STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175425	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Hill Care and Rehab	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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 29 residents, including three residents sampled for abuse. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 1 remained free from staff-to-resident abuse on 10/11/25, when Certified Nurse Aide (CNA) M verbally, mentally, and physically abused R1. This deficient practice placed R1 in immediate jeopardy.Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of displaced fracture (traumatic bone break where two ends of the bone separate out of their normal positions) of the first cervical (neck) vertebra (bone of the spinal column), bilateral hearing loss, dementia (a progressive mental disorder characterized by failing memory and confusion), and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness).The admission Minimum Data Set (MDS) dated [DATE], documented R1 had moderate hearing difficulty. R1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. R1 had no behaviors. R1 required partial or moderate assistance with sitting to standing, chair/bed-to-chair transfers, and toilet transfers. The Quarterly MDS dated [DATE], documented R1 had a BIMS score of 14, which indicated intact cognition. R1 had no behaviors. R1 had impairment on both sides for upper and lower extremities. R1 required substantial or maximal assistance with sitting to standing, chair/bed-to-chair transfers, and toilet transfers. The ADL (Activities of Daily Living) Functional / Rehabilitation Potential Care Area Assessment (CAA) dated 02/19/25, revealed R1 required assistance of one staff for all activities of daily living and transfers.The Communication CAA dated 02/19/25 revealed R1 had moderate hearing loss, made her needs known, and she understood others.The 07/21/25 Care Plan revealed R1 had a communication problem related to bilateral hearing loss and included the following staff interventions:07/21/25- Staff encouraged R1 to state her thoughts even if R1 had difficulty.07/21/25- Staff provided a safe environment for R1, kept R1's call light within reach, and provided R1 with adequate low glare light.The 07/21/25 Care Plan revealed R1 had an ADL self-care performance deficit related to impaired balance and included the following staff interventions:07/21/25- Staff provided one assistance to R1 for transfers.07/21/25- Staff encouraged R1 to use her bell to call for assistance.R1's EMR revealed the following: An admission Note on 08/14/25 at 06:29 PM documented R1 returned from an acute hospital stay. R1 had a hard cervical collar in place. R1's speech was difficult to understand. A Progress Note on 08/17/25 at 07:00 AM documented R1 had a fall which resulted in a C1 (first cervical vertebra) fracture. The plan directed staff continued R1's cervical collar immobilization. A Nursing: Progress Note on 10/12/25 at 04:45 AM documented staff observed R1 raising her recliner and almost falling out of it while trying to self-transfer. Staff educated R1 on the importance of the call light button for safety. R1 became upset from being monitored on the camera. R1 blocked her doorway when staff summoned additional help. R1 started to hit, kick, scratch, pull, and grab staff. Staff helped remove R1's hands from the other staff. Staff assisted R1 to her recliner and later requested to sit at the nurse's station. A Progress Notes note on 10/13/25 at 07:00 AM documented R1 had a cervical spine collar in place. R1 had an episode of aggressive (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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	behaviors the past weekend which was unlike her. Staff expressed concerns R1 might have had a urinary tract infection (UTI- an infection in any part of the urinary system) but she remained afebrile (without a fever), had no urinary symptoms, and had the one isolated incident. R1 recalled the event very well and she reported being very angry. A Progress Notes note on 10/20/25 at 07:00 AM documented R1 continued to have a cervical spine fracture for which she wore a collar. The plan included the following: R1 continued cervical spine collar use, R1 had repeat cervical spine imaging scheduled that week, and the facility was to coordinate with orthopedic (pertaining to bones) spine specialists regarding R1's collar discontinuation timing.A Nursing note on 10/23/25 at 03:59 PM documented R1 saw the orthopedic provider and received instructions to wear the cervical collar during all of R1's physical therapy exercise. R1 should be conservative with her neck movements for an additional six to eight weeks. Orthopedics released R1 from their services.The facility's Investigation dated 10/24/25 documented on 10/20/25 at approximately 10:00 PM, R1's representative sent Administrative Nurse D video recordings from 10/11/25. Upon review of the video footage, Administrative Nurse D observed an altercation between CNA M and R1. At 02:54 AM, R1 sat in her recliner, holding her remote. At 02:57 AM, CNA M entered R1's room and stated they were done with R1 pushing the call light. R1 responded it was her right. The video showed R1 attempted to keep her blanket on and hold onto her chair remote while CNA M assisted her with putting on her shoe. CNA M instructed R1 to leave the remote alone and when R1 did not release the remote, CNA M appeared to attempt to take the remote from her forcefully. R1 responded by kicking towards CNA M then CNA M told R1 Do not kick me, stop. CNA M held onto R1's leg. She released R1's leg but continued to retrieve the remote, stating they had the right to do that. R1 responded they did not have the right, to which CNA M stated Yes she did. R1 leaned forward as though she might bite CNA M, then CNA M told to R1 to bite her, she was done. R1 bit CNA M's shoulder and CNA M yelled R1 stop your biting, that hurt. The exchange continued until LN G and CNA M assisted R1 to stand and escorted her to the nurse's station. During the course of the incident, CNA M demonstrated verbally aggressive behavior toward R1. In several instances, CNA M's tone and language appeared confrontational. Additionally, there were moments in the recordings that suggested potential physical aggression toward R1 as CNA M's actions appeared forceful while attempting to remove the remote from R1's grasp. On 10/20/25 at approximately 11:20 PM, the facility notified law enforcement. Following the facility's internal investigation and review of the video evidence, the facility terminated CNA M's employment on 10/21/25 at 01:30 PM. The facility conducted abuse, neglect, and exploitation (ANE) training with all staff after the incident to reinforce proper resident rights, communication standards, and intervention procedures in accordance with the facility's policy and state regulations. CNA N's notarized Witness Statement dated 10/21/25, stated on 10/11/25 at approximately 02:00 AM, R1 called many times that night and CNA M seemed frustrated. She stated she and CNA M went into R1's room, and CNA M raised her voice at R1 and told R1, she (R1) was going out to the nurse's station. CNA N stated R1 refused, and CNA M continued to try and get R1 out of her chair. R1 bit CNA M on the shoulder and CNA M screamed ouch that hurt. CNA N stated CNA M pulled back. CNA N stated she was going to step in, but she was afraid to get into trouble. She stated LN G entered R1's room to find out what happened. CNA N stated R1 ended up going out of her room and sleeping in a recliner.LN G's notarized Witness Statement dated 10/21/25, stated on 10/11/25 at approximately 02:00 AM, CNA M complained that R1 bit her and CNA M stated she was done with R1. LN G stated CNA M yelled at R1, and she did not intervene because she did not consider the behaviors abuse. LN G stated CNA M should have taken a time out and not have raised her voice at R1.Review of the video recordings revealed on 10/11/25 from 02:57 AM to 03:01 AM R1 sat in her recliner with her legs reclined and a blanket on her. R1 wore a cervical neck brace. CNA M walked into R1's room and asked, What do you want [R1]? R1's response was unintelligible. CNA M stated to R1, Huh? CNA M grabbed the recliner remote and started sitting R1 up in the recliner. R1 stated to CNA M, I didn't call you. CNA M stated to R1, Okay, well you're going up front. R1 responded but some of her response was unintelligible. R1 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stated again, I didn't call you. R1 tugged on the recliner remote cord. CNA M stated to R1, Stop. We have the right to do this. R1 responded to CNA M, You don't have no. and the rest was unintelligible. CNA M stated to R1, Yes, I do. R1 responded to CNA M again, You don't have no. and the rest was unintelligible. CNA M stated to R1, Well, we're done with you pushing the light and everything and saying stuff. R1's response was unintelligible. R1 grabbed the recliner remote cord and stated to CNA M, No, I need the light. CNA M stated to R1, Quit. Quit! CNA M grabbed the remote cord further down, closer to R1's hand on the cord and R1 let go of the cord. CNA M pulled the blanket off of R1. CNA M moved the remote under R1's right arm and hung the remote off the right side of the recliner. CNA M grabbed a shoe from R1's wheelchair seat, located to the left of the recliner, and started putting the shoe on R1's left foot. R1 reached beside her to the right and grabbed the recliner remote cord and pulled on the cord. CNA M stated to R1, Leave it alone. CNA M grabbed the remote with her right hand while R1 continued to hold it in her right hand, both tugged on the remote. CNA M stood to the left side of R1's legs and held onto the recliner remote. R1 grabbed CNA M's left wrist with her left hand while her right hand remained on the recliner remote. CNA M pulled R1's right hand off of the recliner remote. R1 continued to hold onto CNA M's left wrist with her left hand. CNA M stated to R1, Leave it alone. [R1]. No! R1's response was unintelligible. CNA M stated to R1, You are going up front, I am not playing your games. R1's response was unintelligible. R1 leaned forward towards CNA M's right arm. CNA M leaned in towards R1's face and stated to her, Bite me. I'm done. R1 leaned forward and bit CNA M's right shoulder. CNA M jerked upward and rapidly pushed her right forearm towards R1's head while yelling, OW! R1's head and neck, wearing her cervical neck brace, bounced off of the recliner (head rest). CNA M held onto R1's right hand and leaned it towards R1's upper body while she yelled at R1, [R1], stop your biting. CNA M continued to hold onto R1's right hand and moved R1's hand to the right and yelled loudly into R1's face, That hurt. There's no sense in that. Why did you bite me? Why? R1's response was unintelligible. CNA M stated, Well, you are pushing the light, and we can't get nothing done when you're doing that [R1]. R1's response was unintelligible. CNA M talked over R1 and chastised her, CNA M stated to R1, You're acting like a two-year-old.Review of the EHR and facility provided information revealed the facility staff did not report the incident to Administrative Staff.Review of CNA M's timesheet revealed CNA M continued to work with residents after this incident on the following dates:On 10/10/25 at 06:45 PM through 10/11/25 at 07:09 AM, with a lunch break.On 10/11/25 at 06:48 PM through 10/12/25 at 07:02 AM, with a lunch break.On 10/12/25 at 06:54 PM through 10/12/25 at 11:32 PM.On 10/27/25 at 03:14 PM, R1 sat in her wheelchair in the meeting room. She stated she remembered the incident from a couple weeks ago when she wanted to go to the bathroom and CNA M told her she had to go with her. R1 stated she told her no and CNA M tried to get her up to go to the nurse's station and R1 stated she did not want to get up. R1 stated CNA M yelled loudly at her and said she did not want to play that game anymore. R1 became occasionally difficult to understand but she answered questions appropriately when she was directly asked. R1 stated CNA M made her feel bad and she fought back against CNA M. R1 stated she felt very scared of CNA M when CNA M yelled at R1, and felt CNA M acted abusively towards her. R1 started to cry and became visibly shaken when recounting the incident on 10/11/25 involving CNA M. R1 became difficult to understand when she was upset. On 10/27/25 at 01:04 PM, R1's representative stated she was out of the country during the incident and when she returned, she received a call from the facility reporting something happened with R1. She stated she looked back at the videos and the incident was something else than what was reported to her. R1's representative stated R1 reported to her that the staff ganged up on her and tried to tell R1 what to do. She stated R1 became hard to understand and she looked at the videos. On 10/27/25 at 01:24 PM, R1's representative stated at the time of the incident on 10/11/25, R1 wore a neck brace. She stated the camera that faced the bed showed her recliner and the video showed the CNA pushed R1's head. R1's representative reported R1's neck was healed about 50% and R1 only wore the neck brace during therapy now.On 10/27/25 at 01:53 PM, CNA O stated if she witnessed a staff member getting frustrated with a resident, she asked (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	them to step out. She stated if a resident became agitated with her, she asked another CNA to approach the resident. CNA O stated she did not try to force anything, and she reapproached the resident to give them the care they needed. She stated R1 became harder to understand when she became impatient with staff. She stated as long as staff did not rush R1, she remained calm. CNA O stated R1 stayed up most of the night and pushed the call light often. She stated she asked R1 what else she needed help with prior to leaving her room to help R1 not push the call light as often. CNA O stated if she saw staff forcing a resident to do something or becoming verbally aggressive towards a resident, she stepped into the situation and would ask that staff member to step out. She stated she reported staff altercations with residents including verbal altercations, immediately to the nurse or to Administrative Nurse D. She stated Administrative Nurse D told her if she even questioned a situation, to report it to her.On 10/28/25 at 02:32 PM, CNA M stated R1 sat in her recliner at night, and she kept sitting the recliner up where she could have slid out of the recliner. She stated she asked R1 to put her chair back down but R1 would not listen, and she kept moving the recliner up and down. CNA M stated she told R1 she had to put her call light on for help so she would not fall and R1 said she did not have to put the call light on. She stated on 10/11/25, she leaned forward so she could see R1 face to face because R1 got drowsy at night. She stated she bent down to talk to R1 and R1 started getting testy with CNA M and R1 leaned forward a little bit. CNA M stated she told R1 not to bite her and when CNA M leaned up to try and help R1, R1 bit CNA M on the shoulder. She stated R1 did not want to get up to go to the nurse's station, but Administrative Nurse D told CNA M if R1 did not sit still staff brought her to the front, even if she did not want to go. CNA M stated she had a loud voice and to anybody watching the video, they would think she yelled at R1. On 10/28/25 at 05:19 PM, CNA N stated she vaguely remembered what happened on 10/11/25 as it was her first day. She stated she recalled that R1 called quite a bit and CNA M seemed frustrated. CNA N stated CNA M told her that Administrative Nurse D said if R1 kept calling then R1 had to go out to the living room for staff to watch her. She stated CNA M was very forceful and very verbally aggressive. CNA N stated CNA M went to pick R1 up and wrapped her arms around R1 when R1 bit CNA M on the shoulder. She stated CNA M screamed and stated ow [R1] that hurt. CNA N stated R1 made it clear she did not want to get up and she did not want to leave her room. She stated CNA M's actions made her very uncomfortable. CNA N stated she did not report it because she had a history at other jobs where she expressed concerns and got into trouble. CNA N stated LN G did go into R1's room to figure out what happened. She stated R1 had behaviors the next night too and CNA M got into R1's face to ask what was going on and R1 scratched CNA M. CNA N stated she thought R1 continued to be upset with CNA M from the night before. On 10/27/25 at 02:16 PM, LN H stated if she saw staff getting frustrated with a resident, she pulled the staff member away and told them to take a break or a breather. She stated she provided support to staff and offered to help if needed. LN H stated if she saw a resident escalated or became agitated with staff, she intervened right away. She stated if a resident did not want to do something, she reapproached them later, tried a different approach, or had another staff member approach the resident. LN H stated she did not force a resident to get up or pull remotes out of their hands. She stated if she witnessed a CNA do that, she would immediately pull the CNA out of the resident's room. She stated she reported verbal abuse as staff were not allowed to raise their voices at residents or speak to them in a derogatory manner. She stated she reported abuse immediately to Administrative Nurse D. LN H stated R1 did not like to wait if staff helped other residents and sometimes LN H had to pull staff from the other hall to help R1. She stated R1 became anxious and tearful and when that happened, she had a meltdown and became hard to talk to. LN H stated at the time of the incident on 10/11/25, R1 wore the cervical neck brace all the time except when she took it off herself.On 10/28/25 at 05:17 PM, LN G was unavailable for interview. On 10/27/25 at 12:51 PM, Administrative Nurse D stated LN G stated to her that she did not consider CNA M's actions on 10/11/25 to be abuse but looking back on the situation, LN G stated she should have intervened. Administrative Nurse D stated CNA N stated to her that she was scared to report (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA M's actions because she did not want to get into trouble. Administrative Nurse D stated no staff reported the incident between CNA M and R1 on 10/11/25. She stated R1's representative reported the incident and R1 stated staff forced her out of her room and told her she did not have the right to stay in her room. Administrative Nurse D stated she never told staff they could force R1 out of her room.On 10/27/25 at 03:28 PM, Administrative Nurse D stated R1 did not have any behaviors the week before the incident. She stated she received a report that R1 bit CNA M which she found odd because R1 had never tried to hit or bite anybody. Administrative Nurse D stated when R1's representative returned to the country, she contacted R1's representative and asked her to review the videos. She stated R1's representative sent her the videos and she called Administrative Staff A to tell him the facility needed to report the incident. Administrative Nurse D stated the facility suspended CNA M then terminated her. She stated the facility educated staff immediately and wrote up LN G and CNA N Administrative Nurse D stated she expected staff to walk away if they got frustrated with a resident and not continue to stand there to argue and raise their voice with the resident. She stated CNA M should not have tried to make R1 get out of her recliner, but CNA M should have answered R1's call light every five minutes if that was what R1 needed. Administrative Nurse D stated she expected LN G and CNA N to tell CNA M to walk away from R1 and report the incident immediately to her. On 10/27/25 at 03:41 PM, Administrative Staff A stated Administrative Nurse D called him the evening of 10/20/25 and reported she received videos from R1's representative in regard to R1 and CNA M. He stated the incident needed to be reported immediately and the facility reported it to the State Agency (SA) and the police. Administrative Staff A stated after he reviewed the videos, he talked to human resources, and they agreed to terminate CNA M. He stated he invited CNA M into the facility for termination and she stated to him that she felt like she tried to protect R1 from further injury of her neck. He stated CNA M stated to him that she did not feel like she yelled at R1 but felt like she raised her voice. Administrative Staff A stated he expected LN G and CNA N to intervene and tell CNA M they got it and take five minutes. He expressed disappointment in LN G not taking charge of the situation and not calling him and Administrative Nurse D immediately to report what she had witnessed with CNA M and R1. He stated LN G should have removed CNA M to a non-patient care area until she received further direction from him and Administrative Nurse D. He stated it was not LN G's position to determine if the incident was mental or verbal abuse, but it was her responsibility to separate CNA M and R1 then report it immediately. Administrative Staff A stated it was clear that CNA M was out of control.The facility's Abuse Prevention Program, effective August 2025, directed residents had the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment, exploitation, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical condition. Administrative Staff A received the Immediate Jeopardy Template on 10/27/25 at 04:30 PM and was notified of the facility's failure to ensure R1 remained free from staff-to-resident abuse, placed R1 in immediate jeopardy at F600. The immediate jeopardy at F600 also constituted Substandard Quality of Care at 42 CFR 482.The facility identified, implemented, and completed following interventions on 10/21/25:1. The facility immediately suspended CNA M on 10/20/25.2. The facility terminated CNA M on 10/21/25. 3. The facility conducted all-staff education on ANE on 10/21/25.4. The facility completed disciplinary action for LN G and CNA N on 10/21/25.Due to the facility's corrective actions completed prior to the onsite visit, the deficient practice was cited at past noncompliance and existed at a J (isolated, immediate jeopardy) scope and severity.