STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175568	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southwind at Spearville	102 N Pine Street Spearville, KS 67876

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 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 46960 The facility reported a census of 13 residents. Based on interview and record review, the facility failed to conduct criminal background checks for one of three staff members, to ensure no abuse to the residents of the facility. Findings included: - Review of employee files on 03/26/24 at 03:00 PM, revealed a lack of criminal background check for one of three employee records reviewed. Review of Certified Nurse Aide (CNA) G's preemployment screening information with a date of hire of 07/08/22, revealed the file lacked criminal background check information attempted and/or completed by the facility. On 03/26/24 at 03:00 PM, Administrative Nurse B confirmed the lack of criminal background check information for CNA G and stated that she did not know if one had occurred prior or since employment began. Administrative Nurse B stated that criminal background checks should be performed prior to employment offer being extended to prospective employees. The facility's undated Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy documented that the resident abuse, neglect and exploitation prevention program consisted of a facility-wide commitment and resource allocation to conduct employee background checks. The facility failed to conduct a criminal background check. This deficient practice had the potential to negatively affect the care delivered to residents.

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 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** 40801 The facility census totaled 13 residents with 8 residents included in the sample. Based on observation, interview, and record review, the facility failed to revise the care plans for four residents that included Resident (R)5 and R13, related to falls, and R1 and R3 for use of nebulizer equipment (device which changes liquid mediation into a mist easily inhaled into the lungs). Findings included: - Review of R1 signed Physician Orders dated 03/19/24, revealed the diagnosis included chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). Review of the Admission Minimal Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R1 received oxygen (a colorless, odorless reactive gas supporting component of the air). Review of the Care Plan dated 06/23/23, failed to include interventions/staff guidance related to R1's nebulizer treatment for respiratory care. Review of the Physician's Orders dated 06/28/23, included the following: Yupeilri (long-term medication used to treat an ongoing lung disease, chronic obstructive pulmonary disease. It must be used regularly to reduce and prevent symptoms such as shortness of breath, cough, and wheezing) inhalation solution 175 microgram (mcg), three milliliters (ml), inhale orally one time a day. Arformoterol Tartrate (a bronchodilator, relaxing the muscles in the airways to improve breathing) inhalation nebulization solution, 15 mcg/two ml, inhale orally via nebulizer two times a day. Observation on 03/25/24 at 01:04 PM, revealed R1's nebulizer tubing and medication chamber/mouthpiece hung off the bed side cabinet, hooked on a drawer handle. Observation on 03/26/24 at 08:20 AM, R1 was in her room eating breakfast, with oxygen at four liters per nasal cannula. The nebulizer continued to remain stored on the drawer handle. Interview on 03/26/24 at 10:15 AM with Licensed Nurse (LN) C, revealed staff should wash nebulizer chambers and mouthpiece between treatments. R1 has numerous treatments during the day and the nebulizer is not rinsed between the treatments. Interview with LN F on 03/27/24 at 10:30 AM, revealed that the updates on the care plan are wrote on a note and given to the director of nursing to update the care plan or make a revision. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/27/24 at 08:35 AM with Administrative Nurse B, revealed the resident's nebulizers have not been washed and or rinsed after each treatment. Reported the facility would be Implementing that all nebulizers are to be rinsed, air dried, and placed in a bag. The administrative nurse B revealed that she does not know how to update the care plans with the facility's software program. The facility failed to provide a policy regarding Care Plans as requested on 03/27/24. The facility failed to update or revise R1's care plan to reflect the use of a nebulizer. - Review of R3's signed Physician Orders dated on 01/29/24, revealed the following diagnoses included chronic obstruction pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and pleural effusion (abnormal accumulation of fluid in the lungs). Review of the Significant Change Minimal Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of eight, indicating moderate impaired cognition. R3 received oxygen therapy. Review of the Care Plan dated 01/25/24 lacked intervention/staff guidance regarding R3's nebulizer treatments. Review of the Physician's Orders dated 01/25/24 revealed the following orders: Budesonide inhalation suspension, 0.25 milligrams (mg)/2milliliter (ml), one vial, inhale orally, two times a day. Perforomist inhalation nebulization solution, 20 mg/2 ml, one vial, inhale orally via nebulizer, two times a day. Ipratropium-albuterol solution, 0.5 mg/ 3 ml, one vial, inhale orally, every four hours as needed. Observation on 03/26/24 at 10:10 AM, revealed R3 in bed with oxygen on per nasal cannula. Licensed Nurse (LN) C prepared to start R3's nebulizer treatment. Interview on 03/26/24 at 10:15 AM with LN C, revealed staff should wash out the nebulizers in between the treatments R1 has numerous treatments during the day, and the nebulizer is not rinsed between the treatments. Interview with Licensed Nurse LNF on 03/27/24 at 10:30 AM revealed that the updates on the care plan are wrote on a note and given to the director of nursing to update the care plan or make revisions. Interview on 03/27/24 at 08:35 AM with Administrative Nurse B, revealed the nebulizers have not been washed and or rinsed after each treatment. The administrative nurse B revealed that she does not know how to update the care plans with the facility's software program. The facility failed to provide a policy regarding Care Plans as requested on 03/27/24. The facility failed to update or revise R3's care plan to reflect the use of a nebulizer. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Review of R5's signed Physician's Orders, dated 02/04/24, revealed the following diagnosis included Alzheimer's disease unspecified (progressive mental deterioration characterized by confusion and memory failure). Review of the Admission Minimal Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 00, indicating severely impaired cognition. Review of the falls since admission indicated one fall since admission with no major injury. Review of the Care Area Assessment falls, dated 07/13/23 R5 had episodes of weakness, dizziness, and impaired balance. R5 required staff to assist to transfer to a chair. Review of the care plan dated 07/22/23 and revised on 01/16/24, revealed R5 was at risk for falls related to weakness, medication use, and recent falls. R5 had falls on 07/11/23, 09/19/23, and 12/7/23. Review of the care plan lacked no new interventions for falls on 09/23/23 and 12/07/23. Review of the fall reports for 09/19/23, revealed R5 was found on the floor sitting between a small dresser and the bathroom doorway. R5 was unable to voice how he had fallen. The care plan lacked interventions to prevent a further fall. Review of the fall report dated 12/07/23 at 06:20 PM, revealed R5 was found in front of his toilet with no pants on, bowel movement in the stool, and was able to ambulate with a walker. The care plan lacked interventions to prevent a further fall. On 03/25/24 at 11:40 AM, observed R5 in the dining room for lunch, with a walker beside the table. On 03/27/24 at 10:00 AM, observed R 5 ambulating in the commons area with a walker. Interview with Certified Nurse Aide (CNA) D revealed R5 was independent but did require cueing. He is able to go to the bathroom with staff assist. R5 does not use his call light, so staff must check on him frequently. Interview with Licensed Nurse (LN) F on 03/27/24 at 10:30 AM, regrading changes or revisions to the care plan, one would be to changing his toilet routine to prevent falls during the night shift. The staff try to keep him out in the commons area where staff can visualize R5 and keep an eye on him. On 03/27/24 at 08:35 AM, Interview with Administrative Nurse B reported staff should include revisions/ interventions to the care plan to include the falls on R5. The administrative nurse B revealed that she does not know how to update the care plans with the facility's software program. The facility failed to provide a policy regarding Care Plans as requested on 03/27/24. The facility failed to update or revise R5's care plan to reflect the new intervention on falls. 46960 - Review of the Electronic Health Record (EHR) documented R13 had diagnoses which included aftercare following joint replacement surgery. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 01/13/24 Admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of seven, which indicated moderately impaired cognition. R13 required substantial assistance of staff for toileting and dressing but was otherwise independent with cares. R13 had two or more falls in the facility since admission, falls in the month prior to admission, falls in the previous two to six months prior to admission and a fracture (broken bone) in the six months prior to admission. The 01/13/24 Cognitive Loss / Dementia Care Area Assessment (CAA) documented R13 had severe cognitive impairment. The 01/13/24 ADL (activities of daily living such as walking, grooming, toileting, dressing and eating) Functional / Rehabilitation Potential CAA documented R13 was a new admission following hospitalization due to a fall with a fracture of the right femur (thigh bone) with repair and joint replacement. R13 had intermittent confusion with three or more falls in the previous three months. R13 had balance problems when standing and walking with decreased muscle coordination and required maximum assistance for toileting, dressing, transfer and ambulation (walking). R13 used a wheelchair propelled by staff. The 01/13/24 Falls CAA documented R13 had intermittent confusion with three or more falls in the previous three months and was chair bound due to balance problems while standing and walking from decreased muscle coordination. The Care Plan documented R13 was at risk for falls related to confusion and gait (manner or style of walking) and balance problems due to recent right hip replacement and instructed the staff to perform the following interventions: 1. On 01/08/24, staff would anticipate and meet the resident's needs. 2. On 01/08/24, staff would ensure R13's call light was within reach and that R13 required prompt response for all requests for assistance. 3. On 01/08/24, staff would ensure R13 was wearing appropriate footwear when ambulating or self-propelling in the wheelchair. 4. On 01/15/24, staff would place body pillows on both sides of R13's bed when R13 was in bed to define the edges of the bed for R13. 5. On 01/15/24, staff would place R13's four wheeled walker (FWW - a lightweight three-sided structure that aids individuals with balance problems with ambulation) in the middle of the side of his bed facing the bathroom to cue resident to use his walker if R13 got out of bed independently. 6. On 01/15/24, staff would place R13 where he could be quickly visualized by staff and not left alone until his balance and weakness were improved. 7. On 03/17/24, staff would encourage and assist resident to wear non-skid socks at bedtime. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. On 03/18/24, staff would place a video camera on the resident at night, staff were to leave the resident's room door open at night, leave a night light on in R13's room at night, schedule times for staff to go in and assist with toileting and would consider moving resident's room closer to nursing station for easy visualization. The Fall Risk Score Assessments documented between 01/08/24 and 03/18/24 revealed 10 fall risk assessments performed that indicated that R13 was at a high risk for falls. The Progress Notes documented the following: 1. On 01/11/24 at 09:00 PM, an unnamed Certified Nurse Aide (CNA) found R13 on the floor in his room. The care plan lacked an intervention to prevent further falls. 2. On 01/15/24 at 01:45 PM, an unidentified CNA found R13 on the floor in the doorway of his bathroom. 3. On 01/18/24 at 04:15 AM, unidentified staff found R13 on the floor beside his bed. 4. On 02/25/24 at 01:11 AM, (a late entry), that on 02/24/24 at 09:10 PM, unidentified staff found R13 on his bathroom floor in the bathroom shower area. However, the care plan lacked an intervention to prevent further falls. 5. On 03/13/24 at 03:00 AM, R13 fell when he attempted to transfer self to go to the bathroom. However, the care plan lacked an intervention to prevent further falls. 6. On 03/17/24 at 01:41 AM, unidentified staff found R13 on the floor in front of his recliner. R13 reported he lowered himself to the floor when he started to slip. 7. On 03/18/24 at 04:18 AM, unidentified staff found R13 on the floor in his shower. Review of facility's fall investigations revealed the following: 1. On 01/11/24, R13 fell . The facility determined the root cause that the resident was ambulating without assistance and had recently received pain medication and initiated the immediate intervention of placing brightly colored signs to remind the resident to use the call light system for assistance. On 03/27/24 at 10:29 AM, Administrative Nurse B confirmed the care plan lacked an intervention related to this fall to prevent further falls. 2. On 01/15/24, R13 fell . The facility investigation lacked a root cause analysis and staff initiated the immediate intervention of the resident placed for easy visualization for staff. On 03/27/24 at 10:32 AM, Administrative Nurse B confirmed the care plan lacked an intervention related to this fall to prevent further falls. 3. On 01/18/24, R13 fell . The facility investigation determined the root cause to be that resident rolled out of bed since he was unable to determine where the bed edges were, and staff initiated an immediate intervention that resident would be monitored more closely by staff. On 03/27/24 at 10:30 AM, Administrative Nurse B confirmed the care plan lacked an intervention related to this fall to prevent further falls. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 02/24/24, R13 fell . The facility investigation determined the root cause to be that R13 ambulated without assistance to the bathroom and staff initiated the immediate intervention that R13 would always be in sight of staff until R13 was ready for bed. On 03/27/24 at 10:58 AM, Administrative Nurse B confirmed the care plan lacked an intervention related to this fall to prevent further falls. 5. On 03/13/24, R13 fell . The facility investigation determined the root cause to be R13 ambulated without assistance and staff initiated the immediate intervention to reorient the resident to use the call light system for assistance. On 03/27/24 at 11:01 AM. Administrative Nurse B confirmed the care plan lacked an intervention related to this fall to prevent further falls. On 03/27/24 at 09:18 AM, CNA D revealed that cares should be driven by the care plan which is available for staff to view in the EHR in the point of care section. CNA D stated that in the event of a fall, CNA staff were to remain with the resident and use the radio that staff carries for assistance. Upon the arrival of the nurse, CNA staff were to perform whatever tasks were delegated by the nurse. On 03/27/24 at 09:32 AM, CNA F revealed that in the event of a fall, the CNA staff should alert other staff of the fall and then wait with the resident until the nurse arrives, then follow the direction of the nurse. CNA F reported that the cares provided to residents are driven by what's on the care plan, and that the individual care plans are available to view in the EHR, as well as changes that are reported by previous shifts during shift change. On 03/27/24 at 09:42 AM, Licensed Nurse (LN) E defined a fall as a change in the resident's plane (for example, bed to floor, chair to floor or standing to floor). LN E revealed that in the event of a fall, CNA staff were to alert the licensed nurse on duty. The licensed nurse will then respond to the area of the fall and assess the resident for injuries and render aid if needed. CNA staff and licensed nurse would assist the resident back to the bed or the wheelchair or the chair. The licensed nurse on duty was responsible for filling out the fall paperwork which included a root cause analysis to determine if the appropriate safety measures were in place and to develop an immediate intervention to prevent additional falls. The immediate intervention would then be communicated verbally to all the staff on duty. Then the licensed nurse on duty was also responsible to create a permanent intervention to be placed in the resident's care plan binder in the nurses' station. Administrative Nurse B would then transcribe/update the care plan intervention from the binder into the care plan that's in the EHR. On 03/27/24 at 10:06 AM, Administrative Nurse B confirmed LN E's statements and stated that it was her expectation that staff perform those steps. Administrative Nurse B then stated that after a fall report is completed the reports are delivered to her and any needed education is completed as needed and care plan updates are completed at that time. Administrative Nurse B revealed that there was no interdisciplinary team (IDT) meeting or fall huddle that occurred in the facility. Administrative Nurse B confirmed that R13's care plan had not been revised after the falls that occurred on 01/11/24, 01/18/24, 02/24/24 and 03/13/24. The facility failed to provide a policy related to care plan revision as requested on 03/27/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to update the care plan for R13 related to falls and accident hazards. This deficient practice led to additional falls and had the potential for R13 suffering physical and psychosocial injuries.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46960 The facility reported a census of 13 residents with eight residents sampled, which included two residents sampled for accident hazards. Based on observation, interview, and record review, the facility failed to ensure staff provided a safe environment as free of accident hazards as possible for one resident, Resident (R) 13. Findings included: - Review of the Electronic Health Record (EHR) documented R13 had diagnoses which included aftercare following joint replacement surgery. The 01/13/24 Admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of seven, which indicated moderately impaired cognition. R13 required substantial assistance of staff for toileting and dressing but was otherwise independent with cares. R13 had two or more falls in the facility since admission, falls in the month prior to admission, falls in the previous two to six months prior to admission and a fracture (broken bone) in the six months prior to admission. The 01/13/24 Cognitive Loss / Dementia Care Area Assessment (CAA) documented that R13 had severe cognitive impairment. The 01/13/24 ADL (activities of daily living such as walking, grooming, toileting, dressing and eating) Functional / Rehabilitation Potential CAA documented R13 was a new admission following hospitalization due to a fall with a fracture of the right femur (thigh bone) with repair and joint replacement. R13 had intermittent confusion with three or more falls in the previous three months. R13 had balance problems when standing and walking with decreased muscle coordination and required maximum assistance for toileting, dressing, transfer and ambulation (walking) and used a wheelchair propelled by staff. The 01/13/24 Falls CAA documented R13 had intermittent confusion with three or more falls in the previous three months and was chair bound due to balance problems while standing and walking from decreased muscle coordination. The Care Plan documented R13 was at risk for falls related to confusion and gait (manner or style of walking) and balance problems due to recent right hip replacement and instructed the staff to perform the following interventions: 1. On 01/08/24, staff would anticipate and meet the resident's needs. 2. On 01/08/24, staff would ensure R13's call light was within reach and that R13 required prompt response for all requests for assistance. 3. On 01/08/24, staff would ensure R13 was wearing appropriate footwear when ambulating or self-propelling in the wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. On 01/15/24, staff would place body pillows on both sides of R13's bed when R13 was in bed to define the edges of the bed for R13. 5. On 01/15/24, staff would place R13's four wheeled walker (FWW - a lightweight three-sided structure that aids individuals with balance problems with ambulation) in the middle of the side of his bed facing the bathroom to cue resident to use his walker if R13 got out of bed independently. 6. On 01/15/24, staff would place R13 where he could be quickly visualized by staff and not left alone until his balance and weakness were improved. 7. On 03/17/24, staff would encourage and assist resident to wear non-skid socks at bedtime. 8. On 03/18/24, staff would place a video camera on the resident at night, staff were to leave the resident's room door open at night, leave a night light on in R13's room at night, schedule times for staff to go in and assist with toileting and would consider moving resident's room closer to nursing station for easy visualization. The Fall Risk Score Assessments documented between 01/08/24 and 03/18/24 revealed 10 fall risk assessments performed that indicated that R13 was at a high risk for falls. The Progress Notes documented the following: 1. On 01/11/24 at 09:00 PM, an unnamed Certified Nurse Aide (CNA) found R13 on the floor in his room. 2. On 01/15/24 at 01:45 PM, an unidentified CNA found R13 on the floor in the doorway of his bathroom. 3. On 01/18/24 at 04:15 AM, unidentified staff found R13 on the floor beside his bed. 4. On 02/25/24 at 01:11 AM, (a late entry), that on 02/24/24 at 09:10 PM, unidentified staff found R13 on his bathroom floor in the bathroom shower area. 5. On 03/13/24 at 03:00 AM, R13 fell when he attempted to transfer self to go to the bathroom. 6. On 03/17/24 at 01:41 AM, unidentified staff found R13 on the floor in front of his recliner. R13 reported he lowered himself to the floor when he started to slip. 7. On 03/18/24 at 04:18 AM, unidentified staff found R13 on the floor in his shower. Review of facility's fall investigations revealed the following: 1. On 01/11/24, R13 fell . The facility determined the root cause that the resident was ambulating without assistance and had recently received pain medication and initiated the immediate intervention of placing brightly colored signs to remind the resident to use the call light system for assistance. On 03/27/24 at 10:29 AM, Administrative Nurse B confirmed the care plan lacked an intervention related to this fall to prevent further falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 01/15/24, R13 fell . The facility investigation lacked a root cause analysis and staff initiated the immediate intervention of the resident placed for easy visualization for staff. On 03/27/24 at 10:32 AM, Administrative Nurse B confirmed the care plan lacked an intervention related to this fall to prevent further falls. 3. On 01/18/24, R13 fell . The facility investigation determined the root cause to be that resident rolled out of bed since he was unable to determine where the bed edges were, and staff initiated an immediate intervention that resident would be monitored more closely by staff. On 03/27/24 at 10:30 AM, Administrative Nurse B confirmed the care plan lacked an intervention related to this fall to prevent further falls. 4. On 02/24/24, R13 fell . The facility investigation determined the root cause to be that R13 ambulated without assistance to the bathroom and staff initiated the immediate intervention that R13 would always be in sight of staff until R13 was ready for bed. On 03/27/24 at 10:58 AM, Administrative Nurse B confirmed the care plan lacked an intervention related to this fall to prevent further falls. 5. On 03/13/24, R13 fell . The facility investigation determined the root cause to be R13 ambulated without assistance and staff initiated the immediate intervention to reorient the resident to use the call light system for assistance. On 03/27/24 at 11:01 AM. Administrative Nurse B confirmed the care plan lacked an intervention related to this fall to prevent further falls. On 03/27/24 at 09:18 AM, CNA D revealed that cares should be driven by the care plan which is available for staff to view in the EHR in the point of care section. CNA D stated that in the event of a fall, CNA staff were to remain with the resident and use the radio that staff carries for assistance. Upon the arrival of the nurse, CNA staff were to perform whatever tasks were delegated by the nurse. On 03/27/24 at 09:32 AM, CNA F revealed that in the event of a fall, the CNA staff should alert other staff of the fall and then wait with the resident until the nurse arrives, then follow the direction of the nurse. CNA F reported that the cares provided to residents are driven by what's on the care plan, and that the individual care plans are available to view in the EHR, as well as changes that are reported by previous shifts during shift change. On 03/27/24 at 09:42 AM, Licensed Nurse (LN) E defined a fall as a change in the resident's plane (for example, bed to floor, chair to floor or standing to floor). LN E revealed that in the event of a fall, CNA staff were to alert the licensed nurse on duty. The licensed nurse will then respond to the area of the fall and assess the resident for injuries and render aid if needed. CNA staff and licensed nurse would assist the resident back to the bed or the wheelchair or the chair. The licensed nurse on duty was responsible for filling out the fall paperwork which included a root cause analysis to determine if the appropriate safety measures were in place and to develop an immediate intervention to prevent additional falls. The immediate intervention would then be communicated verbally to all the staff on duty. Then the licensed nurse on duty was also responsible to create a permanent intervention to be placed in the resident's care plan binder in the nurses' station. Administrative Nurse B would then transcribe/update the care plan intervention from the binder into the care plan that's in the EHR. (continued on next page)

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	175568	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southwind at Spearville	102 N Pine Street Spearville, KS 67876

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/27/24 at 10:06 AM, Administrative Nurse B confirmed LN E's statements and stated that it was her expectation that staff perform those steps. Administrative Nurse B stated after a resident fell , a fall report would be completed, and the reports delivered to her, and any needed education would be completed, and care plan updates were to be completed at that time. Administrative Nurse B reported the facility did not have an interdisciplinary team (IDT) meeting or fall huddle that occurred. Administrative Nurse B confirmed that the staff did not follow the care plan interventions to prevent additional falls. The facility's undated Accident Prevention policy documented all staff would ensure that each resident's environment remained as free from accident hazards as possible and that each resident would receive adequate supervision and to prevent accidents. The facility failed to ensure staff provided a safe environment as free of accident hazards as possible for R13. This deficient practice led to additional falls and had the potential for R13 suffering physical and psychosocial injuries.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40801 The facility reported a census of 13 residents, with eight residents in the sample and two residents reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to provide necessary respiratory care consistent with professional standards of practice regarding the use of a nebulizer (a device that delivers medication as a mist to the lungs) for Residents (R) 1 and R3. Findings included: - Review of R1 signed Physician Orders dated 03/19/24 revealed the following diagnosis chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). Review of the Admission Minimal Data Set (MDS)dated 06/28/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. R1 received oxygen (a colorless, odorless reactive gas supporting component of the air). Review of the Care Plan dated 06/23/23 failed to include interventions related to use of the nebulizer and/or interventions regarding the care of the nebulizer for R1. Review of the Physician's Orders dated revealed 06/28/23, included the following: Yupeilri (long-term medication used to treat an ongoing lung disease, chronic obstructive pulmonary disease. It must be used regularly to reduce and prevent symptoms such as shortness of breath, cough, and wheezing) inhalation solution 175 microgram (mcg), three milliliter(ml), inhale orally one time a day. Arformoterol Tartrate (a bronchodilator, relaxing the muscles in the airways to improve breathing) inhalation nebulization solution, 15 mcg/two ml, inhale orally via nebulizer two times a day. Observation on 03/25/24 at 01:04 PM, revealed R1's nebulizer tubing and medication chamber/mouthpiece hung off the bed side cabinet, hooked on a drawer handle. Observation on 03/26/24 at 08:20 AM, R1 was in her room eating breakfast, with oxygen at four liters per nasal cannula. The nebulizer continued to remain stored on the drawer handle. Interview on 03/26/24 at 10:15 AM with Licensed Nurse (LN) C, revealed staff should wash nebulizer chambers and mouthpiece between treatments. R1 has numerous treatments during the day and the nebulizer is not rinsed between the treatments. Interview on 03/27/24 at 08:35 AM with Administrative Nurse B revealed the nebulizers have not been washed and or rinsed after each treatment. Implementing that all nebulizers are to be rinsed, air dry and placed in a bag. The facility failed to provide a policy regarding Respiratory Care as requested on 03/27/24. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to provide respiratory care consistent with professional standards of care for R1 regarding the use and cleaning of the nebulizer. - Review of R3 signed Physician Orders dated on 01/29/24 revealed the following diagnoses of chronic obstruction pulmonary disease ((progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and pleural effusion (abnormal accumulation of fluid in the lungs). Review of the Significant Change Minimal Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of eight indicating moderate impaired cognition. R3 receives oxygen therapy. Review of the Care Plan dated 01/25/24 lacked the intervention regarding nebulizer treatments. Review of the Physician's Orders dated 01/25/24 revealed the following orders: Budesonide inhalation suspension, 0.25 milligrams (mg)/2milliliter (ml), one vial, inhale orally, two times a day. Perforomist inhalation nebulization solution, 20 mg/2 ml, one vial, inhale orally via nebulizer, two times a day. Ipratropium-albuterol solution, 0.5 mg/ 3 ml, one vial, inhale orally, every four hours as needed. Observation on 03/26/24 at 10:10 AM revealed R3 in bed with oxygen per nasal cannula, LN C in room preparing to start R3 nebulizer treatment. Interview with Licensed Nurse (LN) C on 03/27/24, revealed staff should wash out the nebulizers in between the treatments R1 has numerous treatments during the day, and the nebulizer is not rinsed between the treatments. Interview on 03/27/24 at 08:35 AM with Administrative Nurse B revealed the nebulizers have not been washed and or rinsed after each treatment. The facility failed to provide a policy regarding Respiratory Care as requested on 03/27/24. The facility failed to provide respiratory care consistent with professional standards of care for R5 regarding the use and cleaning of the nebulizer.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 46960 The facility reported a census of 13 residents. Based on interview and record review, the facility failed to complete an annual performance review at least once every 12 months for three Certified Nurse Aides (CNA) reviewed, to ensure adequate appropriate cares and services provided to the residents of the facility. The facility identified three CNA's employed over 12 month period. Findings included: - Review of employee files on 03/27/24 at 11:40 AM revealed a lack of performance evaluations for three of three records reviewed for CNA D, CNA G and CNA H. On 03/27/24 at 11:40 AM, Administrative Nurse B confirmed the lack of annual performance evaluations. On 03/27/24 at 11:40 AM, Administrative Staff A stated that it was her expectation that either Administrative Staff A or Administrative Staff B perform annual performance evaluations with all staff and confirmed the evaluations were not completed. The facility provided an undated and untitled document that documented that performance evaluations were to be performed at an unknown/undocumented frequency to measure employee's overall effectiveness and to set goals for future performance and professional growth. The facility failed to complete an annual performance review at least once every 12 months for three Certified Nurse Aides (CNA) reviewed, to ensure adequate appropriate cares and services provided to the residents of the facility.

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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. 46960 The facility reported a census of 13 residents. Based on interview and record review, the facility failed to electronically submit complete and accurate staffing information to the federal regulatory agency through Payroll-Based Journaling (PBJ) when the facility failed to accurately submit hourly staffing data for all nursing personnel. Findings included: - Review of the Payroll Base Journal (PBJ) Staffing Data report for the Fiscal Year (FY) report for Quarter 2, 2023 revealed (January 1 - March 31), the data indicated that the facility failed to have Licensed Nursing Coverage 24 hours/Day on the following dates: On 01/01/23, Sunday (SU); 01/07/23, Saturday (SA); 01/09/23, Monday (MO); 01/14/23 (SA); 01/15/23 (SU); 01/20/23, Friday (FR) 01/2;123 (SA);02/04/23 (SA); 02/11/23 (SA); 02/23/23, Thursday (TH); 02/2523 (SA); 02/26/23 (SU); 02/27/23 (MO);03/06/23 (MO); 03/07/23, Tuesday (TU); 03/14/23 (TU); 03/17/23 (FR); 03/18/23 (SA); and 03/25/23 (SA). Review of the PBJ Staffing Data Report for FY for Quarter 3- 2023 (April 1 - June 30), revealed the data indicated that the facility failed to have Licensed Nursing Coverage 24 hours/Day on the following dates: On 04/04/23 (TU); 04/1423 (FR); 04/18/23 (TU); 04/23/23 (SU); 04/24/23 (MO); 04/29/23 (SA);05/07/23 (SU); 05/08/23 (MO); 05/11/23 (TH); 05/20/23 (SA); 05/22/23 (MO); 06/17/23 (SA); 06/24/23 (SA) and 06/30/23 (FR). Review of the PBJ Staff Data Report for FY for Quarter 4 2023 (July 1 - September 30), revealed the data indicated that the facility failed to have Licensed Nursing Coverage 24 hours/Day on the following dates: On 07/04/23 (TU); 07/10/23 (MO); 07/13/23 (TH); 07/17/23 (MO); 07/22/23 (SA); 07/28/23 (FR); 07/31/23 (MO); 08/04/23 (FR); 08/05/23 (SA); 08/07/23 (MO); 08/12/23 (SA); 08/13/23 (SU); 08/17/23 (TH); 08/22/23 (TU); 08/25/23 (FR); 08/31/23 (TH); 09/02/23 (SA); 09/03/23 (SU); 09/04/23 (MO) and 09/08/23 (FR). Review of the nursing schedule and clocking sheets for the above dates revealed adequate hours to account for 24-hour nursing coverage. On 03/27/24 at 11:09 AM, Administrative Nurse B reported that an outside agency contracted by the previous ownership company was responsible for submission of payroll data prior to 11/01/23 and was unable to provide an explanation for inaccurate data. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's undated Mandatory Submission of Uniform Format Staffing Information (PBJ) policy documented that the facility would electronically submit to CMS (Centers for Medicare/Medicaid Services - a federal regulatory agency) complete and accurate direct care staffing information based on payroll and other verifiable and auditable data. The facility administrator was responsible to ensure the submitted data was accurate and timely. The facility failed to submit complete and accurate staffing information to the federal regulatory agency through PBJ when the facility failed to accurately submit hourly staffing data for all nursing personnel.