

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2025
NAME OF PROVIDER OR SUPPLIER Spring Hill Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 251 E Wilson Avenue Spring Hill, KS 66083	

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility identified a census of 35 residents. The sample included three residents, with three residents reviewed for notification of changes. Based on observation, record review, and interviews, the facility failed to notify Resident (R) 1's representative of changes in condition, plan of care changes, and results. This deficient practice placed R1 at risk for further decline and a delay in treatment. Findings included:- R1's Electronic Medical Record (EMR) documented diagnoses of generalized muscle weakness, difficulty in walking, and hemiplegia and hemiparesis (weakness and paralysis on one side of the body) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). The Annual Minimum Data Set (MDS), dated 06/19/25, documented R1 had a Brief Interview for Mental Status (BIMS) score of seven, which indicated severe cognitive impairment. The Cognitive Loss/Dementia (a progressive mental disorder characterized by failing memory and confusion) Care Area Assessment (CAA), dated 07/09/25, documented R1 had some cognitive loss and was at risk for impaired memory and difficulty with communication. R1's Care Plan dated 08/12/24, documented R1 had a communication problem related to minimal hard of hearing in bilateral ears. The plan directed staff to anticipate and meet R1's needs and discussed with the resident/family any concerns or feelings regarding his communication difficulty. R1's EMR revealed the following: A Durable Power of Attorney (DPOA- a legal document that names a person to make healthcare decisions when the resident is no longer able to) for Health Care Decisions General Statement of Authority Granted signed and executed on 08/23/24 that documented R1's representatives were effective as DPOA effective immediately and were not affected by R1's subsequent disability or incapacity or upon the occurrence of his disability or incapacity. A Nursing: Progress Note on 03/27/25 at 02:26 PM, documented the Certified Nurse Aide (CNA) notified the nurse that R1 reported he broke his tooth while eating lunch. The nurse assessed R1, and his bottom middle tooth was broken with only a small amount of tooth remaining. R1 reported he broke his tooth while biting into a pork chop. The nurse informed the dietary manager of the incident and Social Services X about needing to make R1 a dentist appointment. A Nursing: Progress Note on 04/16/25 at 11:01 AM, documented during a post follow-up, R1 reported right shoulder pain. The facility received an order for a two-view x-ray of his right humerus (upper arm bone) and a two-view x-ray of his right shoulder. A Nursing: Progress Note on 04/17/25 at 12:35 PM, documented the facility had notified the provider of R1's x-ray results. R1's right shoulder results documented the findings were compatible with a chronic right rotator cuff (a group of muscles and tendons that hold the shoulder joint in place and allow you to move your arm and shoulder) tear. R1's right humerus results were unremarkable. A Nursing: Progress Note on 04/24/25 at 06:10 PM, documented the facility received an order to obtain a three-view right shoulder x-ray for pain and mobility limitations. The facility notified R1 of the new order. A Nursing: Progress Note on 04/25/25 at 09:55 AM, documented the facility received the results of the x-ray and sent the results to the provider. The X-ray results likely reflect chronic rotator cuff pathology. A Nursing: Progress Note on 04/25/25 at 12:40 PM, documented the facility received an order to obtain an orthopedic (pertaining to bones) evaluation for a possible arthroscopy (surgery performed for the examination of the interior of a joint). A Social Services: Note on 05/08/25 at 04:40 PM, documented R1 was scheduled for a dentist appointment due to a broken tooth. Social Services X notified R1, nursing, and transportation. A Nursing: Progress Note on 05/23/25 at 11:24 AM, documented R1 had an occasional cough with a minimal amount of white, frothy sputum (a mixture of saliva and mucus coughed up from the respiratory tract). R1's provider ordered laboratory tests, a chest x-ray, Lasix (diuretic medication- a medication to promote the formation and excretion of urine) 40 milligrams (mg) twice daily for five days, then resume 40 mg daily, and weigh R1 daily for the next seven days. A Nursing: Progress Note on 05/23/25 at 03:24 PM, documented the facility notified R1's provider of laboratory results and waited for the x-ray results. A Nursing: Progress Note on 05/23/25 at 07:46 PM, documented the facility notified R1's provider of the chest x-ray results and received no new orders. A Nursing: Progress Note on 06/15/25 at 07:29 PM, documented the facility received orders from neurology (a branch of medicine that deals with the diagnoses and treatment of disorders in the nervous system) for memantine (medication used to treat the symptoms of Alzheimer's [progressive mental deterioration characterized by confusion and memory failure] disease) five mg twice daily for dementia and start physical therapy (PT) for balance. The facility notified R1 of the orders and received consent to update his plan of care. There was a lack of documentation that R1's representative was notified of the changes in condition, new orders, and/or results.</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>(continued on next page)</p>

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility identified a census of 35 residents. The sample included three residents, with three residents reviewed for dental services. Based on observation, record review, and interviews, the facility failed to obtain emergency dental services for Resident (R) 1 after he broke a tooth on 03/27/25. This deficient practice had the risk of dental pain, difficulty eating, and unnecessary physical complications for R1. Findings included:- R1's Electronic Medical Record (EMR) documented diagnoses of generalized muscle weakness, difficulty in walking, and hemiplegia and hemiparesis (weakness and paralysis on one side of the body) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). The Annual Minimum Data Set (MDS), dated 06/19/25, documented R1 had a Brief Interview for Mental Status (BIMS) score of seven, which indicated severe cognitive impairment. The Cognitive Loss/Dementia (a progressive mental disorder characterized by failing memory and confusion) Care Area Assessment (CAA), dated 07/09/25, documented R1 had some cognitive loss and was at risk for impaired memory and difficulty with communication. R1's Care Plan, dated 08/12/24, documented R1 had oral/dental health problems related to missing/broken teeth. The plan directed staff to coordinate arrangements for dental care and transportation as needed. R1's EMR revealed the following: A Nursing Note on 03/27/25 at 02:26 PM, documented the Certified Nurse Aide (CNA) notified the nurse that R1 reported he broke his tooth while eating lunch. The nurse assessed R1, and his bottom middle tooth was broken with only a small amount of tooth remaining. R1 reported he broke his tooth while biting into a pork chop. The nurse informed the dietary manager of the incident and Social Services X about needing to make R1 a dentist appointment. A Nutrition: Nutrition Note on 03/27/25 at 04:30 PM, documented the dietary manager interviewed R1 regarding the incident at lunch, where R1 had a partial loss of tooth after eating a pork chop. R1 stated he cut a strip of pork chop off and put it in his mouth, then bit it with his front teeth. He stated he heard a pop, began to chew, and felt the tooth on his tongue. No bleeding occurred, and R1 reported minimal pain. The dietary manager followed up with the charge nurse to confirm findings. There was a lack of evidence that the facility made an emergency dental appointment for R1's broken tooth between 03/27/25 and 05/07/25. A Social Services: Note on 05/08/25 at 04:40 PM, documented R1 was scheduled for a dentist appointment due to a broken tooth. Social Services X notified R1, nursing, and transportation. A Social Services: Note on 07/21/25 at 01:43 PM, documented R1 was having tooth pain, and his representative wanted R1 to be scheduled for the first available appointment by the dentist. R1's appointment is scheduled for tomorrow. Social Services X notified R1, his representative, nursing, and transportation. Upon request, the facility provided a Care Note Summary, dated 05/13/25, from R1's dental visit on 05/13/25. The summary documented R1 had a broken tooth without pain and a recommendation for full mouth endentulation (loss of teeth) and fabrication of complete dentures. On 07/22/25 at 12:47 PM, R1 sat in the recliner in his room and ate lunch. He stated he broke a tooth a while ago, but did not see the dentist until May. On 07/22/25 at 02:03 PM, R1 stated he did not have any dental pain from the broken tooth until recently, but he had difficulty eating food. He stated there was a small piece of tooth left over that came out later. On 07/22/25 at 12:59 PM, Licensed Nurse (LN) G stated if a resident had dental pain or a broken tooth, she would notify the doctor, the family, and her supervisor. She stated the facility had an in-house dentist who visited, but if a resident needed in sooner, she notified the doctor for a dentist referral if needed. On 07/22/25 at 01:12 PM, Social Services X stated the dentist visited the facility every six months, and a dental hygienist visited in between. She stated if a resident had an acute dental issue, the facility sent them to an outside dentist, depending on their preference. Social Services X stated R1 broke a tooth towards the beginning of April and saw the dentist in May for a basic exam. She stated the dentist said they would forward the information on to R1's representative for next steps, but the facility never heard anything else. Social Services X stated she was notified yesterday that R1 had dental discomfort with eating, and he was scheduled with the dentist for today. She stated she communicated with R1's representative after his tooth broke about getting him seen by the dentist, and R1's representative first told her to find a dentist that accepted R1's insurance. Then she told Social Services X that R1 would see the in-house dentist. Social Services X stated that normally, she documented all family communication and attempted communication in the EMR. On 07/22/25 at 01:44 PM, Administrative Nurse D stated R1 had a broken tooth and was sent to the dentist in May. She stated the facility did not receive any paperwork back from the dentist in May, but he went to the dentist today and was told he needed his teeth pulled for dentures. Administrative Nurse D stated</p>		