STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175163	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southwest Medical Center Snf	315 W 15th Street Liberal, KS 67905

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 observation, interview, and record review, the facility failed to provide eight consecutive hours of Registered Nurse (RN) staff daily for the residents of the facility.Findings included:- The 08/05/25 Facility Assessment, documentation included: Staff/Personnel required, which stated Skilled Nursing Unit bases staffing on the resident population and their needs for care and support. A good faith effort and approach is made to ensure sufficient, qualified staff is available to meet the needs of the residents at any given time. The staffing plan in place can be adjusted based on changes in the resident census. The nurse to resident ratio is six residents to one RN and one Certified Nurse Aide. An additional Licensed Practical Nurse (LPN) may be utilized if the resident number increases. Staff are scheduled 12 hours shifts per day. Review of the Nursing schedule for 10/01/25 - 12/31/25, revealed a lack of scheduled RN coverage for the following dates:Thursday, 11/13/25.Sunday, 11/20/25.Saturday, 12/20/25. On 04/22/26 at 01:33 PM, Administrative Nurse E confirmed the lack of scheduled RN coverage as noted above. He stated the facility lacked auditable or verifiable evidence of him working as the RN on duty for eight consecutive hours and confirmed he was not listed or identified as the RN on the schedule or staff postings for RN coverage for the weekend days.On 04/22/26 at 02:00 PM, Administrative Nurse D reported she expected the Skilled Nursing Unit to have a scheduled RN for the required eight consecutive hours of registered nurse staff daily for the residents of the facility.On 04/24/26 at 12:15 PM, Administrative Nurse E confirmed the lack of scheduled RN coverage on Thursday 11/13/25, he reported he was off that day and the house coordinator for the hospital would have covered. Administrative Nurse E reported the house coordinator is not on the Skilled Nursing Unit for eight consecutive hours The facility's policy Provision of Care, Treatment, and Services dated 05/2025 documented how the department is staffed to meet patient needs. The minimal staffing required is RN coverage for 12 hours a day 7 days a week, and on any shift, there will be either an RN or LPN. The average staffing pattern on the unit is based on the average daily census and patient acuity.

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

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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. Based on interviews, observation and record review, the facility failed to utilize Enhanced Barrier Precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) when providing direct care to a Resident (R) 11 with a Stage 2 (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) pressure ulcer. The facility further failed to ensure adequate hand hygiene before medication administration for R11 and R2. Findings included:1. On 04/21/26 at 08:53 AM, Licensed Nurse (LN) G sanitized her hands and applied gloves, LN G did not apply any other personal protective equipment (PPE- gowns, face shields and/or eyeglasses/goggles, and gloves) and entered R11's room with his medications in their blister packs. LN G placed the medications on the counter under the computer in his room. LN G then assisted R11 to sit up in his bed, as he had laid flat in the bed diagonally. LN G applied the gait belt on R11 and assisted him to the side of the bed, they worked together to scoot him up towards the head of the bed. LN G then assessed R11 and covered him up. LN G used the controllers to elevate R11's head of bed. LN G then walked back over to the computer and scanned R11's identification bracelet and scanned the medications, she opened each packet and dropped the pills into the medication cup. She continued to wear the same gloves that she wore when she provided hands on care. LN G then took one pill out of the medicine cup with her gloved hand and administered that pill directly to R11's mouth. LN G took another pill from the medicine cup with her gloved hand and placed that pill directly into R11's mouth. The remainder of the medications were administered from the medicine cup.2. On 04/21/26 at 09:40 AM, LN G sanitized her hands and applied gloves and gown as she entered R2's room. LN G prepared R2's medications with the same gloved hands that she used to touch the computer keyboard, she opened the blister packets administered the medications and then applied a topical (on the surface of the body) medication patch to R4's left hip. On 04/21/26 at 02:52 PM, LN G reported R11 was not on EBP as his Foley catheter (a tube inserted into the bladder to drain urine into a collection bag) had been removed days ago. LN G confirmed R11 had a Stage 2 pressure ulcer on his buttock. LN G reported that he only needed EBP when he had a Foley. LN G reported that she had not realized that she had worn gloves to provide hands on care to R11 before she prepared his medications. Additionally, she reported that she did not think touching objects in the resident's rooms with gloved hands and preparing and administering medications in the resident's room was a concern. On 04/22/26 at 10:14 AM, Administrative Nurse I (Infection Preventionist) revealed she expected staff to wear appropriate PPE when providing direct care for residents on EBP. Additionally, she expected the staff to use clean gloves when administering medications and to remove gloves after hands-on care, perform hand hygiene, and apply new gloves. The facility's policy Medication Administration dated 08/23, documented to maintain clean technique throughout medication administration.The facility's policy Enhanced Barrier Precautions dated 04/25, documented that upon admission to the skilled nursing unit, the admitting nurse will complete the Enhanced Barrier Precautions Screening section. If any of the questions are answered yes, an order for Enhanced Barrier Precautions (EBP) must be placed.Examples of high-contact resident care activities requiring gown and glove use for EBP included dressing, transferring, and wound care: any skin opening requiring a dressing.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a written baseline care plan to Resident (R) 1, R2, 11, and R4. Findings include:- On 04/20/26 at 09:51 AM, R1 reported she had not received a copy of a baseline care plan. She reported that she has not attended a care plan meeting or any discharge planning since she admitted . R1's Electronic Medical Record (EMR) lacked documentation that a written baseline care plan was given or reviewed by R1 or a family member since she admitted on [DATE]. On interview on 04/20/26 at 10:24 AM, R2 reported she was never provided a written copy of the care plan while she had been a resident in this facility.R2's EMR lacked documentation that a written baseline care plan was given or reviewed to R2 or a family member since she admitted on [DATE]. On 04/20/26 at 10:28 AM, R11 reported he was uncertain about a baseline care plan and reported he did not receive any paperwork about a care plan.R11's EMR lacked documentation that a written baseline care plan was given or reviewed to R11 or a family member since he admitted on [DATE]. On 04/22/26 at 11:07 AM R4 reported neither she nor her family member received a copy of care plan. R4's EMR lacked documentation that a written baseline care plan was given or reviewed to R4 or a family member since she admitted on [DATE]. On 04/21/26 at 02:52 PM, Licensed Nurse (LN) G reported the charge nurse would start the baseline care plan in the EMR the day the resident was admitted . LN G revealed they would not review or give a written copy of the baseline care plan to the resident or resident's family. On 04/21/26 at 03:30 PM Administrative Nurse F reported that the baseline care plan was completed in the EMR and started on the first day of the admission by the nurse as it was a basic skilled care plan and it would be developed to a personalized care plan. Administrative Nurse F revealed that the facility did not give a copy of the baseline care plan to the resident or resident's family. Administrative Nurse F reported there was no area in the EMR in the teaching section to document that the care plan was reviewed. On 04/22/26 at 02:00 PM, Administrative Nurse D reported the baseline care plan was completed after the initial assessments were completed and reported that the baseline care plan should be documented when reviewed with the resident or family member. The facility's policy Care Plans dated 07/2011, lacked documentation regarding a baseline care plan.

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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, the facility failed to store and label biologicals adequately when staff failed to date an insulin (medications used to treat high blood glucose levels) pen when opened. Findings included:- On 04/21/26 at 09:50 AM, observation of the Resident (R) 1's Lantus (long-acting insulin) pen revealed the pen lacked an open date or the discard date. On 04/21/26 at 09:51 AM, Licensed Nurse (LN) G reported that all insulin pens should be labeled with an opened date and a discard date.On 04/22/26 at 01:15 PM, Administrative Nurse E reported he expected all insulin pens to be labeled with the date it was opened and a discard date. The facility's policy Medication Administration, dated 08/23, documented insulin vials may be kept at room temperature in the patient's medication drawer. Date the vial when it is opened. Insulin is outdated 28 days after being opened.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure Resident (R) 1 received the opportunity to participate in the care planning process when staff failed to invite R1, or their responsible party to care plan meetings. Findings included:- R1's Electronic Medical Record (EMR) revealed diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) and displaced intertrochanteric fracture of right femur (broken bone outside the hip joint). R1's admission Minimum Data Set (MDS), dated [DATE], documented a brief interview for mental status (BIMS) of 15, indicating intact cognition. R1's MDS documented R1 required moderate assistance with activities of daily living (ADLs) and touching assistance with bed mobility and transfers. R1's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA), dated 04/14/26, documented R1 had a left arm sling, right hip fracture, and falls.R1's Care Plan, dated 04/01/26, documented R1 planned to return to care of her husband once she reached her therapy goals and she is safe to go home.R1's Progress Note, dated 04/14/26 at 02:29 PM, documented a care team meeting held with the following staff present: Administrative Nurse E, Administrative Nurse F, Administrative Nurse H, and Consultant Staff HH (Physical Therapy Aide). R1 had a goal of 150 feet and had ambulated 40 feet twice using the hemi-walker. R1 lived with her husband. Discharge plan to home with home health next week Monday or Tuesday. On 04/20/26 at 09:51 AM, R1 reported she had not been invited or attended a care plan meeting about her care or a discharge plan since she admitted at the beginning of the month. On 04/21/26 at 09:30 AM, R1 completed ambulation in the hallway with Consultant Staff HH using a hemi-walker, she wore a gait belt, and her gait was slow and steady. R1 ambulated approximately 75 feet each way with a brief rest period. On 04/21/26 at 03:30 PM, Administrative Nurse F reported that the care plan meeting would consist of Administrative Nurse E, Administrative Nurse H, Consultant Staff HH, and herself. Administrative Nurse F reported that if a resident wanted to attend a care planning meeting they could, and it would be documented if they did attend in the progress notes. Administrative Nurse F reported it would not be documented if the resident or family member was invited if they refused to attend. On 04/22/26 at 02:00 PM, Administrative Nurse D revealed she expected the staff to invite R1 and or the responsible party to a care plan meeting. The facility's policy Interdisciplinary Care Team, dated 06/2011, documented upon admission to the Skilled Nursing Unit the resident and/or family will receive a letter inviting them to the next Interdisciplinary care meeting to discuss comments/concerns regarding the residents' plan of care. The facility's policy Care Plans, dated 07/2011, documented immediately following admission, the resident will be visited by the nurse responsible for developing the Initial nursing care plan. Resident centered interdisciplinary conferences will be held weekly to ensure continuity of the interdisciplinary plan of care and subsequent changes in the care provided by the team members. Goals will be revised as needed.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to notify the State Long Term Care Ombudsman (LTCO) of facility-initiated transfers/discharges for Resident (R) 10 and R3.Findings included:- R10's Electronic Medical Record (EMR) documented R10 discharged home on [DATE]. R3's EMR documented R3 discharged home on [DATE].The facility was unable to provide evidence that the facility notified the LTCO of the residents' transfer/discharge from the facility.On 04/22/26 at 01:00 PM, Administrative Nurse E reported that the facility did not notify the LTCO when a resident was transferred/discharged . The facility did not provide an Ombudsman Notification policy.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to adequately assess Resident (R) 11's present-on -admission pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) at the time of admission and failed to ensure wound treatment orders were obtained and treatments provided.Findings included:- R11's Electronic Medical Record (EMR) revealed diagnoses of weakness, frailty, and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid).R11's EMR revealed no admission [NAME] Data Set (MDS) was completed since R11 admitted on [DATE].R11's Base Line Care Plan, dated 04/17/26, instructed staff to keep skin dry and intact, avoid pressure on skin, and avoid shearing/friction. Collaborate with Dietitian for R11's dietary needs.R11's Physician Orders instructed staff to apply lanolin ointment (moisturize and protect dry, scaly, or cracked skin) one application topically as need for skin irritation, date ordered 04/17/26. R11's Physician Orders lacked documentation for a treatment for the Stage 2 pressure ulcer. R11's Braden Scale (is a standardized, evidence-based tool used to assess a patient's risk of developing pressure injuries), dated 04/17/26, documented a score of 19, which indicated R11 was at low risk. R11's admission Physical Assessment, dated 04/17/26 at 05:33 PM, documented R11 admitted with a Stage 2 pressure ulcer on his sacrum (large triangular bone/area between the two hip bones). The documentation lacked assessment and measurement. R11's Hospitalist History and Physical, dated 04/18/26, documented a pressure ulcer of the sacral region, Stage 1 (pressure wound which appears reddened, does not blanche, and may be painful but is not open). R11's Nursing Shift Assessment, reviewed from 04/17/26 through 04/19/26, documented R11 had a Stage 2 pressure injury on sacrum, provider aware, and sacral adhesive foam. R11's Nursing Shift Assessment, dated 04/20/26 at 06:00 PM, documented R11 had a Stage 2 pressure injury on right buttock, lanolin ointment applied and a foam dressing. R11's Hospitalist Visit, dated 04/21/26 at 12:04 PM, lacked documentation of pressure ulcer. R11's Nursing Shift Assessment dated 04/21/26 at 04:10 PM, documented R11 had a Stage 2 pressure injury on right buttock, measured 1 centimeter (cm) x 0.8 cm wound base beefy red. On 04/20/26 at 02:33 PM, R11 was seated in his chair with his feet up and eyes closed no issues noted.On 04/21/26 at 08:10 AM, R11 was seated up on the side of the bed eating breakfast he had a family member visiting. R11 reported that he slept well and had no concerns. On 04/20/26 03:38 PM, Licensed Nurse (LN) G reported R11 did not have an order in the physician orders for his wound on his right inner buttocks. LN G reported R11's wound should have been measured and documented on when he admitted on [DATE], she also reported an order should have been obtained from the provider. LN G reported the admitting nurse would take a picture of a wound. She reported R11 did not have a picture completed of his pressure ulcer. LN G reported that there were standing orders but could not locate the standing orders for R11's provider and reported that she did observe R11's wound but he refused to have her place a new foam dressing on the area, and she was unable to measure the wound this morning but stated it was approximately 1 cm in length.On 04/22/26 at 08:30 AM, Administrative Nurse E entered R11's room with a high-performance foam dressing and assisted LN G to complete wound care for R11. LN G removed a 7cm x 7cm pink sacral shaped foam dressing off his sacrum that did not cover the open area on right inner buttock. LN G reported that the dressing was not applied the correct way as it did not cover the open area on right inner buttock. Observed a small amount of serosanguinous drainage on his brief, the open area on the right inner buttock was not measured by the nurse or any pictures were taken, the approximate size was 1.5 cm x 1 cm the wound bed was red, and the peri wound was macerated and blanchable. LN G completed wound care and applied the high-performance foam dressing to the open area on the right inner buttock. No open wound was observed on R11's sacrum.On 04/21/26 at 03:30 PM, Administrative Nurse F reported all the nurses would complete (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound care and should document in the EMR the skin concerns should be measured and assessed, and an order should be obtained. Administrative Nurse F reported there were no standing orders for wound care, the provider would just leave that up to the nurse, and generally the nurse would use the lanolin ointment. Administrative Nurse F expected the nurse to complete a weekly note which included measurements and picture of the wound uploaded in the EMR. The facility's policy Skin Assessment (includes Braden Scale)/Wound Prevention/Wound Protocols, dated 11/2023, documented a wound assessment intervention would be documented on by the nurse who first observed any skin impairment, in collaboration with any member of the health care team. Wound treatment would be according to the stage/type of wound. Continuing assessments would be made by nurse and documented daily and with each dressing change. The Physician would be notified when wound therapy was indicated.

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F 0851 Level of Harm - Potential for minimal 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 observation, interview and record review, the facility failed to electronically submit complete and accurate staffing information through Payroll-Based Journaling (PBJ) related to weekend staffing.Findings included - The PBJ Staffing Date Report revealed No RN Hours triggered four or more days within the quarter with no RN Hours. Additionally, the facility failed to have Licensed Nursing Coverage 24 hours/day for four or more days within the quarter for the following timeframes:Fiscal Year (FY) 2026, Quarter 1 2026 (October 1 - December 31). FY Quarter 3 2025 (April 1 - June 30). Review of the Nursing schedule for 04/01/25 - 06/30/25 and 10/01/25- 12/31/25 revealed the facility had 24 hours/day of Licensed Nursing Coverage when the Skilled Nursing Unit was open. On 04/22/26 at 01:33PM, Administrative Nurse D and Administrative Nurse E confirmed the inaccuracies of the PBJ data for the quarters identified above and reported that neither of them had looked at the PBJ reports prior to today and were unsure why the PBJ reports were submitted inaccurately.On 04/22/26 at 02:00 PM Administrative Nurse D stated she expected the PBJ reports to be submitted accurately. The facility's policy Staffing Data Submission Payroll Based Journal, dated 07/2024, documented Section 6106 of the Affordable Care Act (ACA) required facilities to electronically submit direct care staffing information (including agency and contract staff) based on payroll and other auditable data. The data, when combined with census information, can then be used to report on the level of staff in each nursing home, as well as employee turnover and tenure, which can impact on the quality of care delivered. CMS has developed a system for facilities to submit staffing information - Payroll Based Journal (PBJ). This system allows staffing information to be collected on a regular and more frequent basis than previously collected. It is auditable to ensure accuracy. All long-term care facilities have access to this system at no cost.