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	04/23/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 65 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to provide assistance in privacy for Residents (R) 44 and R48 who wore incontinent briefs, which were visible from the hallway to visitors, staff, and other residents. This deficient practice placed R48 and 4 for impaired dignity and decreased psychosocial well-being. Finding included: - R44's Electronic Medical Record (EMR) recorded diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin(a hormone that lowers the level of glucose in the blood)), morbid obesity (excessive body fat), major depressive disorder (major mood disorder that causes persistent feelings of sadness), delusional (untrue persistent belief or perception held by a person although evidence shows it was untrue) disorder, restless leg syndrome, chronic pain, lymphedema (swelling caused by accumulation of lymph), and chronic respiratory failure The Admission Minimum Data Set (MDS), dated [DATE], documented R44 had intact cognition, had no delirium, no psychosis (any major mental disorder characterized by a gross impairment in reality perception), nor exhibited behaviors. R44 was dependent with rolling in bed and transfers. R44 was dependent on toileting hygiene, bathing, and upper and lower body dressing. The MDS further documented that R48 was frequently incontinent, had occasional pain which interfered with day-to-day activities, was short of breath with exertion or lying flat, used oxygen, and had falls before entering the facility. The MDS also recorded received insulin, antianxiety (a class of medications that calm and relax people), antidepressant (a class of medications used to treat mood disorders), diuretic (a medication to promote the formation and excretion of urine), opioid (a class of medications used to treat pain), and hypoglycemic (greater than normal amount of glucose in the blood) medications. The Functional Abilities Care Area Assessment (CAA), dated 03/17/25, documented R44 with impaired abilities due to weakness and comorbidities (the presence of two or more diseases). R44's Interim Plan of Care dated 03/08/25, directed staff to encourage use of the call light due to fall risk, needed partial assistance from another person for functional cognition and setup or clean-up assistance with toileting hygiene, and upper and lower body dressing. The care plan further directed staff that R44 was dependent on bed mobility and personal hygiene. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R44's Care Plan, dated 03/24/25, documented that R44 had a behavioral problem utilizing the call light appropriately related to difficulty adjusting to the new environment and had self-care performance deficit, required assistance with decision making, and limited mobility. The care plan directed staff to stop and talk with her as they passed by, but lacked specifics related to how much staff assistance was required for functional abilities. The Progress Note dated 03/08/25 at 05:34 AM documented R44 required a mechanical lift for transfers, two persons for turning, was incontinent of urine and bowel, wore pull-ups, to check every two hours, and change due to heavy wetting. R44 had high anxiety, used the call light to ask for help. The Progress Note dated 03/10/25 at 05:50 AM documented R44 had been very restless overnight, pulling on oxygen tubing, spilling drinks, kicking legs completely out of bed every 20 to 30 minutes, taking her oxygen off, and yelling out instead of using her call light. The Progress Note dated 03/28/25 at 09:48 AM documented speech and occupational therapy to see for mild confusion, cognition, and swallowing goals. The Progress Note dated 04/03/25 at 11:58 PM documented that the psychiatric practitioner recommended utilizing as-needed antianxiety medication for panic/breakthrough anxiety and would follow up in one month. On 04/21/25 at 02:33 PM, ongoing observations revealed R44 had coughing and gagging into a basin in the morning, placing her left leg off the bed, had the lower portion of her body uncovered with her brief and legs visible from the doorway and hall as staff and visitors walked by. No staff assistance until the midday meal was brought to her room. The resident was not assisted with positioning for the meal, the resident remained in bed with the head of the bed only raised 30 degrees. R44 plate and drinks were uncovered and left on the overbed table. R44 lacked assistance with positioning in bed, remained with the head of the bed lowered and ate a few bites, and coughed. On 04/21/25 at 03:01 PM, R44 continued with her left leg off the mattress and hanging, not touching the floor or covered from the waist down, exposing her incontinent brief, which was visualized from the hallway. Staff entered the room and told the resident her leg was hanging, and assisted the resident in putting her leg into the bed and covered the resident. On 04/21/25 at 03:45 PM, R44 had her left leg off the side of the bed and lower body, and an incontinent brief was exposed to staff, visitors, and other residents from the hallway. R44 called out for assistance. R44 stated she could not find her call light and needed her oxygen canula. Social Service Staff X entered the room, found R44's call light, which had been off to the right side of the bed, not within reach of the resident, and provided R44 with oxygen tubing. On 04/21/25 at 04:27 PM, R44 again observed from the hallway with left leg off the bed, lower body uncovered exposing her incontinent brief, and trying to drink with the head of bed at a 30-degree angle, with coughing following taking a drink from her cup. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/22/25 at 12:50 PM, staff brought R44's lunch and placed it on the overbed table. R44 was again positioned with the head of the bed at 30 degrees, and no offers to assist R44 into a sitting position for the meal. R44 then moved the plate off the tray and placed it on her abdomen, and tried to take a few bites, then removed the plate and placed it back onto the over-bed table. R44 then attempted to fill her drinking cup with soda from the overbed table while the head of the bed was not elevated. On 04/22/25 at 01:00 PM, R44 stated she relied on staff to adjust her bed, and that she had difficulty managing the bed controls. The bed controls on the right side of the bed, fastened on the bedrail, were not functioning when R44 tried adjusting the bed herself. R44 ' s call light was not within reach of the resident. Social Service Staff X entered the room and found the bed controls not working and placed the call light within reach of the resident. Social Service Staff X reported that he would see that the bed control would be fixed. On 04/22/25 at 03:44 PM, Certified Nurse Aide (CNA) N brought a pizza box into the room and left it on the overbed table. R44, again with the head of the bed lowered to a 30-degree angle, placed the pizza on her abdomen and started to eat it. On 04/22/25 at 03:51 PM, Administrative Staff A, while visualizing R44's head of the bed lowered and trying to eat the pizza, stated R44's position was not safe for eating or drinking and did not accommodate safe swallowing. On 04/23/25 at 01:30 PM, R44 sat in the recliner and called out for assistance. The call light was not within reach, and R44 reported staff had moved it earlier when picking up her meal tray. On 04/23/25 at 02:20 PM, Administrative Nurse E stated staff should assist residents as needed to protect the resident's privacy with closing doors and covering the residents. The facility's Quality of Life-Dignity policy, dated 08/2009, documented that each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Staff shall promote, maintain, and protect residents' privacy, including bodily privacy during assistance with personal care and treatment procedures. - R48's Electronic Medical Record (EMR) documented diagnoses of hypertension (HTN - elevated blood pressure), 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), chronic kidney disease, angina (chest pain) pectoris, delusional (untrue persistent belief or perception held by a person although evidence shows it was untrue) disorder, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, localized edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and major depressive disorder (major mood disorder that causes persistent feelings of sadness). The Annual Minimum Data Set (MDS) recorded R48 had intact cognition, experienced no delirium, or exhibited behaviors. R48 required supervision or touching assistance with functional abilities and mobility. R48 was frequently incontinent of urine and bowel. The MDS further documented R48 received no high-risk medications. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Functional Abilities Care Area Assessment (CAA) dated 03/04/25 recorded that R48 had impairment related to diagnosis, weakness, and comorbidities (several conditions simultaneously). R48's Care Plan dated 04/16/25, recorded R48 exhibited self-care performance deficit, the inability to control urination, and was frequently incontinent. The care plan directed staff R48 required supervision and set up assistance with eating, toileting, to provide an appropriate diet, and had a scheduled toileting program which consisted of taking R48 to the bathroom at 04:00 AM, at bedtime, 11:00 PM, as well as before and after meals, as R48 would allow. On 04/22/25 at 07:50 AM, R48 remained in bed, covered with a blanket, clothing lying on the floor, and the room smelled of urine. On 04/22/25 at 09:33 AM, staff in R48's room gathered urine-soiled clothing and bed linens. R48 had a 600 cc jug of ice water on the bedside table and was standing with the walker wearing only a blue incontinent brief. When staff exited the room and left the door open as R48 proceeded to walk to the dresser to obtain clothing, in which staff and visitors could observe R48 wearing only a brief as they passed in the hall. On 04/23/25 at 02:20 PM, Administrative Nurse E stated staff should assist residents as needed to protect the resident's privacy with closing doors and covering the residents. The facility's Quality of Life-Dignity policy, dated 08/2009, documented each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Staff shall promote, maintain, and protect residents' privacy, including bodily privacy during assistance with personal care and treatment procedures.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 37450 The facility had a census of 65 residents. The sample included 13 residents, with three reviewed for Medicare Liability Notices. Based on the record review and interview, the facility failed to provide the resident (or their representative) a fully completed Advanced Beneficiary Notice (ABN) Centers for Medicare and Medicaid Services (CMS) Form 10055) for skilled services for Resident (R) 12 and R216, which included the estimated cost of services. This placed the residents at risk for uninformed care decisions. Findings included: - The facility provided a CMS Form 10124 to R12 instead of the CMS Form-10055 provided when the skilled services would end on 01/20/25, which informed the R12 that Medicare may not pay future skilled therapy services and provided a cost estimate of continued services. The form included an option for the beneficiary to (1) Receive the specified therapy listed, and bill Medicare for an official decision on payment. I understand if Medicare does not pay, I am responsible for payment, but could appeal Medicare. (2) Receive therapy listed, but do not bill Medicare, I am responsible for payment for services. (3) I do not want the listed therapy services. The facility provided a CMS Form 10124 to R216 instead of the Center of Medicare (CMS)-10055 form provided when the skilled services would end on 03/05/25, which informed the R216 that Medicare may not pay future skilled therapy services and provided a cost estimate of continued services. The form included an option for the beneficiary to (1) Receive the specified therapy listed, and bill Medicare for an official decision on payment. I understand if Medicare does not pay, I am responsible for payment, but could appeal Medicare. (2) Receive therapy listed, but do not bill Medicare, I am responsible for payment for services. (3) I do not want the listed therapy services. On 04/23/25 at 02:30 PM, Administrative Staff A reported the facility had stopped using CMS Form 10055, due to direction from corporate. Upon request, the facility failed to provide a Medicare beneficiary policy.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 32358 The facility had a census of 65 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents who ate in the dining room. This placed the residents who ate in the main dining room at risk for unhomelike, unsanitary conditions. Findings included: - On 04/21/25 at 10:58 AM, approximately 2-3 feet of the mopboard located at the west end of the dining room was coming away from the wall. Approximately 6 inches (in) at the end of the mopboard was lying on the floor. On 04/23/25 at 08:28 AM, Maintenance Staff (MS) U verified the above finding and stated he was aware of the issue with the mopboard; he had placed a table in front of the mopboard, but someone had moved it. MS U stated the facility was changing all the mopboards throughout the facility. MS stated when staff had an environmental issue, they placed it in the telemonitoring system (TELS - refers to a telehealth or telemonitoring platform that uses technology to remotely monitor the health and well-being of residents) in the computer. On 04/23/25 at 08:45 AM, Administrative Nurse E stated she expected MS U to address an issue immediately when it was placed in the TELS system. The facility's Maintenance Service Policy, revised in December 2009, documented the maintenance supervisor was responsible for developing and maintaining a schedule of maintenance service to assure the buildings, grounds, and equipment were maintained in a safe and operable manner.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 37450 The facility had a census of 65 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to revise Resident (R) 48's care plan to include the physician-ordered fluid restriction. This placed the resident at risk of fluid overload and unmet care needs. Findings included: - The Electronic Medical Record (EMR) for R48 documented diagnoses of hypertension (HTN - elevated blood pressure), 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), chronic kidney disease, angina (chest pain) pectoris, delusional (untrue persistent belief or perception held by a person although evidence shows it was untrue) disorder, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, localized edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and major depressive disorder (major mood disorder that causes persistent feelings of sadness). The Annual Minimum Data Set (MDS) recorded R48 had intact cognition, experienced no delirium, or exhibited behaviors. R48 required supervision or touch assistance with functional abilities and mobility. R48 was frequently incontinent of urine and bowel. The MDS further documented that R48 received no high-risk medications. The Functional Abilities Care Area Assessment (CAA) dated 03/04/25 recorded that R48 had impairment related to diagnosis, weakness, and comorbidities (several conditions simultaneously). R48's Care Plan dated 04/16/25, recorded R48 exhibited self-care performance deficit, the inability to control urination, and was frequently incontinent. The care plan directed staff R48 required supervision and set up assistance with eating, toileting, to provide an appropriate diet, and had a scheduled toileting program which consisted of taking R48 to the bathroom at 04:00 AM, at bedtime, 11:00 PM, as well as before and after meals, as R48 would allow. The care plan lacked the physician-ordered fluid restriction. The Physician Order dated 10/23/24, directed staff to implement a fluid restriction of three liters (3000 cubic centimeters - cc's) daily. The order directed the dietary department for the day shift to provide 1500 ccs, and nursing would provide 270 ccs. The evening shift dietary department provided 800 ccs, and nursing could provide 270 ccs, and the night shift nursing provided 160 ccs related to chronic kidney disease. The order for the dietary department would give a total of 2300 ccs, and nursing would provide 700 cc, which totaled 3000 ccs in 24 hours. The Nutritional Progress Note, dated 12/05/24, documented R48 remained on a regular diet with dysphagia (swallowing difficulty), advanced texture, and a fluid restriction of three liters daily. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Weight Change Progress Note dated 03/25/25, documented a decrease in weight trend possibly due to a current urinary tract infection and had a three-liter fluid restriction. The note further documented no edema, no diuretic order, and would see if the fluid restriction could be discontinued. On 04/22/25 at 09:33 AM, staff in R48's room, gathering urine-soiled clothing and bed linens. R48 had a 600-cc jug of ice water on the bedside table and was standing with the walker wearing only a blue incontinent brief, when staff exited the room and left the door open as R48 proceeded to walk to the dresser to obtain clothing, in which staff and visitors could observe R48 wearing only a brief as they passed in the hall. On 04/22/25 at 12:08 PM, Certified Nurse Aide (CNA) M reported she was not aware of a fluid restriction but would check on the restriction with the charge nurse. On 04/22/25 at 12:10 PM, Licensed Nurse (LN) G reported R48 had a fluid restriction but could not recall the amount, but stated the dietary department provided fluids with meals, and R48 should not have a 600-cc ice water mug at the bedside. LN G reported that the charge nurse and CNAs work together to determine the intake for the residents who had fluid restrictions, and the nurse should document the amount of intake on R48, but had not done so for R48. On 04/23/25 at 02:30 PM, Administrative Nurse E stated it was the responsibility of nursing staff to record and monitor the intake of residents on fluid restrictions, and expected the fluid restriction on R48's care plan. The facility's Care Planning-Interdisciplinary Team policy, dated 09/2013, documented the facility's Care Planning/Interdisciplinary Team were responsible for the development of an individualized comprehensive care plan for each resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 65 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to provide activities of daily living support for Resident (R) 44 and R48, who required assistance from staff. This placed the residents at risk for ongoing unmet needs and care. Findings included: - R44's Electronic Medical Record (EMR) recorded diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin(a hormone that lowers the level of glucose in the blood)), morbid obesity (excessive body fat), major depressive disorder (major mood disorder that causes persistent feelings of sadness), delusional (untrue persistent belief or perception held by a person although evidence shows it was untrue) disorder, restless leg syndrome, chronic pain, lymphedema (swelling caused by accumulation of lymph), and chronic respiratory failure The Admission Minimum Data Set (MDS), dated [DATE], documented R44 had intact cognition, had no delirium, psychosis (any major mental disorder characterized by a gross impairment in reality perception), or exhibited behaviors, was dependent with rolling in bed and transfers. R44 was dependent on toileting hygiene, bathing, and upper and lower body dressing. The MDS further documented that R48 was frequently incontinent, had occasional pain which interfered with day-to-day activities, was short of breath with exertion or lying flat, used oxygen, and had falls before entering the facility. The MDS also recorded received insulin, antianxiety (a class of medications that calm and relax people), antidepressant (a class of medications used to treat mood disorders), diuretic (a medication to promote the formation and excretion of urine), opioid (a class of medications used to treat pain), and hypoglycemic (greater than normal amount of glucose in the blood) medications. The Functional Abilities Care Area Assessment (CAA), dated 03/17/25, documented R44 with impaired abilities due to weakness and comorbidities (the presence of two or more diseases). R44's Interim Plan of Care, dated 03/08/25, directed staff to encourage use of the call light due to fall risk, needed partial assistance from another person for functional cognition and setup or clean-up assistance with toileting hygiene, and upper and lower body dressing. The care plan further directed staff that R48 was dependent on bed mobility and personal hygiene. R44's Care Plan, dated 03/24/25, documented that R44 had a behavioral problem utilizing the call light appropriately related to difficulty adjusting to the new environment and had self-care performance deficit, required assistance with decision making, and limited mobility. The care plan directed staff to stop and talk with her as they passed by, but lacked specifics related to how much staff assistance was required for functional abilities. The Progress Note dated 03/08/25 at 05:34 AM documented R44 required a mechanical lift for transfers, two persons for turning, was incontinent of urine and bowel, wore pull-ups, to check every two hours, and change due to heavy wetting. R48 had high anxiety, used the call light to ask for help. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note dated 03/10/25 at 05:50 AM documented R44 had been very restless overnight, pulling on cord/oxygen tubing, spilling drinks, kicking legs completely out of bed every 20 to 30 minutes, taking her oxygen off, and yelling out instead of using her call light. The Progress Note dated 03/28/25 at 09:48 AM documented speech and occupational therapy to see for mild confusion, cognition, and swallowing goals. The Progress Note dated 04/03/25 at 11:58 PM documented that the psychiatric practitioner recommended utilizing as-needed antianxiety medication for panic/breakthrough anxiety and would follow up in one month. On 04/21/25 at 02:33 PM, ongoing observations revealed R48 had coughing and gagging into a basin in the morning, placing her left leg off the bed, had the lower portion of her body uncovered with a brief, and legs visible from the doorway and hall as staff and visitors walked by. No staff assistance until the midday meal was brought to her room. The resident was not assisted with positioning for the meal, the resident remained with the head of the bed, and was only raised 30 degrees. R48 plate and drinks were uncovered and left on the overbed table. R44 lacked assistance with positioning in bed, remained with the head of the bed lowered, ate a few bites, and coughed. On 04/21/25 at 03:01 PM, R44 continued with her left leg off the mattress and hanging, not touching the floor or covered from the waist down, exposing her incontinent brief, which was visualized from the hallway. Staff entered the room and told the resident her leg was hanging, and assisted the resident in putting her leg into the bed and covered the resident. On 04/21/25 at 03:45 PM, R44 had her left leg off the side of the bed and lower body, and an incontinent brief was exposed to staff, visitors, and other residents from the hallway. R48 called out for assistance. R48 stated she could not find her call light and needed her oxygen canula. Social Service Staff X entered the room, found R44's call light, which had been off to the right side of the bed, not within reach of the resident, and provided R44 with oxygen tubing. On 04/21/25 at 04:27 PM, R44 again observed from the hallway with left leg off the bed, lower body uncovered exposing her incontinent brief, and trying to drink with the head of bed at a 30-degree angle, with coughing following taking a drink from her cup. On 04/22/25 at 12:50 PM, staff brought R44's lunch and placed it on the overbed table. R44 was again positioned with the head of the bed at 30 degrees, and no offers to assist R48 into a sitting position for the meal. R44 then moved the plate off the tray and placed it on her abdomen, and tried to take a few bites, then removed the plate and placed it back onto the over-bed table. R48 then attempted to fill her drinking cup with soda from the overbed table while the head of the bed was not elevated. On 04/22/25 at 01:00 PM, R44 stated she relied on staff to adjust her bed, and that she had difficulty managing the bed controls. The bed controls on the right side of the bed, fastened on the bedrail, were not functioning when R48 tried adjusting the bed herself. R44's call light was not within reach of the resident. Social Service Staff X entered the room and found the bed controls not working, and placed the call light within reach of the resident. Social Service Staff X reported that he would see that the bed control would be fixed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/22/25 at 03:44 PM, Certified Nurse Aide (CNA) N brought a pizza box into the room and left it on the overbed table. R44, again with the head of the bed lowered to a 30-degree angle, placed the pizza on her abdomen and started to eat it. On 04/22/25 at 03:51 PM, Administrative Staff A, while visualizing R44's head of the bed lowered and trying to eat the pizza, stated R44's position was not safe for eating or drinking and did not accommodate safe swallowing. On 04/23/25 at 01:30 PM, R44, while sitting in the recliner, called out for assistance. The call light was not within reach, and R44 reported staff had moved it earlier when picking up her meal tray. The facility's Repositioning policy, dated 05/2013, documented the purpose of the procedure was to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for al bed or chair-bound residents, to prevent skin breakdown, promote circulation, and provide pressure relief for residents. A turning/repositioning program includes a continuous, consistent program for changing the resident's position and realigning the body. A program is defined as a specific approach that is organized, planned, documented, monitored, and evaluated. Upon request, the facility failed to provide a policy for activities of daily living support. - The Electronic Medical Record (EMR) for R48 documented diagnoses of hypertension (HTN - elevated blood pressure), 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), chronic kidney disease, angina (chest pain) pectoris, delusional (untrue persistent belief or perception held by a person although evidence shows it was untrue) disorder, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, localized edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and major depressive disorder (major mood disorder that causes persistent feelings of sadness). The Annual Minimum Data Set (MDS) recorded R48 had intact cognition, experienced no delirium, or exhibited behaviors. R44 requires supervision or touching assistance with functional abilities and mobility. R48 was frequently incontinent of urine and bowel. The MDS further documented that R48 received no high-risk medications. The Functional Abilities Care Area Assessment (CAA) dated 03/04/25 recorded that R48 had impairment related to diagnosis, weakness, and comorbidities (several conditions simultaneously). R48's Care Plan dated 04/16/25, recorded R48 exhibited self-care performance deficit, the inability to control urination, and was frequently incontinent. The care plan directed staff R48 required supervision and set up assistance with eating, toileting, to provide an appropriate diet, and had a scheduled toileting program which consisted of taking R48 to the bathroom at 04:00 AM, at bedtime, 11:00 PM, as well as before and after meals, as R48 would allow. The care plan lacked the physician-ordered fluid restriction. The Weight Change progress note, dated 0/25/25, documented a decrease in weight trend possibly due to a current urinary tract infection and had a three-liter fluid restriction. The note further documented no edema, no diuretic order, and would see if the fluid restriction could be discontinued. (continued on next page)

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	175185	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smoky Hill Rehabilitation Center	1007 Johnstown Avenue Salina, KS 67401

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/22/25 at 07:50 AM, R48 remained in bed, covered with a blanket, clothing lying on the floor, and the room smelled of urine. On 04/22/25 at 09:33 AM, staff in R48's room gathered urine-soiled clothing and bed linens. R48 had a 600-cc jug of ice water on the bedside table and was standing with the walker wearing only a blue incontinent brief. The staff exited the room and left the door open. R48 proceeded to walk to the dresser to obtain clothing, in which staff and visitors could observe R48 wearing only a brief as they passed in the hall. On 04/23/25 at 02:20 PM, Administrative Nurse E stated staff should assist the residents as needed and to protect their privacy by ensuring the residents are dressed, covered, or have their doors closed. Upon request, the facility failed to provide a policy for activities of daily living support.

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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** 26768 The facility had a census of 65 residents. The sample included 13 residents, with four residents reviewed for urinary catheter (tube inserted into the bladder to drain urine into a collection bag) or urinary tract infection (UTI - an infection in any part of the urinary system). Based on observation, interview, and record review, the facility failed to provide urinary catheter care in a manner to prevent urinary tract infections for Resident (R) 12. This deficient practice placed R12 at risk for infections and catheter-related complications. Findings included: - R12's Electronic Medical Record documented diagnoses of cerebral infarction (stroke), 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 infection due to an indwelling urinary catheter. R12's Annual Minimum Data Set (MDS), dated [DATE], documented R12 had severely impaired cognition. The MDS documented R12 required moderate assistance for toileting, had a urinary catheter, and received antibiotic and diuretic (medication to promote the formation and excretion of urine) medications. R12's Care Plan, dated 03/27/25, directed staff to change the 18 French catheter as ordered, check for patency and urinary output every shift, and observe for pain or discomfort due to the catheter. Staff were to check the catheter tubing for kinks, position the catheter bag and tubing below the level of the bladder, and obtain and document the output every shift. On 04/21/25 at 03:14 PM, R12 was seated in her wheelchair in the dining room. The catheter bag was in a privacy bag hung to dependent drainage under the wheelchair. Approximately four inches of catheter tubing rested on the floor when her foot was on the floor. On 04/23/25 at 07:45 AM, R12 was seated in her wheelchair in the dining room. The catheter bag was in a privacy bag hung to dependent drainage under the wheelchair. Approximately one inch of catheter tubing rested on the floor. On 04/22/25 at 01:13 PM, Administrative Nurse D verified she expected staff to be aware and not allow the tubing to rest or drag on the floor. The facility's Urinary Catheter Care policy, dated September 2014, directed staff to be sure the catheter tubing and drainage bag were kept off the floor.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 37450 The facility had a census of 65 residents. The sample included 13 residents. Based on observation, interview, and record review, the facility failed to monitor Resident (R) 48's physician order for fluid restriction. This placed R48 at risk of complications related to hydration status due to the resident's cardiac status. Findings included: - The Electronic Medical Record (EMR) for R48 documented diagnoses of hypertension (HTN-elevated blood pressure), 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), chronic kidney disease, angina (chest pain) pectoris, delusional (untrue persistent belief or perception held by a person although evidence shows it was untrue) disorder, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, localized edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and major depressive disorder (major mood disorder that causes persistent feelings of sadness). The Annual Minimum Data Set (MDS) recorded R48 had intact cognition, experienced no delirium, or exhibited behaviors. R44 requires supervision or touching assistance with functional abilities and mobility. R48 was frequently incontinent of urine and bowel. The MDS further documented that R48 received no high-risk medications. The Functional Abilities Care Area Assessment (CAA) dated 03/04/25 recorded that R48 had impairment related to diagnosis, weakness, and comorbidities (several conditions simultaneously). R48's Care Plan dated 04/16/25, recorded R48 exhibited self-care performance deficit, the inability to control urination, and was frequently incontinent. The care plan directed staff R48 required supervision and set up assistance with eating, toileting, to provide an appropriate diet, and had a scheduled toileting program which consisted of taking R48 to the bathroom at 04:00 AM, at bedtime, 11:00 PM, as well as before and after meals, as R48 would allow. The care plan lacked the physician-ordered fluid restriction. The Physician Order dated 10/23/24, directed staff to implement a fluid restriction of three liters (3000 cubic centimeters (cc)) daily. The order directed the dietary department for the day shift to provide 1500 cc, and nursing would provide 270 cc. The evening shift dietary department provides 800 cc, and nursing could provide 270 cc, and the night shift nursing provides 160 cc related to chronic kidney disease. The order for the dietary department would give a total of 2300 cc, and nursing would provide 700 cc, which totaled 3000 cc in 24 hours. The Nutritional Progress Note, dated 12/05/24, documented R48 remained on a regular diet with dysphagia (swallowing difficulty), advanced texture, and a fluid restriction of three liters daily. The Weight Change progress note, dated 0/25/25, documented a decrease in weight trend possibly due to a current urinary tract infection and had a three-liter fluid restriction. The note further documented no edema, no diuretic order, and would see if the fluid restriction could be discontinued. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/22/25 at 07:50 AM, R48 remained in bed, covered with a blanket, clothing lying on the floor, and the room smelled of urine. On 04/22/25 at 09:33 AM, staff in R48's room gathered urine-soiled clothing and bed linens. R48 had a 600-cc jug of ice water on the bedside table and was standing with the walker wearing only a blue incontinent brief. When staff exited the room and left the door open as R48 proceeded to walk to the dresser to obtain clothing, in which staff and visitors could observe R48 wearing only a brief as they passed in the hall. On 04/22/25 at 12:08 PM, Certified Nurse Aide (CNA) M reported she was not aware of a fluid restriction but would check on the restriction with the charge nurse. On 04/22/25 at 12:10 PM, Licensed Nurse (LN) G reported R48 had a fluid restriction but could not recall the amount, but stated the dietary department provided fluids with meals, and R48 should not have a 600 cc ice water mug at the bedside. LN G reported that the charge nurse and CNAs work together to determine the intake for the residents who had fluid restrictions, and the nurse should document the amount of intake on R48, but had not done so for R48. On 04/23/25 at 02:30 PM, Administrative Nurse E stated it was the responsibility of nursing staff to record and monitor the intake of residents on fluid restrictions, and expected the fluid restriction on R48's care plan. The facility's Encouraging and Restricting Fluids policy, dated 10/2010, documents that the purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. General guidelines direct staff to follow specific instructions concerning food intake or restriction. The general guidelines documented the instructions concerning fluid intake or restriction. Record intake of fluids. When a resident has been placed on fluids, remove the water pitcher and cup from the room. If the resident refuses to have a water pitcher and cup from the room.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 26768 The facility had a census of 65 residents. Based on observation, interview, and record review, the facility failed to store medications securely and dispose of expired medications timely. This deficient practice placed residents of the facility at risk for ineffective medication and unsafe access to medications. Findings included: - On 04/21/25 at 08:25 AM, the facility's nurse treatment cart contained one bottle of aspirin (used for pain, fever, and inflammation), 325 milligrams (mg), with an expiration date of 08/2024 and one undated insulin (hormone that lowers the level of glucose in the blood) pen. The observation was verified by Licensed Nurse (LN) I. On 04/21/25 at 08:46 AM, the facility's 300 hall medication cart contained one bottle of biotin (a supplement) 5000 micrograms (mcg) with an expiration date of 03/2025. The expiration date was confirmed by Certified Medication Aide (CMA) R. On 04/22/25 at 02:15 PM, the facility's nurse treatment cart on the 300 hall was unlocked with warfarin (a blood thinner) and other pill medication cards, insulin pens, and breathing treatments accessible. No licensed staff were in sight of the cart for two minutes until the surveyor asked an aide whose cart it was. LN H came around the corner from the other hall and verified she should not have left the cart unlocked. On 04/23/25 at 10:10 AM, the facility's medication room had expired stock medications including: Magnesium chloride (a supplement) 64 mg, one bottle with an expiration date of 02/2025. Folic acid (a supplement) 400 mcg, 6 bottles with an expiration date of 03/2025. On 04/23/25 at 10:19 AM, LN G verified that the magnesium chloride and folic acid had expired dates. On 04/22/25 at 04:40 PM, Administrative Nurse D verified staff should have removed and disposed of the expired medications. Administrative Nurse D verified any cart holding medications should be locked when out of sight of licensed nursing staff. The facility's Storage of Medication policy, dated April 2007, stated that the facility shall not use discontinued or outdated drugs or biologicals, and all such drugs shall be destroyed or returned to the pharmacy. The policy stated that carts, rooms, and cabinets containing drugs and biologicals shall be locked when not in use and shall not be left unattended if open or otherwise potentially available to others.

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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** 32358 The facility had a census of 65 residents. The sample included 13 residents, with one reviewed for hospice services. Based on observation, record review, and interview, the facility failed to ensure a communication process between the hospice provider and the facility for Resident (R) 18, who admitted to hospice on 02/25/25, which included a plan of care and a description of the services provided, such as contact information, visit frequency, medications, and medical equipment. This placed the resident at risk of not receiving needed care. Findings included: - R18's Electronic Health Record (EHR) revealed diagnoses of sarcopenia (a condition characterized by the progressive decline of skeletal muscle mass, strength, and function) and transient ischemic attack (TIA - temporary episode of inadequate blood supply to the brain). R18's Significant Change Minimum Data Set (MDS), dated [DATE], documented R18 had a Brief Interview of Mental Status (BIMS) of 12, which indicated moderately impaired cognition. The MDS documented R18 required staff supervision with eating, oral hygiene, rolling left to right in bed, wheeling in a wheelchair, partial, moderate staff assistance with toileting, showering, upper and lower body dressing, sit to lying and lying to sitting in bed, and transfers. The MDS documented R18 received hospice services. R18's Care Plan, dated 03/20/25, documented R18 required extensive assistance with most activities of daily living (ADL) care. The plan documented R18 had a terminal prognosis related to diagnoses of sarcopenia and TIA and was admitted to hospice services on 02/25/25. The plan instructed staff to adjust provision of ADLs to compensate for residents' changing abilities, encourage R18 to participate to the extent the resident wishes to participate, assess R18 for coping strategies and respect resident wishes, encourage resident to express her feelings, and listen with non-judgment. The plan instructed staff to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. The plan lacked instructions on the services provided by hospice, including the frequency and type of support visits, supplies, and medical equipment provided by hospice, medications covered by hospice, and the hospice contact information. A review of R18's clinical record revealed the resident was admitted to hospice care on 02/25/25. The Hospice Skilled Nursing Facility Contract dated December 2022, documented the nursing facility plan of care shall mean a written care plan established, maintained, reviewed, and modified, if necessary, by the nursing facility's interdisciplinary team (IDT) with the participation of the hospice patient. The nursing facility plan of care shall be consistent with the hospice plan of care for the hospice patient. On 04/21/25 at 02:40 PM, R18 sat quietly in a recliner in her room without signs and symptoms of pain. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/23/25 at 10:26 AM, Administrative Nurse F stated she oversaw updating care plans and verified R18's care plan lacked hospice contact information, medications provided by hospice, supplies, and equipment hospice would provide, visitations, and care they would provide. Administrative Nurse F stated she did not put that information on a hospice resident's care plan. On 04/23/25 at 10:50 AM, Consultant Staff GG verified R18's care plan lacked the services provided by hospice, including the frequency and type of support visits, supplies and medical equipment provided by hospice, medications covered by hospice, and the hospice contact information. Consultant Staff GG stated that staff had not placed this information on the facility care plan; they could get it from the hospice care plan kept at the nurse's station. The facility's Hospice Program Policy, updated August 2010, documented that when a resident participated in the hospice program, a coordinated plan of care between the facility, hospice agency, and resident/family would be developed and should include directives for managing pain and other uncomfortable symptoms.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 65 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to ensure a sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections when staff failed to ensure R43's urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag) tubing and uncovered bag off the floor. Findings included: - R43's Electronic Medical Record (EMR) documented that R43 had diagnoses of obstructive and reflux uropathy (a condition where the normal flow of urine through the urinary tract is blocked, while reflux uropathy (vesicoureteral reflux or VUR) is when urine flows backward from the bladder to the ureters (small tubular structure that drains urine from the bladder) and kidneys (a pair of organs in the abdomen which remove waste and extra water from the blood (as urine) and help keep chemicals (such as sodium, potassium, and calcium) balanced in the body) instead of flowing forward). R43's Quarterly Minimum Data Set (MDS), dated [DATE], documented that R43 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R43 had a urinary catheter, occasional incontinence of urine, and no urinary tract infection (UTI - infection in any part of the urinary system). R43's Care Plan, revised 03/13/25, instructed staff to provide R43 assistance with toileting. The plan documented the resident had a urinary catheter and instructed staff to change the catheter as ordered, check for patency and urinary output every shift, and check the tubing for kinks The plan instructed staff to observe, report to the physician any signs or symptoms of UTI, and position R43's catheter bag and tubing below the level of the bladder On 04/21/25 at 11:15 AM, R43 sat in a wheelchair in the commons area at the front of the facility. Certified Nurse Aide (CNA) M turned the resident's wheelchair around, the wheelchair wheel caught on the urinary catheter tubing, the catheter drainage bag came out of the privacy bag, and landed on the floor. CNA M placed the catheter drainage bag back in the privacy bag on the wheelchair and propelled the resident to the dining room table, with the catheter tubing touching the floor. On 04/22/25 at 01:40 PM, Administrative Nurse E stated she would expect staff to change out R43's urinary catheter drainage bag and tubing if they touched the floor. The facility's Catheter Care, Urinary Policy, revised September 2014, instructed staff to ensure the catheter tubing and drainage bag were kept off the floor.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 37450 The facility had a census of 65 residents. The sample included 13 residents. Based on the interview and record review, the facility failed to offer pneumococcal (type of bacterial infection) PCV20 immunizations for Residents (R)3, R18, and R39, per the guidance from the Centers for Disease Control and Prevention (CDC). This placed the resident at risk for pneumococcal infection. Findings included: - R3's Electronic Medical Record (EMR) documented R3 received one Prevnar 13 dose on 04/30/15. The facility lacked documentation of whether R3 was offered or refused any further pneumococcal vaccinations. R18's EMR documented R18 received one Prevnar 13 dose on 03/12/15. The facility lacked documentation of whether R18 was offered or refused any further pneumococcal vaccinations. R39's EMR lacked pneumococcal information, whether R29 was offered, or refused any pneumococcal vaccinations. On 04/23/25 at 02:06 PM, Administrative Nurse E stated she was not aware of the CDC guidance related to the PCV 20 immunization. The facility's Pneumococcal Vaccine policy, dated 08/2016, documents all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. The administration of the pneumococcal vaccines or revaccinations will be made following the current CDC recommendations at the time of the vaccination.