STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175185	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smoky Hill Rehabilitation Center	1007 Johnstown Avenue 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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 65 residents, with three residents reviewed for lack of assessment and change of condition. Based on record review and interview, the facility failed to ensure Resident (R) 1 remained free from neglect when the facility failed to assess a resident, (R)1 after she had a change in condition on 01/13/26 and 01/14/26, which included lethargy, weakness, inability to ambulate, inability to feed herself, and frequent urination. The facility failed to consider hyperglycemia or dehydration as a potential cause of R1's symptoms. On 01/14/26, R1 required transfer to the emergency room, and R1 had a blood glucose level of 1020 milligrams per deciliter (mg/dL) (an extremely high blood glucose level, which constitutes a severe life-threatening emergency) upon admission to the hospital emergency room. This deficient practice placed R1 in immediate jeopardy. Findings included:- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) with other circulatory complications, dementia (progressive mental disorder characterized by failing memory, confusion), hyperlipidemia (condition of elevated blood lipid levels), and cognitive communication deficit. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 had severely impaired cognition. The Brief Interview for Mental Status (BIMS) could not be completed. The MDS documented R1 as independent with ambulation and transfer and required supervision with eating. The Care Plan, dated 04/01/24, documented R1 was at risk for hyperglycemia (greater than normal amount of glucose in the blood). The care plan directed staff to observe/document/report to the doctor as needed for signs and symptoms of hyperglycemia (increased thirst and appetite, frequent urination, weight loss, fatigue, or dry skin). The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 03/05/25, documented R1 had severe cognitive impairment and resided on a secure unit. The Psychosocial Well-Being CAA, dated 03/05/25, documented R1 enjoyed sitting on the couch or at the end of the hall in the secure unit to watch other peers or staff. R1's cognitive impairment hindered her ability to stay on task. The laboratory report, dated 05/15/25, documented R1 had a hemoglobin A1c (HbA1c, a blood test used to evaluate the level of glucose control over the past 90 days) of 5.8% (high), which indicated the resident was at risk for diabetes. R1's Medication Administration Record (MAR), dated January 2026, documented the facility performed blood glucose monitoring as needed related to type 2 diabetes. The staff were to notify the primary care provider if R1's blood sugar was lower than 70 mg/dL or higher than 400 mg/dL, with a start date of 01/07/25. R1's EMR Task Documentation, for 01/12/26, lacked documentation of the amount of food the resident ate for breakfast or lunch. The Task documentation documented R1 was able to eat with staff assistance and ate 26-50% of her supper meal. The transfer task documentation documented R1 did not transfer and/or the staff provided 100% care for R1 for transfers. The walk-in room and walk-in corridor task documentation noted R1 did not ambulate and/or staff provided 100% of care for R1 for ambulation. The task documentation failed to (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	document milliliters of fluid intake. R1's EMR Task Documentation, for 01/13/26, lacked any documentation of the amount of food the resident ate for breakfast or lunch. The Task documentation noted R1 was able to eat with extensive staff assistance and ate 26-50% of her supper meal. The transfer task documentation documented R1 required extensive assistance from two staff members for transfer. The walk-in room and walk-in corridor task documentation documented R1 required extensive assistance from two staff members for ambulation. The task documentation failed to document milliliters of fluid intake. The Health Status Note, dated 01/13/26 at 03:42 AM, documented staff noted R1 had excessive weakness and the staff had to assist R1 from her chair to a wheelchair from the dining area to her room. R1 was unable to ambulate independently or with assistance. R1 was able to pivot with two staff assistance. The note documented R1's vital signs were within normal limits and R1 was in bed with her eyes closed. The EMR lacked documentation of a complete set of vital signs related to the 01/13/26 Health Status Note. The EMR documented R1's blood pressure was 110/90 millimeters of mercury (mmHg). The EMR lacked a blood glucose total for R1. The Fax Communication with Physician Form, dated 01/13/26 at 02:34 PM, documented R1 was having shakes, was more sleepy, and not awake as normal, with frequency of urine. Facility staff had tried several ways to obtain a urine specimen, including a straight catheterization (a sterile procedure to drain urine using a temporary, flexible tube inserted through the urethra (small tubular structure that drains urine from the bladder) into the bladder), with no luck. R1 also had discharge. Requested order for an antibiotic to treat a urinary tract infection (UTI) and noted Please advise. The EMR lacked documentation of the facility's attempt to obtain a urine specimen for R1. The Fax Communication from Physician, dated 01/13/26 at 03:03 PM, documented an order for Macrobid (an antibiotic) twice a day for ten days for R1. The Health Status Note, dated 01/13/26 at 05:26 PM, documented the first dose of Macrobid (an antibiotic) 100 milligrams (mg) pulled from the Cubex (an automated medication dispensing and inventory management system). The Health Status Note, dated 01/13/26 at 10:30 PM, documented R1 continued to have weakness and cognitive decline. R1 still did not ambulate independently as she did. R1 was non-verbal and staff had to feed her the evening meal. The note documented R1's vital signs were within normal limits and no adverse reaction from the first dose of Macrobid for R1's UTI. The EMR lacked a complete set of vital signs and lacked a blood glucose for R1. The Health Status Note, dated 01/14/26 at 04:20 AM, documented staff notified the nurse that R1's foot was cold and looked colorless. The nurse assessed and found R1's foot was pale, cold to the touch, and non-blanchable (when skin does not turn white or fade when pressed). The staff notified the on-call doctor of the situation, who advised the nurse to send R1 to the emergency department. Emergency Medical Technicians (EMTs) arrived at 03:55 AM and left with R1 at 04:03 AM. The Emergency Department Report, dated 01/14/26, documented R1 presented to the emergency department by ambulance from the nursing home. Staff reported R1 had a cold, pale, and pulseless right foot. The report documented R1 was confused and laid in bed all day. R1 had a history of dementia, type 2 diabetes, and a new prescription for Macrobid which started yesterday. On arrival, R1 was obtunded (decreased consciousness). Point of care (POC) glucose obtained, which read HI on the glucometer (instrument used to calculate blood glucose). Vital signs were as follows: temperature 97.8 degrees Fahrenheit (F), pulse 81 beats per minute, respirations 16 breaths per minute, blood pressure 127/116 mmHg, and pulse oximetry of 91% on room air. R1's laboratory glucose was 1020 mg/dL. Sodium level was 158 milliequivalents per liter (mEq/L), which indicated severe dehydration, a high salt diet, or diabetes. Urine specimen resulted in clear yellow urine, glucose level greater than 1000 (Hi), negative for bacteria, and negative for nitrites. After a two-liter bolus (medication administered over a short period of time), Lactated Ringer's (LR - an isotonic intravenous (IV) (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	solution used for fluid resuscitation) along with ten milligrams of IV Humulin insulin (insulin used for rapid glucose control), R1's laboratory glucose was 861 mg/dL. At 05:50 AM, R1's guardian was given a review of problems: profound hyperglycemia, hypernatremia, hyperchloremia (excessive level of chloride in the blood), and acute kidney injury (sudden drop in kidney function). R1's guardian was made aware of R1's critical condition and decision was made to place R1 on hospice care and have R1 kept comfortable. The Health Status Note, dated 01/14/26 at 08:15 AM, documented R1 was to return to the facility on hospice for palliative care. The Health Status Note, dated 01/15/26 at 09:20 PM, documented R1's guardian told the nurse she believed R1 had cessation of vital signs. The nurse assessed R1 and was unable to obtain vital signs and documented cessation of vital signs at 09:23 PM. On 02/19/26 at 10:00 AM, Administrative Nurse E stated R1 had a decline in functioning, they thought R1 had a UTI, and R1 was placed on an antibiotic. Administrative Nurse D stated she did not know anything about R1 having blood sugar monitoring. On 02/19/26 at 11:30 AM, Certified Nurses Aid (CNA) M stated noticed R1 had a significant decline in functioning. CNA M stated he told the nurse R1 was not herself. CNA M stated he did not remember obtaining vital signs for R1, but if he had, he would have documented them in the EMR. CNA M stated he thought the nurse went back and assessed R1, but he could not remember. On 02/19/26 at 01:00 PM, Administrative Nurse D stated she really thought R1 had a UTI, and that is what they went with when they notified the doctor. Administrative Nurse D stated she did not know why the nurses had documented R1's vital signs as within normal limits, but no vital signs were documented and she further said if they weren't documented, they weren't done. On 02/19/26 at 01:30 PM, Licensed Nurse (LN) G stated R1 did have a decline and just was not herself. R1 was not able to walk like she normally did, was not really eating or drinking, and the staff thought, given her age, she probably had a UTI, so the staff contacted the doctor and asked for R1 to be started on an antibiotic. LN G stated they really could not obtain a urine specimen on R1 because she did not urinate in the hat. LN G stated she did not really try to get a straight catheterization because even though she could see the urinary meatus, it just was not in the right position. LN G stated R1 was exhibiting more frequent urination, but not to the extent it would have been her blood sugars, just more like a UTI. LN G stated she did not even know what R1 came back from the hospital with, if she was septic or had an infection. LN G stated they had never taken R1's blood sugar because there was no order to do so. On 02/19/26 at 03:24 PM, R1's Primary Care Physician (PCP) stated he had been treating R1 since 2024, and in that time, he had obtained her HGB A1C every three months, and it had never been above 6. He stated he thought R1 went through organ shutdown, and that was why her blood sugar was so high, as well as the other high labs. The physician stated if nursing had obtained labs and they had not been within normal limits within the first 36 hours of her change of condition, interventions could have been put in place to try to get R1 better before she got to organ shutdown. The facility's Acute Condition Changes Protocol, revised December 2012, documented that the nurse shall assess and document/report the following baseline information: VS's, neuro status, current level of pain, level of consciousness, cognitive status, onset, duration, and severity, recent labs, all active diagnoses, and all current medications. Before calling a physician about someone with an acute change in condition, nursing staff will make detailed observations and collect pertinent information to report to the physician. The nursing staff and physician will discuss possible causes of the condition change based on factors including resident history, current symptoms, medication regimen, and existing test results. The nurse and physician shall discuss and evaluate the situation. The physician should ask questions to clarify the situation, for example, vital signs, physical findings, and description of symptoms. On 02/19/26 at 03:45 PM, Administrative Staff were provided the IJ (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	template and notified the facility failure to ensure Resident (R) 1 remained free from neglect when the facility failed to assess a resident, (R)1 after she had a change in condition on 01/13/26 and 01/14/26, which included lethargy, weakness, inability to ambulate, inability to feed herself, and frequent urination. The facility identified and implemented immediate corrective actions, which were completed on 02/19/26 and included: Effective 2/19/2026 Upon change of condition of any resident Smoky Hill Nurses will: Complete Change of Condition Form and notify resident physician immediately. Any Resident with Diabetes Diagnosis will be assessed for hypo/hyper glycemia and labs as ordered by physician. Nursing Staff will be in-serviced on Hypo/Hyper Glycemia or any other conditions such as frequent urination, lethargy, weakness, inability to ambulate, and inability to feed self as associated with diabetes. All residents with Diabetes will be assessed for signs and symptoms of Dehydration or hypo/hyperglycemic or any other changes associated with Diabetes. Facility will monitor change in conditions 7 days a week and 5 days a week for 3 week. The immediate jeopardy was removed on 2/19/26 when the facility implemented their plan of removal and reviewed by the surveyor on-site. The scope and severity remained at a G.

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 65 residents, with three residents sampled. Based on record review, observation, and interview, the facility failed to provide required respiratory care and equipment for Resident (R) 2 when the facility failed to provide a working Bi-Level Positive Airway Pressure (Bi-Pap-medical device which helps with breathing) for R2 upon release from the hospital, which contributed to R2 developing mucous plugs overnight and R2 becoming hypercapnic (a condition defined by abnormally high levels of carbon dioxide (CO2) with retention of CO2. Due to the failure, R2 was readmitted to the hospital the next day with a high CO2 level of 87 milliequivalents per liter (mEq/L), normal ranges of CO2 is 23 to 30 mEq/L. Findings included:- R2's Electronic Medical Record (EMR) documented R2 had diagnoses of chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), respiratory failure (occurs when the lungs cannot properly transfer oxygen to the blood or remove carbon dioxide), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), and atrial fibrillation (rapid, irregular heart beat). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R2 had a Brief Interview for Mental Status score of 15 which indicated intact cognition. The MDS documented R2 required set-up/supervision assistance for eating, required two staff assistance for bathing, toileting, transfer, and dressing. The MDS documented R2 required continuous oxygen administration. The Functional Abilities Care Area Assessment (CAA), dated 09/05/25, documented R2's activities of daily living (ADLs) capabilities were impaired due to weakness, diagnoses, and comorbidities. The Care Plan dated 09/14/22, documented R2 had an ADL deficit and required assistance. R2 required two staff total assistance with transfer, bathing, toileting, and dressing (08/12/24). The care plan included R2 required oxygen at all times and to monitor R2 for signs and symptoms of respiratory distress and report to the primary care physician as needed: respirations, pulse, oximetry, increased heart rate, restlessness, sweating, headaches, lethargy, confusion, cough, accessory muscle usage, and skin color (09/14/24). The Discharge Instructions, dated 02/09/26, documented R2 was in the local hospital for hypercapnia and pneumonia (inflammation of the lungs). The instructions for R2 included 3 Liters (L) of oxygen at all times and to use a BiPap at night. The Follow-up Visit and Plan, dated 02/10/26, documented R2's primary care physician saw R2 following R2's dismissal from the local hospital. The assessment and plan documented that R2 reported he was doing fine, however R2 did not have the Bi-Pap he was supposed to have prior to leaving the hospital. R2 reported to the primary care physician the hospital told him the Bi-Pap would be at the nursing facility prior to his arrival there. R2's primary care physician documented in his plan: when R2 returned to the nursing facility, he was supposed to be on Bi-Pap, and the facility told the hospital they had a functioning Bi-Pap in the facility. At this time, the facility will need to see if they can acquire Bi-Pap. R2 was dismissed from the hospital on [DATE], and as of the time of this dictation, R2 had not been placed on the Bi-Pap. R2 needed an Arterial Blood Gas (ABG, a test that measures oxygen, carbon dioxide, and acidity levels in the blood) to evaluate R2's CO2 retention status to prevent any worsening of his mental status. If the facility could not get the Bi-Pap in a timely fashion and R2's CO2 continued to rise, he would likely need to go back to the emergency room. The 02/11/26 Health Status Note documented, per R2's primary care physician, R2 needed to go to the local emergency room due to his lab result. R2 had an ABG drawn that morning and the result was a CO2 of 85. The staff notified Emergency Medical Service and transported R2 to the hospital for further assessment. The Health Status Note, dated 02/16/26, documented R2 arrived to the facility via facility transport, and R2 was in good spirits and (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	talked with staff. The Emergency Department Report, dated 02/11/26, documented R2 presented to the emergency department with elevated levels of CO2. R2 had an ABG drawn and showed CO2 of 82.6. The differential diagnosis was pneumonia, COPD exacerbation, mucous plug, hypoventilation syndrome, and viral respiratory illness. The note documented: will order a Bi-Pap to wash out the elevated CO2. The Hospital Health and Physical, dated 02/11/26, documented R2 readmitted for mucous plugging (occurs when thick retained mucous accumulates and blocks airways), left pleural effusion (abnormal accumulation of excess fluid in the space between the lungs and the chest wall), acute hypercapnic respiratory failure, and decreased responsiveness. R2 was dismissed two days ago with orders for Bi-Pap ventilation and the hospital kept R2 an extra day so the facility could arrange a Bi-Pap. R2, for some reason, did not have access to a Bi-Pap machine. The chest computed tomography (CT scan- test that used x-ray technology to make multiple cross-sectional views of organs, bone, soft tissue, and blood vessels) showed near complete appearing collapse of the left upper lobe, small left pleural effusion, and potential mucous plugging in the left mainstem bronchus (a major airway in the respiratory system that conducts air to the lungs). The pulmonologist consulted and stated the CT scan showed likely mucous plugging. The Pulmonology Consult Note, dated 02/11/26, documented R2 came in with recurrent acute hypercapnic respiratory failure requiring Bi-Pap. R2 was recently seen in the hospital for hypercapnic respiratory failure and was discharged on Bi-Pap; however, R2 returned with similar symptoms. The note included they would run tests to determine if R2 was mucous plugging or if he had a pleural effusion. If there was mucous plugging, the Bi-Pap should help open up that area. If R2 had a pleural effusion, R2 would need a thoracentesis (removal of excess fluid from the air space between the lungs and the chest wall). The noted documented R2's mentation was already improving with Bi-Pap. On 02/19/26 at 12:45 PM, observation revealed R2 lay in his bed with a sheet covering his lower extremities and bare-chested. A fan cooled the room. R2 had oxygen on via nasal cannula. The Bi-Pap machine was on the right side of R2's bed and R2 had shortness of breath while speaking. On 02/19/26 at 12:45 PM, R2 stated he was upset because he was told the facility had the Bi-Pap machine, then the facility did not have one, and he had to go right back to the hospital. R2 said it was scary when he got so loopy, and he did not know what was going on. On 02/19/26 at 01:00 PM, Administrative Nurse D stated she talked to R2's physician and the physician said it was an unfortunate circumstance that led to R2 not having the Bi-Pap. Administrative Nurse D said nursing kind of dropped the ball a little bit, but what else could they do. Administrative Nurse D stated she did not know if the evening nurse had contacted anyone about R2 not having Bi-Pap overnight. On 02/19/26 at 01:30 PM, Licensed Nurse (LN) G stated the facility had told the hospital they had a Bi-Pap machine in-house they could use for R2. When she and the Administrative Nurse E went to set up the Bi-Pap with the appropriate settings, they could not get the settings put in the machine. They called the medical equipment company, and the medical equipment company told them the Bi-Pap was no longer functional. The medical equipment company told them they would send a new Bi-Pap machine to the facility, and it should be there by that evening. LN G stated she did not know until the next morning the Bi-Pap machine had not been delivered and R2 was without a Bi-Pap the previous night. The facility failed to provide a Respiratory Care Policy applicable to the deficient practice.