STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175425	A. BUILDING _____ B. WING _____	03/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SPRING HILL OPERATOR LLC	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 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 41 residents. The sample included 14 residents. Based on observation, record review, and interviews, the facility failed to document a recapitulation of the facility stay upon discharge from the facility for Resident (R) 42, sampled for discharge. Findings included: - R42's electronic medical record (EMR) from the [DIAGNOSES REDACTED]. The Admission Minimum Data Set ((MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R42 required extensive assistance of two staff for her Activities of Daily Living (ADL). The ADL Care Area Assessment (CAA) dated 11/19/19 documented R42 required assistance with ADL's. The Care Plan dated 11/12/19 directed staff R42 required one to two staff members for assistance with transfers. The Miscellaneous (MISC) tab of the EMR documented an order dated 12/09/19 to discharge resident to home with home health services for bathing assistance, therapy and nursing services for dressing changes. The Progress Note tab of the EMR dated 12/12/19 at 01:20 PM documented R42 was discharged from the facility accompanied by her son. She was discharged with a list of medications, her personal belongings and written discharge instructions. During an interview on 03/12/20 at 10:00 AM with Administrative Staff A stated that the medical records department was unable to locate a recapitulation of R42's stay at the facility. During an interview on 03/16/20 at 09:40 AM Licensed Nurse (LN) G stated she charted in the nurse's note for any resident who discharged to community, any follow up appointments for that resident. She charted education and medication instructions were given. During an interview on 03/16/20 at 11:05 AM Administrative Nurse D stated the nurse writes a note in the EMR regarding follow up appointments, list of medication, education and side effects of medication. Administrative Nurse D stated that the facility has a new form that has just been implemented in the week that will cover the discharge and recapitulation of a resident's stay. The Discharge Summary and Plan policy dated 01/20 documented the discharge summary will include a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of discharge. The facility failed to document a recapitulation for R42's stay at the facility after her discharge to the community.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 41 residents. The sample included 14 residents. Based on observation, record review, and interviews, the facility failed to provide routine medication for Resident (R) 4 as ordered. Findings included: - R4's electronic medical record (EMR) from the [DIAGNOSES REDACTED]. The Annual Minimum Data Set ((MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R4 required supervision after setting up assistance for Activities of Daily Living (ADL's). The MDS documented R4 had received anticoagulant (used to prevent blood clots) medication and diuretic (used to promote the formation and excretion of urine) medication for seven days during the look back period. The Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. The MDS documented R4 required supervision after setting up assistance for ADL's. The MDS documented that R4 had received anticoagulant medication and diuretic medication for seven days during the look back period. The ADL Care Area Assessment (CAA) dated 04/27/19 documented that R4 required minimal assistance with ADL'S at times. The Care Plan revised on 10/22/19, directed staff to give R4 medication as ordered, to monitor and document any side effects and effectiveness. The Orders tab in the EMR from the Medication Administration Record [REDACTED]. The January 2020 MAR indicated [REDACTED]. January 2020 MAR indicated [REDACTED]. The Progress Notes tab lacked documentation for medication not administered or physician notification. The February 2020 MAR indicated [REDACTED]. The February 2020 MAR indicated [REDACTED]. The Progress Notes lacked any documentation of the medication not administered or physician notification. Observation on 03/12/20 at 10:16 AM R4 sat in her wheelchair in the activity room visiting with her family. No distress noted. During an interview on 03/16/20 at 09:40 AM Licensed Nurse (LN) G stated the medication was not covered by her insurance and pharmacy could not provide. LN G stated the physician was not notified of medication not administered as ordered. During an interview on 03/16/20 at 11:05 AM with Administrative Nurse D stated the medication was not available due to insurance and the physician was not notified and R4's medication was not administered as ordered. Administrative Nurse D stated the medication should have been placed on hold or changed till it was available. The Pharmacy Services Overview policy dated 01/20 documented the pharmacy will help the facility develop mechanisms to communicate, address, and resolve issues related to pharmacy services. The facility failed to ensure medication was available to be administered as ordered by the physician for R4. This deficient practice placed R4 at risk for adverse consequences of medical complications.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 41 residents. The sample included 14 residents. Five residents were sampled for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure Consultant Pharmacist (CP) GG identified the facility's failure to notify the physician of weights outside of physician ordered parameters for Resident (R) 10. The facility failed to ensure CP GG identified the lack of blood pressure monitoring for an antihypertensive (medication used to treat high blood pressure) medication and an inappropriate [DIAGNOSES REDACTED]. Findings included: - The electronic medical record (EMR) for R10 documented a [DIAGNOSES REDACTED]. The Annual Minimum Data Set assessment dated [DATE] documented staff assessed R10 as having short and long-term memory problems. He required extensive assistance of one person for most of his Activities of Daily Living (ADL), with no limitations in his range of motion. He had no weight loss or weight gain during the lookback period. He received diuretic medication seven days of the assessment. The Nutrition Care Area assessment dated [DATE] documented R10 is at risk for impaired nutrition. The Nutrition care plan dated 04/27/18 instructed staff to monitor R10's weight. The Order tab of the EMR revealed an order for [REDACTED]. Notify physician if a weight gain of three pounds in a day or five pounds in a month. Review of the Medication Administration Record [REDACTED].) and on 01/08/20 R10's weight was documented as 181.5 lbs. On 01/20/20 R10's weight was documented as 179.5 lbs. and on 01/21/20 R10's weight was documented as 182.5 lbs. Review of the EMR and Physician

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Communication Book revealed lack of documentation for physician notification of R10's weights being out of the physician ordered parameters. Review of the Medication Administration Record [REDACTED]. and on 02/26/20 R10's weight was documented as 182.5 lbs. Review of the EMR and Physician Communication Book revealed lack of documentation for physician notification of R10's weights being out of the physician ordered parameters. CP GG's Monthly Medication Review (MMR) for R10 reviewed for January and February lacked documentation CP GG identified and notified the facility about R10's weights being out of physician ordered parameters. On 03/12/20 at 03:06 PM R10 was sitting in the day room, listening to the television and looking at a book. R10 was interacting well with staff and peers. On 03/16/20 at approximately 09:35 AM Licensed Nurse (LN) G stated R10 does have an order for [REDACTED]. The nurses enter the weights into the medical record. When the physicians or nurse practitioners are in the building, they review the weights when they are here. If the weight is outside of physician ordered parameters after hours or on the weekend, the nurse will call the physician. The consequence of not following the physician ordered parameters would be increased [MEDICAL CONDITION] or fluid overload. On 03/16/20 at 10:05 AM CNA R stated the nurses obtain the vital signs and help the CNA's obtain the weights. The CNA reports the weights to the nurse and the nurse enters the weight into the EMR. The nurse will tell the CNA if a resident needed to be reweighed. Usually, the nurse will have the CNA reweigh the resident if there is a three-pound weight difference from the previous weight. On 03/16/20 at 11:13 AM Administrative Nurse D stated the nurses should notify the physician if a vital sign or weight is out of the physician ordered parameters. The facility has a physician communication book that is used to make some of the notifications. The physician was not notified of R10's weights being out of the physician ordered parameters. On 03/17/20 at 12:52 PM CP GG stated he comes to the facility on ce a month. He reviews parameters for weights and blood pressure. He has been to this facility three times. He did identify parameters were not consistently being followed by staff on his reports provided to leadership at the conclusion of each visit. The facility policy Medication Regimen Review dated 01/2020 documented CP GG will report irregularities to the attending physician, the facility medical director and the director of nursing. The facility failed to ensure CP GG identified and reported weights out of physician ordered parameters for R10. This deficient practice placed R10 at risk for complications from increased [MEDICAL CONDITION]. - R35's electronic medical record (EMR) from the [DIAGNOSES REDACTED]. The Admission Minimum Data Set ((MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. The MDS documented R35 required extensive assistance of one staff member for Activities of Daily Living (ADL). The MDS documented R35 received an antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medication and opioid (medication used for pain) medication for six days during the look back period. The [MEDICAL CONDITION] (class of medications used to treat [MEDICAL CONDITION] and other mental emotional conditions) Drug Use Care Area Assessment (CAA) dated 02/13/20 documented R35 was at risk for adverse effects related to medication use. The Care Plan dated 03/05/20 directed staff R35 had medical issues that required monitoring and treatment. The Orders tab of EMR documented a physician order [REDACTED]. The order listed the indication for use as personal history of [MEDICAL CONDITION] embolism (a blockage in one of the [MEDICAL CONDITION] arteries in the lungs). The physician order [REDACTED]. The Monthly Medication Review (MMR) reviewed for February 2020 did not address the [DIAGNOSES REDACTED]. Observation on 03/12/20 at 10:15 AM R35 sat in her wheelchair at her bedside table working on a word puzzle. During an interview on 03/16/20 at 09:40 AM with Licensed Nurse (LN) G, she stated an antihypertensive medication should be monitored daily prior to administration of the medication. LN G stated history of [MEDICAL CONDITION] embolism is not an appropriate [DIAGNOSES REDACTED]. During an interview on 03/18/20 at 11:05 AM with Administrative Nurse D stated an antihypertensive medication should be monitored, and history of [MEDICAL CONDITION] embolism is not the correct [DIAGNOSES REDACTED]. During an interview on 3/17/20 with CP GG was unable to answer questions. The Medication Regimen Reviews policy dated 01/20 documented the pharmacist reported irregularities to the attending physician, the facility medical director and the director of nursing. The facility failed to ensure CP GG identified and reported the lack of adequate monitoring and appropriate [DIAGNOSES REDACTED].
F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The sample included 14 residents. Five residents were sampled for unnecessary medications. Based on observation, record review, and interviews, the facility failed to notify the physician of weights outside of physician ordered parameters for Resident (R) 10. The facility failed to identify the lack of blood pressure monitoring for an antihypertensive (medication used to treat high blood pressure) medication and an inappropriate [DIAGNOSES REDACTED]. Findings included: - The electronic medical record (EMR) for R10 documented a [DIAGNOSES REDACTED]. The Annual Minimum Data Set assessment dated [DATE] documented staff assessed R10 as having short and long-term memory problems. He required extensive assistance of one person for most of his Activities of Daily Living (ADL), with no limitations in his range of motion. He had no weight loss or weight gain during the lookback period. He received diuretic medication seven days of the assessment. The Nutrition Care Area assessment dated [DATE] documented R10 is at risk for impaired nutrition. The Nutrition care plan dated 04/27/18 instructed staff to monitor R10's weight. The Order tab of the EMR revealed an order for [REDACTED]. Notify physician if a weight gain of three pounds in a day or five pounds in a month. Review of the Medication Administration Record [REDACTED].) and on 01/08/20 R10's weight was documented as 181.5 lbs. On 01/20/20 R10's weight was documented as 179.5 lbs. and on 01/21/20 R10's weight was documented as 182.5 lbs. Review of the EMR and Physician Communication Book revealed lack of documentation for physician notification of R10's weights being out of the physician ordered parameters. 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On 03/16/20 at 10:05 AM CNA R stated the nurses obtain the vital signs and help the CNA's obtain the weights. The CNA reports the weights to the nurse and the nurse enters the weight into the EMR. The nurse will tell the CNA if a resident needed to be reweighed. Usually, the nurse will have the CNA reweigh the resident if there is a three-pound weight difference from the previous weight. On 03/16/20 at 11:13 AM Administrative Nurse D stated the nurses should notify the physician if a vital sign or weight is out of the physician ordered parameters. The facility has a physician communication book that is used to make some of the notifications. The physician was not notified of R10's weights being out of the physician ordered parameters. The facility failed to provide a policy that addresses following physician ordered parameters for weights. - R35's electronic medical record (EMR) from the [DIAGNOSES REDACTED]. The Admission Minimum Data Set ((MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. The MDS documented R35 required extensive assistance of one staff member for Activities of Daily Living (ADL). The MDS documented R35 received an antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medication and opioid (medication used for pain) medication for six days during the look back period. The [MEDICAL CONDITION] (class of medications used to treat [MEDICAL CONDITION] and other mental emotional conditions) Drug Use Care Area Assessment (CAA) dated 02/13/20 documented R35 was at risk for adverse effects related to medication use. The Care Plan dated 03/05/20 directed staff R35 had medical issues that required monitoring and treatment. The Orders tab of EMR documented a physician order [REDACTED]. 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