:07 P.M., the Director of Nursing (DON) said he/she knows the requirement is for the NA to complete the CNA training course within 120 days from the date of hire. He/She said he/she was not aware and is not sure why they have not completed the training. He/She said he/she is new to the facility and has only been the DON for 29 days. During an interview on 04/22/26 at 4:16 P.M., the corporate DON said the facility was sharing the CNA classes with their sister facilities. He/She said he/she was not sure why each of them had not completed the CNA classes in the 120 days but that he/she knows some of the staff were not reliable with going to classes. He/She said human resources helps with the process, but the DON is ultimately responsible for ensuring the NA's complete training timely. During an interview on 04/22/26 at 4:52 P.M., the Administrator said he/she knows that NA's should be certified in 120 days from when they start. He/She said he/she was aware they were having issues with completing the classes timely. He/She said they had a teacher walk out and had to work with their sister facility to get a new trainer and the processes took a long time.

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	265856	A. Building B. Wing	04/22/2026

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Fair View Health Care Center	1714 W 16th Street Sedalia, MO 65301

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, facility staff failed to ensure medications were stored in a safe and effective manner, when staff failed to ensure medications not in use and expired medications were properly discarded. The facility census was 53.1.Review of the facility's policy, Storage of Medications, dated 05/18/24, showed medications housed in the facility premises and follow in accordance the manufacturer's recommendations related to unused medications. 2. Observation on 04/19/26 at 10:30 A.M., showed the 200 hall medication cart contained: -One bottle of Prednisolone Acetate 1% Ophthalmic Suspension five milliliter (mL) (steroid eye drop) with an expiration date of 04/15/26; -One bottle of Systane Balance Lubricant Eye Drops 0.5%, 10 mL with an expiration date of 02/12/26; - Albuterol inhaler HFA 90 microgram (mcg) (used to open the lung airways) with a use by date of 04/06/26; -Biscodyl 5 milligrams (mg), (a stimulant laxative) with an expiration date of 02/2024. 3.Observation on 04/19/26 at 11:00 A.M., showed the 200 hall overflow medication cart contained: -Levetiracetam 100 mg/mL oral solution (to treat seizure disorders) with an expiration date of 3/16/26; -Lactulose 10 gram/15 mL oral solution (to treat constipation and liver disease) with a use by date 04/11/26; - Valproic acid 250 mg/5 mL (to treat seizure disorders) with a use by date 03/24/26; -Stomach relief Pink Bismuth with an expiration date of March 2026; -Baclofen (muscle relaxer) 10 mg with a use before 04/07/26; -Senexon-S 8.6 -50 mg (stool softener) with a use by date of 2/16/26; - Ondansetron 4mg (to prevent nausea and vomiting) with a use by date of 02/16/26. During an interview on 4/19/26 at 12:00 P.M., the certified medication technician (CMT) J said he/she is responsible to go through his/her medication cart to ensure expired or discontinued medications are discarded. The CMT said we usually go through the carts weekly. The CMT said he/she is unsure if there is a system in place to document or chart med storage completion requirements. The CMT said the director of nursing (DON) is overall responsible to ensure the medication carts are in order. During an interview on 04/22/26 at 3:30 P.M., Registered Nurse (RN) E said he/she is primarily responsible for his/her medication cart. He/She reconciles the medications and ensures there are no (continued on next page)

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	265856	A. Building B. Wing	04/22/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expired medications. The CMT's go through the cart and are responsible to dispose of expired or discontinued medications. He/She is unsure if there is a documented process of charting med storage reconciliation/organization of carts. He/She would not place sole responsibility on the DON. He/She has responsibility as the nurse to ensure the medication carts are in order. During an interview on 04/22/26 at 4:07 P.M., the DON said the CMT's go through the carts to ensure the medications are disposed. He/She said to his/her knowledge, there's not a system in place to ensure proper medication storage audits. He/She is responsible for ensuring the carts are in order and to audit each individual cart. He/She said the expectation of this process is to ensure expired or discontinued medications are not used. He/she was not aware there were expired or discontinued medications in the medication carts. During an interview on 04/22/26 at 5:06 P.M., the Administrator said he/she expects proper storage of medications to be utilized. He/She would expect weekly inspections conducted of the medication carts. The administrator said if the medications are expired or discontinued, they should be removed immediately. He/She said the DON is overall responsible to ensure proper medication storage in the medication carts.

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	265856	A. Building B. Wing	04/22/2026

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility staff failed to ensure prepared food items were served at a safe and appetizing temperature when the facility staff failed to maintain the internal temperatures of hot food items at 120 degrees Fahrenheit (F) or higher upon service to residents who ate in their rooms. The facility census was 53.1. Review of the facility's policy titled, Dietary Food Preparation, dated 07/05/23, showed the temperature of hot food items are expected to be greater than 135 F at the time of service to residents. During an interview on 04/19/26 at 12:50 P.M., Resident #23 said he/she eats in his/her room. The resident said when staff bring his/her food the food is barely warm and he/she prefers his/her food to be hot. During an interview on 04/19/26 at 1:11 P.M., Resident #43 said his/her food is mostly cold when delivered. Review of the facility menus, dated 04/22/26, showed the menu directed staff to provide the residents on a regular diet with rosemary herbed baked chicken, mushroom rice, and cauliflower au gratin at the lunch meal. Observation on 04/22/26 at 1:11 P.M., showed staff served lunch room trays to residents from the 100 hall food cart. Observation of a resident tray from the food cart showed the internal temperature of the rosemary herbed baked chicken and cauliflower au gratin both measured 103 F and the mushroom rice measured 106 F. During an interview on 04/22/26 at 1:13 P.M., Certified Medication Technician (CMT) H said the residents on the 100 hall who choose to eat in their rooms complain nearly every day about the hot food being cold when their meal trays are served. The CMT said the residents who eat in their rooms on the 100 hall are the last residents to be served meal trays. The CMT said he/she had reported the resident's complaints to the previous dietary manager (DM) who stopped working at the facility one or two months ago, but the issue had not improved and he/she still receives complaints from residents. During an interview on 04/22/26 at 1:16 P.M., Certified Nursing Assistance G said residents who choose to eat in their rooms frequently complain about their hot food being cold when they receive the meal trays. During an interview on 04/22/26 at 1:28 P.M., Dietary Aide (DA) I said depending on the day, it can take a while to dish up plates for the meal trays being served to residents who eat in their rooms. The DA said he/she checks the temperature of the food on the steam table before they start service and again approximately mid-way through service. The DA said the residents who eat in their rooms on the 100 hall are the last residents to be served. During an interview on 04/22/26 at 1:36 P.M., the DM said hot food should be served to the residents at 120 F or higher, regardless if they eat in the dining room or receive a room tray. The DM said once the hall cart leaves the kitchen, it is the nurse's responsibility to serve the residents eating in their rooms. During an interview on 04/22/26 at 2:33 P.M., the administrator said the DM is responsible to make sure hot food is served to all residents at 120 F or higher. The administrator said he/she did not know that some residents had complained to staff about their hot food being cold when it is served.

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	04/22/2026

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to maintain resident dignity, when staff stood over four residents (Resident #4, #22, #23 and #34) while assisting the residents to eat. The facility census was 53.1. Review of the facility's Promoting/Maintaining Resident Dignity policy, revised 09/21/25, showed all staff will speak to and treat all residents with dignity and respect, all staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights, and when interacting with a resident, pay attention to the resident as an individual.2. Review of Resident #4's Quarterly Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 02/04/26, showed staff assessed the resident as severely impaired cognition, upper extremity impairment on both sides and dependent on staff for eating.Review of the resident's care plan, dated 02/16/26, showed the plan did not direct staff on how to assist the resident with meals.Observation on 04/20/26 at 12:33 P.M., showed Nurse Aide (NA) F stood over the resident as he/she fed him/her. 3. Review of Resident #22's Quarterly MDS, dated [DATE], showed staff assessed the resident as severely impaired cognition, upper extremity impairment on both sides, and dependent on staff for eating.Review of the resident's care plan, dated 02/16/26, showed the resident is dependent on staff for meeting emotional, intellectual, physical, and social needs due to cognitive deficits.Observation on 04/19/26 at 12:26 P.M., NA B stood over the resident as he/she fed him/her.Observation on 04/20/26 at 12:22 P.M., NA F stood over the resident as he/she fed him/her.Observation on 04/22/26 at 12:19 P.M., Certified Nurse Aide (CNA) G stood over the resident as he/she fed him/her.During an interview on 04/22/26 at 12:30 P.M., CNA G said facility staff receive education on assisting residents to eat. He/She said staff are allowed to stand while feeding residents, and that it is staff preference to either stand or sit. 4. Review of Resident #23's Quarterly MDS, dated [DATE], showed staff assessed the resident as severely impaired cognition, upper extremity impairment on both sides and dependent on staff for eating.Review of the resident's care plan, dated 12/29/25, showed the resident with dysphagia (difficulty swallowing) needs assistance and encouragement with meals and fluids.Observation on 04/20/26 at 12:21 P.M., showed NA F stood over the resident as he/she fed him/her. 5. Review of Resident #34's Quarterly MDS, dated [DATE], showed staff assessed the resident as severely impaired cognition and requires substantial maximal assistance with meals.Review of the resident's care plan, dated 12/29/25, showed the resident does not feed himself/herself and requires staff assistance and encouragement.Observation on 04/20/26 at 12:33 P.M., showed NA F stood over the resident as he/she fed him/her.6.During an interview on 04/22/26 at 4:07 P.M., the Director of Nursing (DON) said he/she expects his/her staff to sit at eye level when assisting residents with meals. He/She said sitting at eye level is important to maintain dignity and respect for the resident. He/She said he/she was not aware staff were not sitting with the residents during meals. He/She said his/her staff should know better and are educated about not standing during meal assistance.During an interview on 04/22/26 at 4:52 P.M., the Administrator said it is his/her expectation that staff sit at the same level as the resident while assisting residents with meals. He/She said it is good for dignity and for the residents to not feel rushed through the process. He/She said he/she was not aware staff were standing while assisting residents to eat.

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	265856	A. Building B. Wing	04/22/2026

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and record review, facility staff failed to complete or post required nurse staffing information in an area readily accessible to residents and visitors. The facility census was 53.1. Review of the facility's policy titled, Nurse Staffing Posting Information Policy, reviewed 06/26/24, showed the nurse staffing sheet will be posted on a daily basis and will contain: -Facility Name; -Current date; -Facility current resident census; -The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directedly responsible for resident care per shift: -Registered nurses (RN); -Licensed Practical Nurses (LPN)/Licensed Vocational Nurses (LVN); -Certified nurse aides (CNAs). -The facility will post the Nurses Staffing Sheet at the beginning of each shift. -The information posted will be presented in a clear and readable format and in a prominent place readily accessible to residents and visitors. 2. Observation on 04/19/26 10:30 A.M., showed facility staff did not post the nurse staff posting sheet in an area readily accessible to residents and visitors. Observation on 04/20/26 11:00 A.M., showed facility staff did not post the nurse staff posting sheet in an area readily accessible to residents and visitors. Observation on 04/21/26 5:10 P.M., showed facility staff did not post the nurse staff posting sheet in an area readily accessible to residents and visitors. Observation on 04/22/26 3:04 P.M., showed facility staff did not post the nurse staff posting sheet in an area readily accessible to residents and visitors. During an interview on 04/22/26 at 4:07 P.M., the Director of Nursing (DON) said the daily staff schedule should be posted at the nurse station. He/She said it is the responsibility of the staffing coordinator to post it daily. He/She said he/she was not aware it was not being posted with the correct information. During an interview on 04/22/26 at 4:17 P.M., the corporate DON said the daily staffing should be posted at the nurse station. He/She said it should have the total hours worked per day/per shift for each direct care staff and include the census for the day. He/She was not aware it was not being posted. (continued on next page)

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	265856	A. Building B. Wing	04/22/2026

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/22/26 at 4:52 P.M., the administrator said he/she knows the daily staffing numbers should be posted daily where residents and visitors can see it. He/She said he/she was not aware it was not being posted.