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	11/18/2025

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 0689 Level of Harm - 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 had a census of 39 residents, with three residents sampled for falls. Based on observation, interview, and record review, the facility failed to ensure staff implemented fall prevention interventions to prevent a fall for Resident (R) 1. On 10/16/25, a Certified Nurse Aide (CNA) rolled R1 to her side in bed, and R1 fell out of bed onto the floor. On 10/17/25, after emergency transport for evaluation of R1's complaints of pain, an X-ray revealed R1 had a right femoral neck (top of the thigh bone) fracture (broken bone), which required surgical repair. Findings included: - R1's Electronic Medical Record included diagnoses of osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) and a closed fracture of the right distal femur (thigh bone).R1's Quarterly Minimum Data Set dated 10/03/25 documented R1 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R1 was dependent on staff for most activities of daily living, including bed mobility. R1's Care Plan dated 10/03/23 directed staff to provide two staff assistance with bed mobility, dressing, and transfers. The 04/04/25 update noted a specialty mattress was on R1's bed. The 10/16/25 update directed staff to ensure a perimeter-defined mattress was on her bed. The Fall Risk Assessment dated 08/28/25 documented R1 had no falls, was alert and oriented, and chairbound. The fall risk score was less than 10, indicating a low risk for falls. The facility investigation regarding R1's 10/16/25 fall documented R1 was in bed when Certified Nurse Aide (CNA) M assisted R1 with dressing at 03:30 PM. The investigation noted R1 held the positioning rail while CNA M rolled R1 away from her, to adjust the back of the resident's dress, and R1 rolled out of bed onto the floor. The staff observed R1 on the floor with her legs partially folded under her, R1 was crying and displayed signs of anxiety. Licensed Nurse (LN) G performed a full assessment with no abnormalities noted, no signs of increased pain noted, and documented normal range of motion (ROM) for R1. Staff assisted R1 back to bed with the total mechanical lift and three staff assistance. R1 complained of some pain when the staff removed the lift sling. LN G called the physician requesting X-ray orders. R1 requested to get back in her wheelchair, staff repositioned her and administered pain medication per her request. At that time, staff noted R1 was comfortable with no signs of distress. On 10/17/25 staff called for emergency services transport to obtain an X-ray, which noted a partially impacted right femoral neck fracture (a break in the neck of the thigh bone where the broken ends are jammed together but not fully displaced). R1 admitted to the hospital for surgical repair of the fracture.The Progress Note dated 10/16/25 at 04:20 PM documented the nurse performed a head-to-toe assessment of R1 and no tenderness noted to R1's upper torso. R1 was seated against her bed. Two CNAs and a LN positioned R1 on the total lift sling and used the total lift to transfer R1 to her bed. The LN documented R1's lower extremity ROM was normal for the resident, but R1 complained of right hip pain. The LN assessed R1's ROM and documented no bruising, no redness, and no pain. The Staff repositioned R1 in bed, and then R1 insisted on being in her wheelchair. The nurse obtained vital signs and administered pain medication.The Progress Note dated 10/16/25 at 08:31 PM documented R1 cried earlier in the shift due to pain in her right leg, and the nurse had administered pain medication.The late entry Progress Note dated 10/16/25 at 10:14 PM documented R1 told staff all about her fall. R1 rated (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	her pain at a five out of 10 on the pain scale. The nurse documented no visible injuries and noted the resident was in a low bed, a CNA assisted the nurse with pulling R1 up in bed, and the resident tolerated it well.The Progress Note dated 10/17/25 at 01:23 AM documented R1 had ROM deficits. The LN assessed and attempted ROM, but R1 could not move her legs on her own. R1 said it was painful, but did not yell out or seem in any increased distress than her normal demeanor. R1's legs appeared the same length, and R1 assisted the staff with turning.The Progress Note dated 10/17/25 at 09:16 AM documented the nurse called the physician's office due to R1's increased tearful episodes and complaints of pain related to her 10/16/25 fall. The physician ordered the staff to send R1 to the emergency room for evaluation and treatment for right leg pain.On 10/27/25 at 09:30 AM, R1's bed had a perimeter mattress; however, R1 was not in the building for observation.On 10/27/25 at 09:30 AM, LN H stated the previous mattress on R1's bed before the fall was a plain air mattress.On 10/27/25 at 10:45 AM, LN G stated she was on the telephone when R1 fell out of bed on 10/16/25. LN G said she saw the resident seated on the floor, by her bed, with her legs straight out, and a CNA at her back helping her sit. The resident held onto the bed cane rail on that side of the bed. She verified two staff were to provide cares for R1 and said R1 had an air mattress. She verified the CNA should not have rolled the resident without the assistance of another staff person.On 10/27/25 at 11:11 AM, CNA M stated she did not know R1 required two staff assistance for dressing, but she knew R1 required two staff assistance for transfers. CNA M stated she used the walkie to request assistance to get R1 up and transferred to her wheelchair. CNA M stated all the other staff replied they were busy in other rooms so she thought she could start providing activities of daily living (ADL) cares to R1, such as dressing, while she waited for help. CNA M stated when she finished dressing the resident, she told the resident she was going to roll her over to her side to pull her dress down and place a lift sling under her. R1 grabbed the cane rail and assisted (rolling to her side), but R1 pulled on the rail too much, and when rolled, she slid out of her bed. CNA M said R1 had an air mattress at that time, and R1 was still holding onto the rail when she sat on the floor (after falling out of the bed). CNA M said the other staff came into the room, and the nurses assessed the resident before we transferred her back to bed.On 10/27/25 at 08:22 AM, Administrative Nurse D stated R1 was still in the hospital due to a fractured femur. Administrative Nurse D stated the facility educated CNA M post fall, and with a separate in-service on 10/17/25. On 10/27/25 at 09:35 AM, Administrative Staff A stated CNA M had an in-service regarding falls on 08/23/25, as part of her orientation to the facility. On 10/27/25 at 09:40 AM, Administrative Nurse D stated R1's mattress was a plain air mattress prior to the fall, but post-fall the facility added a concave mattress. Administrative Nurse D stated before the fall, R1 required two staff members for most ADL. Administrative Nurse D verified CNA M was the only staff in R1's room at the time of the fall, and verified CNA M had not followed the care plan. The facility's Fall Prevention Program dated 12/23/21 stated all staff were to be aware of fall interventions for residents and know the residents who were at risk for falls. The facility identified, implemented, and completed the following corrective actions by 10/17/25:1. The facility placed a perimeter mattress on R1's bed on 10/16/25. 2. All nursing staff attended or completed an in-service for the transfer of residents on 10/17/25.The facility completed corrective actions by 10/17/25, prior to the onsite survey; therefore, the deficient practice was deemed past noncompliance, at the scope and severity of a G (isolated, actual harm).