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	01/29/2026

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 22 residents. Based on observation, interview, and record review, the facility failed to ensure a copy of Resident (R) 17's advanced directive for a Do Not Resuscitate (DNR- or no code, a legal document or order that means the person does not desire CPR in the event of cardiac arrest) was included in the clinical record. Findings included:- R17's Electronic Medical Record (EMR) revealed a diagnosis of atrial fibrillation (rapid, irregular heartbeat). R17's admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. R17's Care Plan, dated [DATE], indicated she chose to be a DNR and the DNR order would be part of the medical record and would be reviewed with the care plan review. R17's EMR documented a physician's order for a DNR dated [DATE]. R17's EMR lacked evidence of the signed DNR document. Observation on [DATE] at 08:10 AM revealed R17 was in the dining room at the table visiting with another resident. On [DATE] at 04:01 PM, Administrative Nurse D said during R17's transfer from the assisted living to the long-term care, her signed DNR did not transfer over into her current chart, Administrative Nurse D stated the facility did not have a process or system in place to monitor or verify changes for advanced directives. The facilities policy Advance Directives, undated, documented it is the policy of this facility to recognize the right of residents and or representative to make informed decision about medical care, including the right to accept or refuse medical treatment. A signed physician's DNR order indicates the physician has discussed the use of cardiopulmonary resuscitation (CPR- an emergency lifesaving procedure performed when the heart stops beating) with the resident/representative to recognize the residents' decisions to refuse CPR. The physician DNR order will be accompanied by supporting documentation in the resident clinical record.

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 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. The facility reported a census of 22 residents and three residents who were cognitively impaired but independently mobile. Based on observation, record review, and interviews, the facility failed to provide a safe environment when the beauty shop, which contained heating devices and chemicals, was left unlocked. Findings included:- On 01/27/26 at 10:06 AM observation revealed the door to the beauty shop was unlocked and open with the following items on the counter: two cans of Clippercide spray (liquid disinfectant chemical), shampoo, hair spray, two curling irons, and an electric razor. Further observation revealed an unlocked cabinet with access to a can of Lysol (spray disinfectant). There were no staff in the beauty shop at the time of the observations. On 01/28/26 at 02:09 PM, Administrative Staff D stated she expected the beauty shop to be closed and locked if there was no one in there. The facility policy Control of Hazardous Chemicals undated the facility is committed to eliminating and controlling hazards that could cause injury or illness to our elder. The facility will meet the requirements of safety standards where there are specific rules about hazards or potential hazards in our facility.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. The facility reported a census of 22 residents. Based on observation, interview, and record review, the facility failed to monitor bowel movements for Resident (R) 4, a resident with a colostomy (surgical creation of an artificial opening on the stomach wall to excrete feces from the body). Findings included:- R4's Electronic Medical Records (EMR), documented diagnoses which included colostomy and obstruction of the intestinal tract. R4's 11/13/2025 admission Minimum Data Set (MDS) documented R4 had a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. R4 had a colostomy bag. R4's Care Plan, dated 05/19/25, documented R4 had dehydration or a potential fluid deficit related to use of a diuretic and the care plan directed staff to monitor and document bowel sounds and frequency of bowel movements. R4's Progress Notes lacked documentation of monitoring of bowel movements. R4's Tasks documented that continence was not rated due to a colostomy. The documentation lacked documentation of amount, frequency, or consistency. On 01/28/26 at 01:00 PM, Certified Nurse Aide (CNA) M emptied the colostomy bag into a plastic trash bag, tied the bag, and threw it away. On 01/28/26 at 01:00 PM, Certified Nurse Aide (CNA) M stated the staff do not monitor, frequency of bowel movements, amount, or consistency. They do not tell the nurse about the bowel movements. CNA M stated that R4 had loose stool. On 01/28/26 at 1:08 PM, Licensed Nurse (LN) G stated the night shift nurse runs a bowel movement report for the residents to check for constipation. The staff did not document or monitor R4's bowel movements. On 01/28/26 at 02:49 PM, Administrative Nurse D stated she expected staff to document and monitor R4's bowel movements. The facility's undated Ostomy (Ileostomy, Colostomy) Care policy documented the stool output, consistency, and color were to be documented in the resident's chart every shift.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 22 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to prevent significant medication errors for Resident (R) 16 who did not receive medications as ordered Additionally, the facility further failed to notify the physician of the error. Findings included:- R16's Electronic Medical Records (EMR), documented diagnoses which included hypertension (HTN-elevated blood pressure) and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid). R16'sQuarterly Minimum Data Set (MDS), dated [DATE], documented R16 had a Brief Interview for Mental Status (BIMS) of 12, indicating moderately impaired cognition. R16 had hypertension and heart failure. R16 took a diuretic (a medication to promote the formation and excretion of urine). R16's Care Plan, dated 08/07/24, documented R16 had hypertension related to lifestyle choices and directed staff to give medications as ordered, monitor R16's blood pressure, and hold medications per parameters set by the physician. R16's Physicians Orders, ordered on 08/12/25, revealed an order for valsartan (an antihypertensive medication) 320 milligrams (mg) one time a day for hypertension. Staff are to notify the physician if the systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) is less than 90 millimeters (mm) of mercury (Hg) or over 180 mm/Hg, diastolic blood pressure (DBP-minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) less than 4 mm/Hg0 or over 100 mm/Hg, or a pulse less than 50 or greater than 110 on two consecutive checks two hours apart. R16's Physicians Orders, ordered on 08/12/25, revealed an order for metoprolol tartrate 50 mg two times a day related to hypertension. Staff are to notify the physician if SBP is less than 90 mm/Hg or greater than 180 mm/Hg; DBP less than 40 mm/Hg or greater than 100 mm/Hg, pulse less than 50 or greater than 110 on two consecutive checks two hours apart.R16's Physicians Orders, ordered 06/25/25, revealed an order for furosemide (diuretic medication) 40 mg one time a day related to hypertension. Notify the physician if SBP is less than 90 mm/Hg or greater than 180 mm/Hg; DBP less than 40 mm/Hg or greater than 100 mm/Hg, pulse less than 50 or greater than110 on two consecutive checks two hours apart. R16's Physicians Orders, ordered 08/13/25, revealed an order for hydrochlorothiazide (diuretic medication) 12.5 mg one time a day related to hypertension. Hold and notify the physician if SBP is less than 90 mm/Hg or greater than 180 mm/Hg; DBP less than 40 mm/Hg or greater than 100 mm/Hg, pulse less than 50 or greater than110 on two consecutive checks two hours apart. R16's Medication Administration Record, reviewed from 11/01/25 to 01/27/26, documented on 01/27/26 that valsartan, metoprolol tartrate, furosemide, and hydrochlorothiazide were not given to R16. R16's blood pressure was 105/45 mm/Hg at that time. R16's Orders - Administration Note on 01/27/26 at 08:47 AM, revealed Certified Medication Aide (CMA) R documented hydrochlorothiazide 12.5 mg was held per nursing judgement. R16's Orders - Administration Note on 01/27/26 at 08:48 AM, revealed CMA R documented furosemide 40 mg was held per nursing judgement. R16's Orders - Administration Note on 01/27/26 at 08:49 AM, revealed CMA R documented metoprolol tartrate 50 mg was held per nursing judgement. R16's Orders - Administration Note on 01/27/26 at 08:49 AM, revealed CMA R documented valsartan 320 mg was held per nursing judgement. On 01/28/26 at 08:42 AM, R16 sat in her wheelchair in her room. Certified Medication Aide (CMA) S entered R16's room and obtained her blood pressure. It was 125/58 mm/Hg. CMA S then gave R16 her blood pressure medications. On 01/27/26 at 04:45 PM, CMA R stated that she took R16's blood pressure and it was about 111/49 mm/Hg. CMA R stated she rechecked it and the bottom number was still in the 40's, so she told the nurse and the nurse said to hold the medications. On 01/27/26 at 04:47 PM, Licensed Nurse (LN) H stated she did tell the CMA to hold the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications because R16's blood pressure was low. LN H confirmed she did not notify the physician. On 01/28/26 at 02:49 PM, Administrative Nurse D stated that the CMA notified the nurse of the low blood pressure, and the nurse used her nursing judgement to tell the CMA to hold the medication. Administrative Nurse D said LN H did not notify the physician because the blood pressure was not in the parameters to notify the provider. The facility's undated Medication Administration Policy documented medications shall be administered in a safe method as ordered by the physician.

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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 22 residents and one main kitchen. Based on observation, record reviews, and interviews, the facility failed to prepare and serve food under sanitary conditions to prevent potential for food borne bacteria. Findings included:- On 1/28/26 at 11:50 AM observation during the noon meal revealed Dietary Staff CC wore gloves. She picked up the plates, removed the lid to the roasting pan, and used utensils for the meat, potatoes, and spinach. Wearing the same gloves, she picked up the roll with her gloved hand. She touched her face and glasses then, without removing her gloves and washing her hands, she continued the plating process. In an interview on 01/28/26 at 12:15 PM, Dietary Staff CC stated she had been trained to serve that way. She stated she typically would change her gloves about three times during the process. On 01/29/26 at 08:16 AM Dietary Manager BB said she would re-educate her staff regarding the serving process and not touching their face and glasses without washing their hands and changing gloves. The facility's policy on Food Preparation and Handling: Hand Hygiene Policy for all food handlers, hands must always be washed in designated hand washing sinks. Gloves would be worn when serving residents who are on transmission-based precautions but do not need to wear gloves when distributing foods to residents at dining tables or when assisting residents to dine unless they are touching ready to eat food. Staff will perform hand washing prior to disturbing meals.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. The facility had a census of 22 residents and identified 22 residents with signed arbitration agreement and no residents in active arbitration. Based on record review and interview, the facility failed to ensure the arbitration agreement contained the required language to notify the residents or representatives of their right to rescind the agreement within 30 days of signing and failed to ensure the Arbitration agreement notified the residents or representatives that signing the agreement is not a requirement of admission. Findings included:- The admission Packet contained Exhibit E Arbitration Provision. Review of the provision revealed it lacked notification to the residents or representatives of their right to rescind the Abirritation Provision within 30 days of signing. The provision also lacked notification to the residents or representatives that signing the agreement is not a requirement of admission. On 01/28/26 at 04:13 PM, Administrative Staff B stated the Abirritation Provision provided with the admission Packet was all which was provided about the agreement. She stated she did explain the agreement to new admits when they signed it. On 01/29/26 at 11:23 AM, Administrative Nurse D stated the previous company which ran the facility wrote the Arbitration Provision. The current board of directors and the administrator might have changed it a bit. Administrative Nurse D was not aware of the language required to be in the Arbitration Provision. On 01/29/26 at 11:24 AM, Administrative Staff A stated the facility followed whatever the admission Agreement says about the Abirritation Provision. Administrative Staff A was not aware of the items which were required to be in the Arbitration Provision and said she would get it corrected immediately.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide a neutral and fair arbitration process and agree to arbitrator and venue. The facility had a census of 22 residents and identified 22 residents with signed arbitration agreement and no residents in active arbitration. Based on record review and interview, the facility failed to ensure the arbitration agreement provided for the selection of a neutral arbitrator agreed on by both parties and for selection of a venue convenient to both parties. Findings included:- The admission Packet contained Exhibit E Arbitration Provision. Review of the provision revealed it lacked notification to the residents or representatives of their right for the selection of a neutral arbitrator agreed on by both parties and for the selection of a venue convenient to both parties. On 01/28/26 at 04:13 PM, Administrative Staff B stated that the Abirritation Provision provided with the admission Packet was all that was provided about the agreement. She stated she did explain the agreement to new admits when they signed it. On 01/29/26 at 11:23 AM, Administrative Nurse D stated the previous company that ran the facility wrote the Arbitration Provision, and the current board of directors and the administrator might have changed it a bit. Administrative Nurse D was not aware of the language required to be in the Arbitration Provision. On 01/29/26 at 11:24 AM, Administrative Staff A stated the facility followed whatever the admission Agreement says about the Arbitration Provision. Administrative Staff A was not aware of the items that were required to be in the Arbitration Provision and said she will get it corrected immediately.