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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175504	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring View Manor Healthcare and Rehabilitation	412 S 8th Street Conway Springs, KS 67031

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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. The facility reported a census of 40 residents with one kitchen. Based on observation, interview, and record review, the facility failed to provide sanitary conditions for food storage and preparation to prevent the potential spread of foodborne illness to the residents of the facility. Findings included:- Initial tour of the facility kitchen on 03/15/26 at 08:05 AM with Dietary Staff (DS) EE, revealed the following areas of concern:Three open plastic bags of food in the freezer have ice crystals formed directly on the food items inside the bags.One unsealed bag of meat. One package of opened cheese. During an observation on 03/16/26 at 11:17 AM, DS EE checked the dishwasher water temperature with a thermometer. The thermometer recorded the dishwasher's water temperature at 103 degrees Fahrenheit (F). During an interview with DS EE on 03/16/26 at 11:20 AM, DS EE said the water temperature of the dishwasher should be 120 degrees F. to properly disinfect/sanitize dishware/cookware in the dishwasher. During an observation on 03/15/26 at 11:36 AM, DS CC carried a resident's meal plate on a tray. DS CC placed their thumb on the eating surface of the plate as they delivered it to the resident. During an observation on 03/15/26 at 11:37 AM, DS DD carried two resident meal plates on a tray and placed their thumb on the eating surface of the plates as they delivered them to the resident.Review of the Clean Slate Kitchen Service Report dated 01/30/26 revealed the following water temperatures in the dishwasher:Wash Temp 123.0 degrees F.Final Rinse Temp 123.0 degrees F. Review of the Clean Slate Kitchen Service Report dated 02/25/26 revealed the following water temperatures in the dishwasher:Wash Temp 122.0 degrees F.Final Rinse Temp 122.0 degrees F.On 03/16/26 at 11:25 AM, DS BB revealed that the pilot light on the water heater went out at times. DS BB said the staff should monitor the dishwasher water temperatures, and dishes/cookware should not be run through the dishwasher if the water temperature is not at least 120 degrees F. Review of the Dishwashing: Machine Operation Policy/guideline and Procedure Manual dated 2020 revealed it did not include a specific temperature to clean, disinfect, or sanitize kitchen cookware or dishware.

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. The facility reported a census of 40 residents. Based on interview and record review, the facility failed to develop, implement, and permanently maintain an in-service training program for Certified Nurse Aide (CNAs) with the required topics and no less than 12 hours per year for two out of five staff reviewed.Findings included:- On 03/16/26 at 12:44 PM, review of training records for five Certified Nurse Aides (CNAs) employed by the facility for more than one year revealed two CNAs had less than 12 hours of documented in-service training for the previous 12 months. CNA P, with a start date of 12/20/23, had eight hours of documented training, and CNA Q, with a start date of 07/22/24, had seven hours of documented training. On 03/17/26 at 09:18 AM, Administrative Nurse E confirmed that all CNAs were required to have 12 hours of training annually and stated that there were no records of additional training for those CNAs. The facility did not provide a policy.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. The facility identified a census of 40 residents. The sample included 12 residents with three reviewed for Center for Medicare and Medicaid Services (CMS) Beneficiary Lability notices. Based on record review and interviews, the facility failed to provide form CMS-10055 Skilled Nursing Facility (SNF) Advanced Beneficiary Notice of Non-Coverage (ABN- which included the estimated cost for continued services) to the resident or their representative for Resident (R) 6 and R25.Findings included: - R6's Electronic Medical Record (EMR) documented a Medicare Part A episode beginning on 09/18/25 and ending on 10/20/25. R6 remained in the facility for custodial care. R6's EMR lacked evidence that the ABN was provided. Review of the R25's EMR documented a Medicare Part A episode that began on 10/25/25 and ended on 12/24/25. R25 remained in the facility for custodial care. R25's EMR lacked evidence that the ABN was provided. On 3/17/26 at 07:45 AM, Social Service Staff X stated she was not aware she needed to complete and issue the ABN. She reported she discussed this with Administrative Nurse D and started a progress improvement plan. Upon request, the facility was unable to provide evidence that the Form CMS-10055 was provided to R6 and R25. The facility policy Advance Beneficiary Notices reviewed 05/07/25 documented the facility to provide timely notices regarding Medicare eligibility and coverage. The facility shall inform Medicare beneficiaries of their potential liability for payment. A liability notice shall be issued to Medicare beneficiaries upon admission or during the residents' stay before the facility provides an item or service that is usually paid for by Medicare, but may not be paid for in a particular instance because it is not medically reasonable and necessary or custodial care.

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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. The facility reported a census of 40 residents. The sample included 12 residents with four residents reviewed for hospitalization. Based on interview and record review, the facility failed to provide Resident (R) 50 with a written notification of transfer to the resident and/or his representative as soon as practicable and failed to send a copy of that notification to the ombudsman.Findings included:-R50's Electronic Medical Record (EMR) revealed a diagnosis of obesity (excessive body fat), dependence on supplemental oxygen, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and skin cancer. R50's Nurse's Note dated 12/11/25 at 05:34 PM documented R50 was short of breath, coughing up yellow sputum, and had an oxygen saturation (percentage of oxygen in the blood) level of 88 percent (%). New medication orders were given at that time, as well as lab orders and an order for a mobile chest X-ray.R50's Nurse's Note dated 12/11/25 at 06:21 PM documented the nurse left a message for the responsible party that R50 was going to the hospital.R50's Nurse's Note dated 12/11/25 at 06:33 PM documented R50 was leaving with emergency services for the hospital.R50's Nurse's Note dated 12/22/25 at 06:01 PM documented R50 returned to the facility at 11:30 AM and would be receiving skilled therapy services.R50's EMR had a bed hold assessment with a verbal confirmation for R50.R50's EMR lacked documentation of written notification to the resident and/or her representative, which explained the reason for the transfer to the hospital.On 03/16/26 at 8:08 AM, R50 wheeled himself from the dining room to his room. R50 stated he was supposed to sign the bed hold, but they did not give it to him before he left for the hospital.On 03/16/26 at 8:11 AM, Social Service X stated that Social Service Y obtained the bed holds when a resident left the facility. Social Service X was not aware of a letter to the residents or representatives.On 03/16/26 at 8:16 AM, Social Service Y stated she did a verbal bed hold and would get it. Social Service Y was not sure whether to send a letter to the resident or representative or send it to the ombudsman.On 03/16/26 at 2:52 PM, Administrative Nurse E stated the facility has not been sending a notification to the family in writing with the reason for the transfer, nor have they sent it to the ombudsman notification. The facility sent an email one month ago, then not again.The facility's Transfer and Discharge (including AMA) policy dated 07/14/25 documented that a transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided:a. The specific reason and basis for transfer or discharge.b. The effective date of transfer or discharge.c. The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged .d. An explanation of the right to appeal the transfer or discharge to the State.e. The name, address (mailing and email), and telephone number of the State entity that receives such appeal hearing requests.f. Information on how to obtain an appeal form.g Information on obtaining assistance in completing and submitting the appeal hearing request.h. The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care Ombudsman.i. For nursing facility residents with intellectual and developmental disabilities (or related disabilities) or with mental illness (or related disabilities), the notice will include the name, mailing and e-mail addresses, and phone number of the state agency responsible for the protection and advocacy of these populations.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 40 residents and one kitchen. Based on observation, interview, and record review, the facility failed to ensure staff served meals at safe and appetizing temperatures. The facility also failed to follow the recipe of pureed green beans, which altered the nutritive content. Findings Included:- During an observation on 03/16/26 at 11:08 AM, Dietary Staff (DS) EE added tap water to the green beans during the puree process of the green beans. Immediate review of the facility recipe for pureed green beans revealed that if the puree consistency needed to be thinned, the staff were to gradually add an appropriate hot liquid such as broth, gravy, milk, or reserved cooking liquid.During an observation on 03/16/2026 at 11:35 AM, DS EE handed the cooked pureed spaghetti to DS BB, who then took the cooked pureed spaghetti to a resident in the dining room. Upon prompting/request, DS BB obtained a temperature of the pureed spaghetti and reported it was 127 degrees Fahrenheit (F).During an observation on 03/16/26 at 12:01 PM, DS BB delivered a hall meal tray. The hall meal was plated onto a heated covered plate that was transported to room [ROOM NUMBER] in an enclosed insulated food box on a cart. Upon prompting/request, DS BB obtained the temperature of the cooked spaghetti delivered and noted it was 130 degrees F. DS BB then obtained a temperature on the Italian tossed salad at 52 degrees F.During an interview on 03/16/26 at 12:05 PM, Resident (R)7 stated that when the staff served food to R7's room, the food was not hot, but it was kind of warm.During an interview on 03/16/26 11:34 AM, DS EE stated they do not obtain temperatures on cooked food or on cooked pureed food before sending it to the dining room to be served to residents. During an interview on 03/16/26 at 11:50 AM, DS BB stated the facility expected cooked pureed spaghetti to maintain a holding temperature of 135 degrees F or above before serving it to a resident. DS BB stated this ensured the food was not in the danger zone and was at the appropriate safe temperature to prevent foodborne illness.During an interview on 03/16/26 at 12:01 PM, DS BB stated the temperature of the cooked spaghetti should be maintained at 135 degrees or above before serving it, and the Italian tossed salad should maintain a holding temperature of 41 degrees F or below before serving it.The facility's policy Monitoring Food Temperatures for Meal Service guideline and Procedure Manual dated 2020, documented that the serving/holding temperature of a hot food item should be 135 degrees F or higher, and the serving/holding of a cold food item should be at 41 degrees F or below.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. The facility identified a census of 40 residents. The facility identified 10 residents on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record review, observations, and interviews, the facility failed to ensure Resident (R) 37 and R5's nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) masks were stored in a sanitary manner when not in use. The facility also failed to ensure staff wore the required personal protective equipment (PPE) for EBP and sanitized hands when doing direct care.Findings included:-Observation on 03/15/26 at 09:01 AM revealed Certified Medication Aide (CMA) R & Certified Nurse Aide (CNA) N applied gloves but did not perform hand hygiene when entering R8's room. CNA N raised the bed and grabbed the trash can around the rim of the can. CMA R opened R8's incontinence brief and wiped R8's peri area. CNA N took a wipe and wiped R8's peri area. CNA N removed R8's soiled brief and CMA R attached the clean brief. CNA N removed her gloves and washed her hands, while CMA R continued pulling up R8's pants with her soiled gloves. CMA R then removed her gloves and applied a clean pair of gloves without performing hand hygiene. CMA R put on R8's shoes, and both staff assisted R8 to a seated position in bed.On 03/15/26 at 09:33 AM, R37 sat on the recliner next to the window. R37's nebulizer mask lay directly on the bedside table, not in a sanitary container, next to his bed across the room.On 03/15/2026 at 11:53 AM, R5's nebulizer lay directly on her bedside table with a small amount of fluid in the chamber. R5's nebulizer mask was not in a sanitary container. On 03/16/26 at 09:00 AM, Licensed Nurse (LN) G entered R3's room and performed a dressing change on R3's enteral (within or via the small intestine) feeding site. LN G donned and doffed gloves during the dressing change. LN G took gloves from his pants pocket and donned them to complete the dressing change. LN did not don a gown for this direct care. LN G discarded R3's feeding syringe from the container, opened the new syringe from the package, removed the plunger from the new feeding syringe, and then placed the plunger into the soiled container. On 03/16/26 at 01:25 PM, LN G donned gloves, which he removed from his pants pocket, and a gown, then entered R1's room to perform a wound dressing change. LN G left the room to verify R1's treatment order for the dressing change, then returned to R1's room without changing his gloves or performing hand hygiene. He knelt on the floor and removed R1's socks, then left the room to retrieve an item from the treatment cart. LN G assisted R1's roommate, who was in a wheelchair, into the room. Wearing the same gloves, LN G knelt again onto the floor and opened the gauze dressing packages. LN G cleansed the wound with wound cleanser and dried the wound with the gauze dressings. Continuing with the same soiled gloves, LN G applied Skin-prep (liquid skin protectant) around the wound edges, then applied the clean dressing to R1's wound. LN G retrieved a marker from his pocket and dated the new wound dressing.On 03/16/26 at 03:13 PM, Administrative Nurse D stated the nebulizer should be placed in a bag between treatments. On 03/16/26 at 03:55 PM, LN G stated the nebulizer tubing and masks were changed weekly on Sundays. LN G stated the nebulizer should be placed in a bag between treatments. LN G stated he should have worn the right PPE, including a gown, for R3's dressing change. LN G stated he should have cleaned the container prior to placing the syringe plunger into the soiled container and said he should have performed hand hygiene and changed his PPE during R1's wound care.On 03/16/26 at 04:10 PM, Administrative Nurse E, the facility's Infection Preventionist, stated staff should perform hand hygiene between glove changes. She stated that gloves should be changed between soiled and clean. She stated PPE should be worn during any dressing change.The facility's Hand Hygiene policy dated 06/11/25 documented that all staff would perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.The facility's Enhanced Barrier Precautions policy dated 04/01/24 documented that it was the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 40 residents. The sample included 12 residents with five reviewed for immunization status. Based on record reviews, and interviews, the facility failed to offer or obtain informed declinations, consent, or a physician-documented contraindication for the influenza (highly contagious viral infection that attacks the lungs, nose, and throat and can be deadly in high-risk groups) vaccination for Resident (R) 28.Findings included:- On 03/15/26, R28's clinical record revealed he was admitted on [DATE]. The Electronic Medical Record (EM) under the Immunization tab lacked documentation of whether the influenza vaccination was offered or declined, and lacked documentation of a historical administration or physician-documented contraindication. The facility provided a declination for the annual influenza vaccination dated 03/16/26.On 03/16/26 at 03:50 PM, Administrative Nurse E, the facility's Infection Preventionist, stated she was the person responsible for tracking immunizations. She stated she had left a message regarding R28's immunizations with his legal representative. Administrative Nurse E stated the legal representative had declined the influenza vaccination.The facility's Influenza Vaccination policy dated 06/ 11/25 documented it was the policy of the facility to minimize the risk of acquiring, transmitting, or experiencing complications from influenza by offering the residents, staff members, and volunteer workers annual immunization against influenza.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. The facility reported a census of 40 residents. Based on observation, interview, and record review, the facility failed to ensure the posted daily nurse staffing sheets included accurate and identifiable information to include actual staff hours, as required.Findings included:- During an observation on 03/16/26 at 08:36 AM, the daily staffing sheet hung on the wall near the nurse's station. The daily nurse staffing form for 03/16/26 was posted and lacked the actual hours worked per shift for licensed and unlicensed staff providing resident care.On 03/16/26 at 08:35 AM, Licensed Nurse (LN) G stated that the nurse does not change the time or add actual hours on the posted staffing sheet. An example is today, there was a staff member who was late, and he would not write anything on the sheet. The business office will do it later.On 03/16/26 at 08:47 AM, Administrative Nurse E stated she put the staff sheet out, and at the end of the week, the office put actual hours on the sheet. No actual hours are adjusted until then.On 03/16/26 at 12:12 PM, the daily nurse staffing form for 03/16/26 was posted and lacked the actual hours worked per shift for licensed and unlicensed staff providing resident care.On 03/16/26 at 12:12 PM, Administrative Nurse D stated the nurse should put the actual hours on the posted staffing sheet and not wait until the end of the week.The facility's Nurse Staffing Posting Information policy last reviewed on 02/05/25, documented the Nurse Staffing Sheet will be posted on a daily basis and will contain the name of the facility, date, resident census, the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered Nurses, Licensed Practical Nurses/Licensed Vocational Nurses, and Certified Nurse Aides. The facility will post the Nurse Staffing Sheet at the beginning of each shift, and the information shall reflect staff absences on that shift due to call-outs and illness. After the start of each shift, actual hours will be updated.