STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175127	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Salina	623 S 3rd Street Salina, KS 67401

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 - Actual harm 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** 32358 The facility had a census of 40 residents. The sample included 3 residents. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 1, R2, and R3 remained free of neglect and abuse. Based on the reasonable person concept, this deficient practice resulted in feelings of belittlement for R1, R2, and R3 and placed all three residents at risk of neglect and the potential for a negative psychosocial impact. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), and urine retention (lack of ability to urinate and empty the bladder). R1's Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R1 was dependent on staff with toileting. R1's Care Plan, revised 03/01/25, documented R1 had a urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag). The care plan instructed staff to assess the resident's catheter quarterly and as needed (PRN) for continued use, change as the physician ordered, monitor and document intake and output, notify the physician of any signs of infection, and use a catheter strap on the catheter. The care plan documented the resident did not use a toilet, bedpan, or bedside commode, access with checking and changing brief, and provide perineal (private area) care with every incontinent episode as R1 allowed. The facility's investigation sheet, dated 02/17/25, documented the charge nurse Licensed Nurse (LN) G called Administrative Nurse D at 06:38 AM on 02/17/25 to report R1 needed to talk to Administrative Nurse D as soon as she came in to work. The investigation documented Administrative Nurse D and Social Service Designee (SSD) X saw R1 as they arrived for work. R1 reported Certified Nurse Aide (CNA) M would not change her the night prior when R1 called CNA M to her room. R1 reported CMA M told her she did not need changed and left the room. R1 reported this to the other aide who came in and changed R1's brief, which was soaked. The investigation documented R1 was afraid of CNA M. The incident report documented CMA M was terminated on 02/18/25. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175127	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Legacy at Salina		STREET ADDRESS, CITY, STATE, ZIP CODE 623 S 3rd Street Salina, KS 67401	

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 - Actual harm Residents Affected - Few	The Witness Statement from LN G documented on 02/14/25 on the 10:00 PM to 06:00 AM shift CNA M answered R1's call light and R1 reported to CNA M she was wet and needed to be changed. CNA M told R1 You are not wet, you have a catheter. The statement documented R1's catheter did leak around it. The Witness Statement noted LN G attempted to educate CNA M, and CNA M stated She [R1] is lying to me [CNA M] and you [LN G] and I [CNA M] did my job. LN G noted CNA M was unable to be educated. On 03/04/25 at 11:00 AM, observation revealed R1 sat in a wheelchair in the living room area of the facility at an activity. On 03/04/25 at 09:13 AM, Administrative Staff A verified LN G's witness statement revealed that R1 had reported to LN G on the night shift starting on 02/16/25 and ending on 02/17/25. Administrative Staff A stated she was unaware the incident was reported to LN G. Administrative Staff A stated the facility would educate LN G on reporting the incident to the administration immediately. On 03/04/25 at 11:14 AM, Administrative Nurse D stated whenever there is an allegation of abuse, the staff should immediately report it to her and Administrative Staff A. Administrative Nurse D verified CNA M was not immediately suspended when the allegation was reported to LN G, and that CNA M should have been. The facility's Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy, revised 03/03/22, documented that upon receiving a report of an allegation of resident abuse, neglect, exploitation, or mistreatment the facility would immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. If this involved an allegation of abuse by an employee, this would be accomplished by separating the employee accused of abuse from all residents through the following or a combination of the following, if practicable: 1) suspending the employee 2) segregating the employee by moving the employee to an area of the facility where there will be no contact with any residents of the facility. The facility failed to ensure R1 remained free from neglect when staff failed to provide the necessary care and services required for R1's incontinent care and R1 said she was scared of the CNA. Based on the reasonable person concept, this deficient practice placed the resident at risk for neglect and the potential for negative psychosocial impact. - R2's EMR documented R2 had diagnoses of chronic kidney disease (a long-term condition where the kidneys gradually lose their ability to filter waste products and excess fluid from the blood), constipation, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), muscle weakness, and neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying). R2's Admission Minimum Data Set (MDS), dated [DATE], documented R2 had a BIMS of 15, which indicated intact cognition. The MDS documented R2 required substantial, maximal staff assistance with toileting and had a urinary catheter. The Activity of Daily Living (ADL) Functional / Rehabilitation Potential (CAA), dated 01/19/25, documented R2 required substantial, maximal staff assistance with toileting. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Legacy at Salina		STREET ADDRESS, CITY, STATE, ZIP CODE 623 S 3rd Street Salina, KS 67401	

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(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 - Actual harm

Residents Affected - Few

The Urinary Incontinence and Indwelling Catheter CAA dated 01/19/25 documented R2 required substantial to maximal staff assistance with toileting hygiene, had a diagnosis of neurogenic bladder, and had a urinary catheter. The CAA instructed staff to provide catheter care every shift and PRN, monitor output, and record in R2's EMR.

R2's Care Plan, revised 01/16/25, documented R2 had renal insufficiency and was at risk of fluid overload. The plan instructed staff to obtain lab reports and report any abnormal values to her physician as necessary. The plan documented R2 required one staff assist with toileting and instructed staff to provide perineal care for every incontinent episode and as necessary. The plan documented R2 had a urinary catheter for diagnosis of neurogenic bladder and instructed staff to assess R2's catheter quarterly and PRN to assess the need for continued use, change as physician ordered, encourage additional fluids to aid in the flow of urine, and monitor and document intake and output as facility policy.

The Facility's Investigation sheet, dated 02/17/25, documented the investigation discovered CNA M had denied R2 assistance to the bathroom. The investigation sheet documented CNA M had stated to R2 You already have been twice, you don't need to go again.

On 03/04/25 at 11:30 AM, R2 sat in a wheelchair in her room and wore pants, which covered her urinary catheter.

On 03/04/25 at 11:14 AM, Administrative Nurse D stated whenever there is an allegation of abuse staff should immediately report it to her and Administrative Staff A. Administrative Nurse D verified CNA M was not immediately suspended when the allegation was reported to LN G, and CNA M should have been suspended immediately.

The facility's Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy, revised 03/03/22, documented that upon receiving a report of an allegation of resident abuse, neglect, exploitation, or mistreatment the facility would immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. If this involved an allegation of abuse by an employee, this would be accomplished by separating the employee accused of abuse from all residents through the following or a combination of the following, if practicable: 1) suspending the employee 2) segregating the employee by moving the employee to an area of the facility where there will be no contact with any residents of the facility.

The facility failed to ensure R2 remained free from neglect when staff failed to provide the necessary care and services required for R2's incontinent care. Based on the reasonable person concept, this deficient practice resulted in feelings of fear for R2 and placed R2 at risk for further psychosocial harm, intimidation, and neglect.

- R3's EMR documented R3 had diagnoses of cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), muscle weakness, retention of urine (lack of ability to urinate and empty the bladder), and neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying).

R3's Quarterly MDS, dated [DATE], documented R3 had a BIMS of 15, which indicated intact cognition. The MDS documented R3 as dependent on staff with most activities of daily living (ADL).

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	175127	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Salina	623 S 3rd Street Salina, KS 67401

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(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 - Actual harm Residents Affected - Few	R3's Care Plan, revised 01/30/25, documented the following: Staff would know R3 was incontinent of the bladder. Staff were to make sure R3 had an unobstructed path to the bathroom. Staff were to monitor, and document for signs and symptoms of urinary tract infection (UTI - an infection in any part of the urinary system). Staff were to obtain labs as the physician ordered and notify him/her of the results. Staff would know R3 required two staff assist with toileting. The Facility Incident Report dated 02/17/25, documented an investigation was conducted when R3 reported CNA M would not change her incontinent brief when she requested. It was discovered CNA M had not checked or changed R3 ' s brief for her entire eight-hour night shift. On 03/03/25 at 11:45 AM, staff propelled R3 down the hall to her room and no signs or symptoms of incontinence were noted. On 03/04/25 at 09:13 AM, Administrative Staff A verified LN G's witness statement revealed R1 had reported to LN G on the night shift starting on 02/16/25 and ending on 02/17/25. Administrative Staff A stated she was unaware the incident was reported to LN G. Administrative Staff A stated the facility would educate LN G on reporting the incident to the administration immediately. On 03/04/25 at 11:14 AM, Administrative Nurse D stated whenever there was an allegation of abuse staff should immediately report it to her, and Administrative Staff A. Administrative Nurse D verified CNA M was not immediately suspended when the allegation was reported to LN G and that CNA M should have been. The facility's Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy, revised 3/3/2022, documented that upon receiving a report of an allegation of resident abuse, neglect, exploitation, or mistreatment the facility would immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. If this involved an allegation of abuse by an employee, this would be accomplished by separating the employee accused of abuse from all residents through the following or a combination of the following, if practicable: 1) suspending the employee 2) segregating the employee by moving the employee to an area of the facility where there will be no contact with any residents of the facility. The facility failed to ensure R3 remained free from neglect when staff failed to provide the necessary care and services required for R3's incontinent care. Based on the reasonable person concept, this deficient practice placed the resident at risk for neglect and the potential for negative psychosocial impact.

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NAME OF PROVIDER OR SUPPLIER: Legacy at Salina		STREET ADDRESS, CITY, STATE, ZIP CODE: 623 S 3rd Street Salina, KS 67401	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 40 residents. The sample included 3 residents. Based on observation, record review, and interview, the facility failed to ensure staff immediately reported an allegation of potential abuse and neglect to the administrator. Resident (R)1 reported an allegation of potential abuse and neglect to Licensed Nurse G, after Certified Nurse Aide M did not provide assistance to R1 for urinary care and R1 had a soaked brief. LN G did not report the incident to administrative staff. This failure placed R1 at risk for continued neglect. Findings Included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), and urine retention (lack of ability to urinate and empty the bladder). R1's Quarterly Minimum Data Set (MDS), dated [DATE], documented that R1 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R1 was dependent on staff with toileting. R1's Care Plan, revised 03/01/25, documented R1 had a urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag). The care plan instructed staff to assess the resident catheter quarterly and as needed (PRN) for continued use, change as the physician ordered, monitor and document intake and output, notify the physician of any signs of infection, and use a catheter strap-on the catheter. The care plan documented the resident did not use a toilet, bedpan, or bedside commode, access with checking and changing brief, and provide perineal (private area) care with every incontinent episode as R1 allows. The Facility's Investigation sheet, dated 02/17/25, documented Administrative Nurse D was called by charge nurse Licensed Nurse (LN) G at 06:38 AM on 02/17/25 to report R1 needed to talk to Administrative Nurse D as soon as she came in to work. The investigation documented Administrative Nurse D and Social Service Designee (SSD) X went in to see R1 as they arrived for work. R1 reported Certified Nurse Aide (CNA) M would not change her last night when R1 called CNA M to her room. R1 reported CMA M told her she did not need changed and left the room. R1 reported to the other aide who came in and changed R1's brief. R1's brief was soaked. The investigation documented that R1 was afraid of CNA M. The incident report documented CMA M was terminated on 02/18/25. The Witness Statement, from LN G documented on 02/14/25 on the 10 PM - 6 AM shift CNA M answered R1's call light and R1 reported to CNA M she was wet and needed to be changed, and CNA M told R1 You are not wet, you have a catheter. The statement documented that R1's catheter does leak around it. The note documented LN G attempted to educate CNA M and CNA M stated She [R1] is lying to me [CNA M] and to you [LN G], and she did her job. CNA M was unable to be educated. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Legacy at Salina		STREET ADDRESS, CITY, STATE, ZIP CODE 623 S 3rd Street Salina, KS 67401	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/04/25 at 11:00 AM, observation revealed R1 sat in a wheelchair in the living room area of the facility at an activity. On 03/04/25 at 09:13 AM, Administrative Staff A verified LN G's witness statement revealed R1 had reported to LN G on the night shift starting on 02/16/25- 02/17/25 and stated she was unaware the incident had been reported to LN G. Administrative Staff A stated LN G would be getting educated on reporting the incident to administration immediately. 03/04/25 at 11:14 AM, Administrative Nurse D stated whenever there is an allegation of abuse staff should immediately report it to her and Administrative Staff A. Administrative Nurse D verified CNA M was not immediately suspended when the allegation was reported to LN G and that CNA M should have been. The facility's Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy, revised 3/3/2022, documented that upon receiving a report of an allegation of resident abuse, neglect, exploitation, or mistreatment the facility would immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. If this involved an allegation of abuse by an employee, this would be accomplished by separating the employee accused of abuse from all residents through the following or a combination of the following, if practicable: 1) suspending the employee 2) segregating the employee by moving the employee to an area of the facility where there will be no contact with any residents of the facility. The facility staff failed to report to the administration immediately a potential allegation of abuse when staff failed to provide incontinent care for R1. Based on the reasonable person concept, this deficient practice placed the residents at risk for neglect and the potential for negative psychosocial impact.