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	09/10/2025

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. The facility had a census of 41 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to employ a full-time certified dietary manager for the 41 residents who reside in the facility and received meals from the facility kitchen. This placed the residents at risk for inadequate nutrition.Findings included:- On 09/08/25 at 12:00 PM, observation of the noon meal consisted of ham, scallop potatoes, peas, and fruit salad. Dietary Staff (DS) BB was observed overseeing the preparation of the noon meal. DS BB would also assist staff with taking meal trays to the residents.On 09/09/25 at 11:30 AM, DS BB verified she was not certified but had passed the course and just needed to take the test. DS BB further stated she had many years in the food service industry. On 09/10/25 at 01:00 PM, Administrative Nurse D stated DS BB had taken her course, but there was a waiting period before she could take the test.The facility's Dietician policy, dated 10/17, documented that a food and nutrition services manager would oversee the production, storage, and delivery of food and would work closely with the dietician.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility had a census of 41 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to measure and record daily refrigerator and freezer temperatures for the evening shift. This placed the residents at risk for food-borne illnesses.Findings included:- On 09/08/25 at 08:00 AM, during the initial kitchen tour, the daily temperature logs for the large silver refrigerator and freezer lacked documentation. Temperatures were not taken during the following days on the evening shift:09/01/2509/03/2509/06/25On 09/08/25 at 08:00 AM, during the initial kitchen tour, the daily temperature logs for the small silver stand-alone refrigerator were not taken during the following days on the evening shift:09/01/2509/03/25On 09/08/25 at 08:00 AM, during the initial kitchen tour, the daily temperature logs for the tan refrigerator lacked documentation; temperatures were not taken during the following days on the evening shift:09/01/2509/03/25On 09/08/25 at 08:45 AM, Dietary BB verified the lack of documentation and stated the temperatures were to be taken as directed.The facility's Refrigerator and Freezer policy, dated 10/14, documented the facility would ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and would observe food expiration guidelines. Monthly tracking sheets for all refrigerators and freezers would be posted to record temperatures. The monthly tracking sheets would include the time, temperature, initials, and actions taken. The food service supervisor or designated employees would check and record the refrigerator and freezer temperatures daily upon opening and at closing in the evening.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 41 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to post signage for six of seven residents regarding the use of enhanced barrier precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms, which employ targeted gown and glove use during high contact cares) to ensure staff were aware. This deficient practice placed all residents of the facility at risk for the spread of infections. The facility also failed to ensure staff changed gloves properly during incontinence care for Resident (R) 44, placing the resident at risk for infection. Findings included: - On 09/09/25 at 09:15 AM, observation in six of seven facility identified resident rooms where EBP protocol was to be followed; no EBP signage was found in the room or on the doorway. On 09/08/25 at 11:10 AM, Administrative Nurse D verified the lack of EBP signage for residents with EBP precautions and stated there should be signage. The facility's Enhanced Barrier Precautions policy, dated 03/25/24, stated signs would be posted indicating the resident required EBP, and personal protective equipment was available. - The Electronic Medical Record (EMR) for R44 documented diagnoses of urinary retention (lack of ability to urinate and empty the bladder), malignant neoplasm (tumor) of the upper lobe, right bronchus or lung, secondary malignant neoplasm (tumor) of the brain, hypertension (high blood pressure), and diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) type two. The admission Minimum Data Set (MDS), dated [DATE], documented R44 had intact cognition. R44 was dependent upon staff for toileting hygiene, dressing, and transfers. The MDS further documented R44 had a catheter. R44's Care Plan, dated 08/28/25, directed staff to assess the catheter every quarter, and as needed, to assess the need for the catheter, change the catheter as needed, and encourage additional fluids. The care plan further directed staff to monitor and document intake and output as per facility policy, notify the physician of any signs of infection, and provide catheter care per facility policy. The EMR lacked documentation. R44 had an order for the Foley catheter, and the documentation staff monitored intake and output. On 09/09/25 at 02:00 PM, R44 had a catheter, and the drainage bag had a small amount of amber (dark yellow) colored urine. Certified Nurse Aide (CNA) M and CNA P donned gowns and gloves and used a full-body mechanical lift to put R44 into bed. Once in bed, CNA M had R44 roll to her right side and back onto her back so she could remove her pants to do catheter care. CNA M removed R44's incontinence brief, took an incontinence wipe, and provided catheter care. R44 asked CNA M if she had a bowel movement (BM), and CNA M stated she was not sure, but she was not done with care. CNA M removed her gloves and donned a clean pair. CNA M assisted R44 to her right side and began to provide personal care. R44 had started to have a BM, and CNA M provided care and put a clean incontinence brief on her. CNA M did not remove her soiled gloves, CNA M and CNA P put R44's pants back on, and adjusted R44's clothing with the soiled gloves still on. CNA M stated she should have removed the soiled gloves before she put on the clean brief and clothing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/08/25 at 01:45 PM, Licensed Nurse (LN) G stated CNA M should have removed the soiled gloves. On 09/10/25 at 01:00 PM, Administrative Nurse D stated she expected staff to follow facility protocol after providing care. The facility's Personal Protective Equipment-Gloves policy, dated 07/09, documented that gloves must be worn when handling blood, body fluids, secretions, excretions, mucus membranes/ and/or no intact skin. The use of gloves varies according to the procedure involved. The policy further directed staff to wash their hands after they remove their gloves.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 41 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observations, interviews, and record review, the facility failed to ensure an appropriate indication, or a documented physician rationale which included the unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of Resident (R) 4's antipsychotic (a medication used to treat any major mental disorder characterized by a gross impairment testing) medication. This placed R4 at risk for unintended effects related to psychotropic (alters mood or thought) drug medications.Findings included:- R4's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).R4's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R4 had severely impaired cognition. The MDS recorded R4 required limited assistance with most activities of daily living (ADL). The MDS recorded the resident received antipsychotic medication during the observation period.The Psychotropic Drug Use Care Area Assessment (CAA), dated 05/14/25, recorded R4 received antipsychotic medication.R4's Care Plan dated 08/14/25 recorded R4 received antipsychotic medication for the diagnosis of irritability and anger/physical aggression. The care plan documented the facility would administer antipsychotic medications as ordered by the physician, and staff would monitor for side effects and effectiveness every shift and consult with the pharmacist to consider dose reduction when clinically appropriate.The Physician's Order initial order date 08/01/25 directed the staff to administer Seroquel (antipsychotic medication) 25 milligrams (mg), 25 mg three times a day for diagnoses of irritability and anger.R4's EMR lacked a documented physician rationale, which included unsuccessful attempts for nonpharmacological symptom management and a risk versus benefits statement for the Seroquel use.On 09/09/25 at 09:33 AM, observation revealed R4 was standing in her room and changing her clothes. Continued observation revealed Licensed Nurse (LN) H administered the residents' morning medications, which included Seroquel 25 mg. On 09/09/25 at 02:30 PM, Administrative Nurse D verified the resident received Seroquel, an antipsychotic medication, with a diagnosis of irritability and anger. Administrative Nurse D verified that the pharmacist had identified the inaccurate diagnosis of the Seroquel, and the facility had been working with the physician to get the appropriate diagnoses for the residents on antipsychotic medications. The facility's Medication Management policy, dated July 2022, recorded that the residents would not receive medications that were not clinically indicated to treat a specific condition. Antipsychotic medication would be prescribed at the lowest possible dosage for the shortest amount of time and were subject to gradual dose reduction and review. The residents would only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The attending physician and other staff would gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risk to the resident and others. The attending physician would identify, evaluate, and document with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications. Residents who were admitted from the community or transferred from a hospital and who were already receiving antipsychotic medications would be evaluated for the appropriateness and indications for use. The interdisciplinary team would complete PASARR (preadmission screening for mentally ill and intellectually disabled individuals,) if appropriate: re-evaluate the use of antipsychotic medication at the time of admission and/or within two weeks (at the initial MDS assessment) to consider whether or not the medication can be reduced, tapered, or discontinued, based on assessment of the resident's (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	symptoms and overall situation, the physician would determine whether to continue, adjust, or stop the existing antipsychotic medication. Antipsychotic medication would generally be used for the following conditions/diagnoses as documented in the record, consistent with the definitions in the Diagnostic and Statical Manual of Mental Disorders: Schizophrenia, Schizoaffective disorder, Schizophreniform disorder, Delusional disorder, Mood disorder (bipolar disorder, depression with psychotic features, and treatment refractory major depression), Psychosis in the absence of dementia, Mental illnesses with psychotic symptoms and/or treatment-related psychosis or mania, Tourette's Disorder, Huntington's Disease, Hiccups not induced by other medications or Nausea and vomiting associated with cancer or chemotherapy. Residents and/or representatives would be informed of the recommendations, risks, benefits, purpose, and potential adverse consequences of antipsychotic medication use. The staff would observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medications.

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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** The facility had a census of 41 residents. The sample included 12 residents, with one reviewed for abuse. Based on observation, record review, and interview, the facility failed to report to the state agency the allegation of abuse and neglect when R4 slapped another resident. This placed the residents at risk for ongoing abuse and/or mistreatment. Findings included: - R4's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).R4's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R4 had severely impaired cognition. The MDS recorded R4 required limited assistance with most activities of daily living (ADL). The MDS recorded R4 received antipsychotic medication during the observation period and had a wander guard/elopement alarm that was used daily.The Activities of Daily Living (ADL) Care Area Assessment (CAA), dated 05/14/25, recorded R4 was alert to self with confusion noted.The Behavioral CAA, dated 05/14/25, recorded R4 had been noted to wander during the look back period, had a wander guard for safety, and staff would redirect as she tolerated. R4's Care Plan, dated 08/14/25, recorded R4 received antipsychotic medication for the diagnosis of irritability and anger/physical aggression. The care plan documented R4 had the potential to be physically/verbally aggressive, as evidenced by R4 hitting, kicking, biting, and spitting on other residents, screaming out, and using profanities. The care plan directed staff to administer medications as ordered, use interventions before agitation escalates, guide her away from the source of distress, engage calmly in conversation, request a psychiatric evaluation, remind R4 to verbalize knowledge of angry, physically aggressive behaviors, and discuss alternatives to those behaviors. If the resident's response was aggressive, staff were to walk calmly away and approach R4 later, making sure the other residents were safe.The 04/20/25 at 05:14 PM, Nurse's Notes, documented another unidentified resident wandered into R4's room, loud yelling was heard, and the other unidentified resident walked out of the room holding her face. The unidentified resident agreed R4 hit her in the face, and she was removed from R4's room. The note documented all parties were safe at the time. The 04/21/25 at 01:00 PM, Nurses Notes, documented the interdisciplinary team met to discuss the incident, and it was determined the intervention was adequate at this time.The 04/21/25 at 11:38 PM, Nurses Notes, documented the resident had kept to herself, and there were no reports or observations of any resident contact. R4 was at the nurse's station numerous times, joking and laughing. Review of R4's EHR lacked evidence the investigation, including witness statements, was reported to state. Upon request, the facility was unable to provide the investigation related to the event that was sent to the state.On 09/09/25 at 09:33 AM, observation revealed R4 was standing in her room and changing her clothes. Continued observation revealed Licensed Nurse (LN) H administered the residents' morning medications, which included Seroquel (antipsychotic medication) 25 mg. On 09/09/25 at 02:00 PM, Administrative Nurse D stated she was not employed by the facility on the date the incident occurred and was unable to find if the information was sent to the state. Administrative Nurse D said the facility did conduct an investigation, and it was documented in the nurse's notes that the interdisciplinary team met and documented the incident with interventions.On 09/09/25 at 02:30 PM, Administrative Staff A verified the facility had not reported to the State agency when the incident occurred.The facility's Abuse Prevention, Identification, Investigation and Reporting policy, dated 07/08/24, recorded that all residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subjected to abuse by anyone, including, but not limited to, facility (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The risk for abuse may increase when a resident exhibits behavior(s) that may provoke a reaction by staff, residents, or others, such as: verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group, intimidating, physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects, sexually aggressive behaviors such as saying sexual things, inappropriate touching/grabbing, talking, touching, or rummaging through others' property, wandering into others' rooms/space, and resistive to cares and services. An example of injuries that could indicate abuse included, but were not limited to, injuries that were non-accidental or unexplained, such as bruises, bite marks, scratches, skin tears, and lacerations with or without bleeding, including those that are in locations that would unlikely result from an accident. The policy documented that all allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin, and misappropriation should be reported immediately to the Administrator. All allegations of resident neglect, exploitation, mistreatment, injuries of unknown origin, and misappropriation shall be reported to the appropriate state entity not later than two hours after the allegation is made, if the events that cause the allegation involved neglect, exploitation, mistreatment, injuries of unknown origin, and misappropriation, but do not result in serious bodily injury. If there is a reasonable suspicion that the allegation of abuse also constitutes a crime committed against the resident by any person, whether or not the alleged perpetrator is employed by the facility. The Elder Justice Act requires the matter must also be reported to law enforcement. The state entities are to be notified of a resident-to-resident physical contact that occurs. Which includes but is not limited to where residents are hit, slapped, pinched, or kicked and result in physical harm, pain, or mental anguish, is considered resident-to-resident abuse.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 41 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to promote an environment free of hazards for Resident (R) 7, who smoked cigarettes but was not assessed timely for safe smoking practices by the facility, and kept his smoking materials in his nightstand beside his bed. This placed the resident at risk for avoidable injuries and fire-related hazards.Findings included:- R7's Electronic Medical Record recorded diagnoses of 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), hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body), unsteady gait, and weakness.R7's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R7 used a wheelchair and was dependent on staff for toilet hygiene and personal hygiene. The MDS documented the resident required substantial to maximal assistance to shower/bathe self, sit to stand transfers, and chair to bed transfers. R7's Fall Care Area Assessment (CAA), dated 04/17/25, documented R7 was at risk for falls and utilized a wheelchair for mobility. The CAA documented R7's balance was unsteady, and he was diagnosed with a stroke with deficits, and had a grab bar on the upper portion of his bed to aid in independence with bed mobility.R7's Activities of Daily Living (ADL) Care Plan, dated 09/05/25, directed staff to assist the resident to use a wheelchair and he could self-propel short distances, with staff to propel long distances. The care plan recorded R7 required assistance with ADLs due to impaired balance during transitions.R7's Smoking Care Plan, dated 09/05/25, documented R7 preferred to smoke and did not want a smoking cessation program. The care plan stated the facility would complete a smoking assessment quarterly and as needed, and make sure the facility's smoking policy would be followed correctly to ensure R7 and others' safety. The care plan stated the resident could smoke in a designated smoking area. Staff would report any incidents of smoking and/or non-compliance with the smoking policy to Social Services, the Director of Nursing, or the Administrator. The Smoking Safety Screen dated 11/25/24, documented R7 required assistance to get to and from the smoking area, but could light his cigarettes and put them out without assistance. The assessment documented that the resident smoked 2-5 times a day and could light his own cigarettes. He was safe to smoke without supervision. R7's clinical record lacked evidence the facility had recently assessed R7 for safe smoking practices, including safe storage of smoking materials. On 09/10/25 at 12:45 PM, observation revealed R7 lying in bed on his right side with his eyes closed. On 09/08/25 at 04:00 PM, Social Service (SSD) X stated R7 smoked with staff and kept his cigarettes in a nightstand in a locked box with a key he kept on a necklace around his neck. SSD X verified the resident also had two packages of cigarettes in his nightstand that were not locked up. On 09/09/25 at 09:20 AM, Administrative Nurse D verified R7 did smoke with staff to assist him and verified the last smoking assessment the facility had completed was on 11/24/25, and the facility was to complete quarterly assessments and as-needed assessments. Administrative Nurse D verified the resident was not to keep his smoking materials in his room and was unaware he had the cigarettes and lighter in a locked box in the room.The Tobacco policy, dated 09/21/23, documented the facility would establish and maintain safe resident tobacco/smoking/electronic cigarettes, vape use practices. All persons coming onto the facility property and/or buildings would comply with this policy. When the resident requested to smoke, they would be evaluated for safe smoking upon admission and quarterly. Any tobacco use/smoking-related privileges, restrictions, and concerns shall be noted in the care plan, and all persons caring for the resident shall be alerted to these issues. The facility may impose tobacco use/smoking/electronic cigarettes/vape restrictions at any time if it is determined that the resident cannot do so safely with (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the available levels of support and supervision. Tobacco/smoking, including electronic cigarette/vape materials, for all residents will be secured by the facility when not in use. Tobacco/smoking areas would be designated by the facility and identified by signage. Any resident with restricted tobacco use/smoking/electronic cigarette/vape privileges requiring monitoring shall have direct supervision by a staff member, family member, visitor, or volunteer, always while using tobacco/smoking.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 41 residents. The sample consisted of 12 residents, with two reviewed for urinary catheters (tubes inserted into the bladder to drain urine into a collection bag). Based on observations, record review, and interview, the facility failed to obtain an order for the urinary catheter for one resident, Resident (R) 44, and failed to monitor urinary catheter output for R44 and R35. This placed the residents at risk for catheter-related complications. Findings included:- The Electronic Medical Record (EMR) for R44 documented diagnoses of urinary retention (lack of ability to urinate and empty the bladder), malignant neoplasm (tumor) of the upper lobe, right bronchus or lung, secondary malignant neoplasm (tumor) of the brain, hypertension (high blood pressure), and diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) type two. The admission Minimum Data Set (MDS), dated [DATE], documented R44 had intact cognition. R44 was dependent upon staff for toileting hygiene, dressing, and transfers. The MDS further documented R44 had a catheter. The Urinary Catheter Care Area Assessment (CAA), dated 09/01/25, documented R44 had a diagnosis of urinary retention. R44 had an indwelling Foley catheter (a tube inserted into the bladder to drain urine into a collection bag) for bladder elimination. R44 was to have catheter care done every shift, and input and output monitored per the facility protocol. R44 was dependent upon staff for toileting hygiene tasks. R44's Care Plan, dated 08/28/25, directed staff to assess the catheter every quarter, and as needed, to assess the need for the catheter, change the catheter as needed, and encourage additional fluids. The care plan further directed staff to monitor and document intake and output as per facility policy, notify the physician of any signs of infection, and provide catheter care per facility policy. The EMR lacked documentation R44 had an order for the Foley catheter, or documentation staff monitored intake and output. On 09/09/25 at 02:00 PM, R44 had a catheter, and the drainage bag had a small amount of amber (dark yellow) colored urine. Certified Nurse Aide (CNA) M and CNA P donned gowns and gloves and used a full-body mechanical lift to put R44 into bed. Once in bed, CNA M had R44 roll to her right side and back onto her back so she could remove her pants to do catheter care. CNA M removed R44's incontinence brief, took an incontinence wipe, and provided catheter care. R44 asked CNA M if she had a bowel movement (BM), and CNA M stated she was not sure, but she was not done with care. CNA M removed her gloves and donned a clean pair. CNA M assisted R44 to her right side and began to provide personal care. R44 had started to have a BM, and CNA M provided care and put a clean incontinence brief on her. CNA M did not remove her soiled gloves, CNA M and CNA P put R44's pants back on, and adjusted R44's clothing with the soiled gloves still on. CNA M stated she should have removed the soiled gloves before she put on the clean brief and clothing. CNA M stated she had drained the catheter bag earlier. When asked when she had documented the output, she stated that she didn't; she had told the nurse the amount. On 09/08/25 at 01:45 PM, Licensed Nurse (LN) G verified there was no order for R44's catheter. (continued on next page)

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	175127	A. Building B. Wing	09/10/2025

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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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/09/25 at 02:30 PM, LN G stated that staff did not document the output from catheters and that she has the CNAs tell her if the resident does not have any output. On 09/09/25 at 03:00 PM, Administrative Nurse D stated she would make sure she had the nurse call the physician for an order for a catheter. Administrative Nurse D further stated that there should be documentation of urinary output when a resident has a catheter. On 09/10/25 at 01:00 PM, Administrative Nurse G stated she expected staff to follow facility protocol after providing care. The facility's Catheter Care, Urinary policy, dated August 2022, documented staff were to review the resident's care plan to assess for any special needs of the resident. The policy documented staff were to review and document the clinical indications for catheter use and for ongoing need. The policy documented staff were to follow facility procedures for documented input and output. - R35's Electronic Medical Record (EMR) documented diagnoses of neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system) and a history of bladder cancer. R35's Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of four, indicating severely impaired cognition. The MDS documented R35 required moderate staff assistance with toileting and had a urinary catheter. R35's Care Plan, dated 06/19/25, stated R35 had a urinary catheter and directed staff to monitor and document intake and (urinary) output as per facility policy. The care plan stated enhanced barrier precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms, which employ targeted gown and glove use during high contact care) would be used during high contact activities. R35's medical record lacked documentation of urinary output for the past 30 days. On 09/09/25 at 02:00 PM, Certified Nurse Assistant (CNA) O assisted R35 to ambulate to his bathroom. CNA O donned a gown and gloves and emptied the urinary leg bag of approximately 100 milliliters (ml) of urine. She used an alcohol wipe to disinfect the port. When asked where she documented the output, she replied that there was no place to document it, so she did not. On 09/09/25 at 02:10 PM, Administrative Nurse D verified the lack of urinary output documentation and stated staff should document the output when the resident has a catheter. The facility's Urinary Catheter Care policy, dated August 2022, directed staff to follow the facility procedure for measuring and documenting input and output.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. The facility had a census of 41 residents. Based on observation, interview, and record review, the facility failed to label and date one insulin pen (a hormone that lowers the level of glucose in the blood) after opening for use. This deficient practice placed residents at risk for ineffective or outdated medication. Findings included: - On 09/08/25 at 08:12 AM, the facility's north medication cart held one Novolog (fast-acting insulin) insulin pen, which was unlabeled and undated. On 09/08/25 at 08:12 AM, Licensed Nurse (LN) G verified the insulin pen should have been labeled and dated when opened. On 09/10/25 at 01:25 PM, Administrative Nurse D verified that staff were to label and date insulin pens when opened. The facility's Insulin Administration policy, dated September 2014, directed staff to record the expiration date and time on the insulin vial after opening.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 41 residents. The sample included 12 residents, with one reviewed for Hospice (specialized care that mainly aims to provide comfort and dignity to the patients, by providing physical comfort and emotional, social, and spiritual support for people nearing the end of life) services. Based on observation, record review, and interview, the facility failed to ensure collaboration between the hospice provider and the facility for one resident, Resident (R) 44, who was admitted to hospice on 08/28/25. This placed the resident at risk of inadequate end-of-life care.Findings included:- The Electronic Medical Record (EMR) for R44 documented diagnoses of urinary retention (lack of ability to urinate and empty the bladder), malignant neoplasm (tumor) of the upper lobe, right bronchus or lung, secondary malignant neoplasm (tumor) of the brain, hypertension (high blood pressure), and diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) type two.The admission Minimum Data Set (MDS), dated [DATE], documented R44 had intact cognition. R44 was dependent upon staff for toileting hygiene, dressing, and transfers. The MDS further documented R44 required set-up assistance from staff for eating and oral hygiene. The MDS documented R44 required pain medication and was on Hospice services.R44's Care Plan, dated 08/28/25, directed staff to administer medications as ordered, assess respiratory and cardiac status as needed, and encourage family and friends to visit and be supportive of her needs. The care plan documented that hospice was to provide medications, equipment, and supplies due to the resident's terminal diagnosis, and staff were to utilize pressure reduction equipment and procedures as indicated. The care plan directed staff to refer to facility social services and/or hospice social services and the pastor as needed. The care plan lacked documentation of what supplies, medications, and when hospice staff would be in the building.On 09/09/25 at 02:00 PM, R44 had a catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid), and the drainage bag had a small amount of amber (dark yellow) colored urine. Certified Nurse Aide (CNA) M and CNA P donned gowns and gloves and used a full-body mechanical lift to put R44 into bed. Once in bed, CNA M had R44 roll to her right side and back onto her back so she could remove her pants to do catheter care. CNA M removed R44's incontinence brief, took an incontinence wipe, and provided catheter care. R44 asked CNA M if she had a bowel movement (BM), and CNA M stated she was not sure, but she was not done with care. CNA M removed her gloves and donned a clean pair. CNA M assisted R44 to her right side and began to provide personal care. R44 had started to have a BM, and CNA M provided care and put a clean incontinence brief on her. CNA M did not remove her soiled gloves, CNA M and CNA P put R44's pants back on, and adjusted R44's clothing with the soiled gloves still on.On 09/08/25 at 01:45 PM, Licensed Nurse (LN) G stated R44 was on Hospice services, and the nurse comes a couple of times a week, and staff can call if they need to report anything or need them to come to the facility. On 09/10/25 at 01:00 PM, Administrative Nurse D stated the care plan should be specific to the resident's needs and what the facility and hospice would provide.The Hospice Program policy, undated, documented that hospice services were available to residents at the end of life. Coordinated care plans for residents who received hospice services would include the most recent hospice plan of care, as well as the care and services provided by the facility. The coordinated care plan would reflect the resident's goals and wishes, as stated in his or her advance directives and during ongoing communication with the resident or representative. The plan of care would be revised and updated as necessary to reflect the resident's current status.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. The facility had a census of 41 residents. Based on record review and interview, the facility failed to submit complete and accurate staffing information through the Payroll Based Journal (PBJ) as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing. Findings included: - The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) 2024 Quarter 4 indicated the facility had excessively low weekend staff.On 09/09/24 at 03:30 PM, Administrative Staff A verified the facility would complete the quarterly PBJ data and then would send that information to corporate, then corporate would send that collected information to Prime View, which is a data collection program, and that was the final information that was submitted to the PBJ data. Administrative Staff A verified the facility had adequate staffing during the 2024 Quarter 4 and stated they were unsure how it was incorrectly submitted. The Reporting Direct Care Staffing Information (PBJ) policy, dated August 2022, documented that direct care staffing information is reported electronically to the Centers for Medicare and Medicaid Services (CMS) through the PBJ system. Complete and accurate direct care staffing information is reported electronically to CMS through the PBJ system in a uniform format specified by CMS. Direct care staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain and maintain their highest practicable physical, mental, and psychosocial well-being. Direct care staffing information includes staff hired directly by the facility, those hired through an agency, and contract employees. For auditing purposes, reported staffing information is based on payroll records, invoices, tied back to a contract, or other verifiable information. Data is submitted by the designated personnel with training on the PBJ user interface. Direct care staffing information is submitted on the schedule specified by CMS, but no less frequently than quarterly.