STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175300	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salina Presbyterian Manor	2601 E Crawford Street Salina, KS 67401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 58 residents with three residents reviewed for accidents and hazards. Based on record review, observation, and interview, the facility failed to identify risk for burns and provide adequate supervision to prevent accidental hot liquid burns for Resident (R) 1 and R2. On 10/07/24 at approximately 12:30 PM, R1 ate lunch in the dining room. R1 required staff assistance with eating and drinking. R1 took the plastic wrap off the coffee on his tray, lifted it towards his mouth, and lost control of the coffee cup, spilling hot coffee on his right thigh. R1 sustained a second-degree burn (potentially painful burn that affects the first and second layers of the skin) to his right thigh. On 12/03/24 at approximately 05:30 PM, Student Certified Nurse's Aide (CNA) GG took R2's supper tray to R2's room and placed the tray on the bedside table. Student CNA GG attempted to adjust the height of the bedside table and instead pressed the latch that tilted the bedside table, causing hot tomato soup and hot coffee to land on R2's left thigh causing a burn to R2's left thigh. These deficient practices placed R1 and R2 at risk for injury, pain, and delayed healing. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) after 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) affecting his non-dominant left side, calcific tendonitis (a painful condition that occurs when calcium deposits build up in the tendons, usually in the shoulder and causes inflammation, pain and limited range of motion in the joint) of his right shoulder, and rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. The MDS documented R1 required substantial assistance from staff for dressing, toileting, bathing, and bed mobility. R1 was dependent on staff for all transfers. R1 required moderate staff assistance for eating, oral care, and personal hygiene. The MDS incorrectly documented R1 did not have any first or second-degree burns. The Activity of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 09/06/24, documented R1 had a diagnosis of hemiplegia and calcific tendonitis of his right shoulder. The CAA documented R1 required partial to substantial assistance with his activities of daily living (ADLs). (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Nutritional Status CAA, dated 09/06/24, documented R1 was on a mechanical soft, nectar-thickened liquid diet. R1's intakes had decreased. Staff attempted to give R1 thin liquids and R1 coughed and choked. The CAA documented R1 required assistance with eating. R1's Care Plan documented R1 had a self-care deficit and required assistance with ADLs such as repositioning, toileting, bathing, transfer, and locomotion (09/09/24). The care plan documented R1 was on a regular diet with thin liquids and high protein (10/01/24). After the hot liquid spill, R1's Care Plan was updated, and it documented R1 preferred to use a lid on his coffee due to R1's decrease in hand dexterity (10/07/24). The care plan directed staff to ensure a lid was present on R1's hot liquids at all times due to poor hand dexterity (10/07/24). The care plan documented R1 had a blister on his right groin area (10/07/24). The care plan directed staff to cleanse the blister to R1's inner thigh with wound cleanser, apply Aquacel (anti-bacterial dressing) to the wound bed, cover it with a foam dressing, and change the dressing every other day and as needed until healed (10/23/24). The Nursing Note, dated 08/12/24, documented R1 readmitted to the facility after suffering a hemorrhagic stroke. R1 required extensive assistance from two staff with a gait belt for transfers and toileting. R1 was on a regular diet with nectar-thickened liquids. R1 was unable to have conversations but was able to answer yes or no. R1 had generalized weakness, bilaterally. The Nursing Note, dated 08/12/24 documented R1 required a mechanical soft diet with nectar-thickened liquids due to having difficulty taking medication with regular water and pocketing food at dinner. The Social Service Note, dated 08/13/24, documented R1 readmitted yesterday from the hospital post-hemorrhagic stroke. R1 was unable to converse but could say yes or no. R1 required assistance with meals. Staff had to crush R1's medications due to swallowing issues. The Nursing Note, dated 08/13/24, documented R1 required help in the dining room and needed assistance with meals. R1 was unable to complete full sentences. R1 was able to follow verbal cues. The Nursing Note, dated 08/13/24, documented R1 ate 50% of his meals that shift. The CNA stated R1 was talking gibberish while the CNA assisted him with his meal. R1 was not having difficulty eating a mechanical soft diet with nectar-thickened liquids. The Nursing Note, dated 08/14/24, documented R1 was being monitored post-hemorrhagic stroke. R1 had been up for meals and was fed all meals by staff. R1 refused to help with feeding or drinking. The Nursing Note, dated 08/21/24, documented R1 ate his meal in his room with assistance from staff. R1 appeared to be coughing often while eating. R1 ate 25% of his meal. The Nursing Note, dated 08/24/24, documented R1 came out of his room for meals. R1 needed some assistance with eating. The Health Status Note, dated 10/07/24, documented R1 spilled coffee in his lap at lunch. Staff cleaned R1 and noted there was mild redness on his thighs. R1 had no complaints of pain or discomfort. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Skin Alteration/Injury Report, dated 10/07/24, documented dietary staff in the dining room notified Licensed Nurse (LN) LN G around 12:45 PM, during lunch, R1 spilled coffee in his lap. R1 had finished eating and was taken to his room where his clothes were removed, and he was placed in bed. R1's skin was cleansed, patted dry, barrier cream was applied, and then the area was left open to air. There was mild redness present on R1's right inner thigh before the end of the shift. R1 had no comment on the incident but did deny pain. The Skin/Wound Noted, dated 10/08/24, documented R1 had a blistered area on his right upper thigh close to the groin. Measurements of the blistered area were 11.7 centimeters (cm) by 2.7 cm. Staff applied Skin-Prep (liquid skin protectant) and covered it with a foam dressing. The Health Status Note, dated 10/08/24, documented staff notified R1's primary care physician's nurse of the blister to R1's right inner thigh related to his spilling coffee the previous day at lunch. The current plan was to apply Skin-prep every shift and may apply a foam dressing for protection. The nurse stated she would let R1's primary care physician know and would call if he had any other recommendations. The Health Status Note, dated 10/09/24, documented therapy was contacted and asked if they could work with R1 on dexterity such as holding cups at meals related to his issue of spilling coffee earlier that week. The Skin/Wound Note, dated 10/13/24, documented the blister to R1's right inner thigh was assessed and noted the previous foam dressing was soiled. The previous dressing was removed and a small amount of serous (clear) drainage was noted. No odor or signs or symptoms of infections were noted. The lower part of the blister no longer had skin covering it and was open. The open area measured 4.2 cm by 1.5 cm. There was still a closed area to the upper part of the blister and Skin-prep was applied to the closed area. The open area was cleansed, patted dry, triple antibiotic ointment applied, and covered with a foam dressing. The Health Status Note, dated 10/14/24, documented a fax was sent to R1's primary care physician that the blister on R1's right thigh had opened, and staff were waiting on new orders. The Health Status Note, dated 10/15/24, documented R1 continued to receive outpatient speech therapy. R1 used lids on his cups but did not like the lids. The Health Status Note, dated 10/16/24, documented orders were received to continue the current treatment of applying triple antibiotic ointment to the open area on R1's thigh, Skin-prep the intact area, and cover with a foam dressing. R1's October 2024 Treatment Administration Record (TAR), documented an order for facility staff to apply Skin-prep (liquid skin protectant) to R1's right inner thigh blister every shift. Let dry. May apply foam dressing for protection. Staff were to monitor for signs and symptoms of infection and discontinue the treatments when healed. The start date was 10/08/24. The October 2024 TAR, documented a new order directing facility staff to cleanse R1's right inner thigh wound with wound cleanser, apply Aquacel to small area with drainage, apply a foam dressing, and change the dressing every other day and as needed until healed. The start date was 10/25/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's Hot Liquids Assessment, (not completed until after the event on 10/18/24), documented R1 drank hot liquids, had a burn or a hot liquid spill in the last year, R1 had a neurological disease that affected his functioning, had a loss of hand or arm function, and R1 had weakness in his dominant hand or arm. The Hot Liquid risk score for R1 was sixteen, which indicated R1 was a high risk for hot liquids. The Facility Incident Report, dated 10/30/24, documented on the afternoon of 10/07/24 at approximately 12:45 PM, R1 was seated in his wheelchair at his table when the dietary staff assisted him with a cup of coffee. The cup was a standard cup that had a plastic wrap on top of the cup. R1 removed the plastic wrap and proceeded to take a sip. Dietary staff observed R1 lose his grip on the handle and spill the entire cup of coffee on his lap. Dietary staff immediately assisted R1 by attempting to absorb the liquid and requested a nurse. LN G immediately responded to the situation. LN G requested that R1 remove his clothing, which he declined, and the resident requested to stay in the dining room to finish his noon meal. Upon R1 finishing the meal, LN G assisted him back to his room, removed his pants, and noted a red area on the right inner thigh. R1 denied any pain at that time of the assessment. LN G updated R1's responsible party and R1's primary care physician about the incident. During the early morning hours of 10/08/24, the night shift nurse noted R1 had a fluid-filled blister to his right inner thigh/groin area. The area measured 11.7 cm by 2.7 cm. Staff cleansed the area with normal saline, applied Skin-prep, and covered it with a foam dressing to keep the fluid-filled blister intact. R1 was served coffee as usual from a carafe that had been prepared at least thirty minutes earlier. The coffee was not assessed for temperature at the time of the event because there was none [coffee] available. The coffee machine from the hospitality bar machine was checked later and the temperature was 138.7 degrees Fahrenheit (F). Coffee obtained from the kitchen measured 178.7 degrees F. The staff could not determine where the coffee filling the carafe was obtained. R1 insisted on continuing his meal following the spill which most likely contributed to the severity of the burn. R1 was provided a lidded coffee cup. Dietary staff were to check the temperature of the coffee carafe to ensure the temperature was below 140 degrees F. The staff received instructions and the care plan was updated. The facility incident report lacked witness statements. The November 2024 TAR, documented the continued order directing facility staff to cleanse R1's right inner thigh wound with wound cleanser, apply Aquacel to small area with drainage, apply a foam dressing, and change the dressing every other day and as needed until healed. R1's December 2024 TAR, documented the continued order directing facility staff to cleanse R1's right inner thigh wound with wound cleanser, apply Aquacel to small area with drainage, apply a foam dressing, and change the dressing every other day and as needed until healed. On 12/10/24 at 10:00 AM, observation revealed R1 sat in his wheelchair dressed for the day. R1 had his tray table beside him with a filled water pitcher on it. On 12/11/24 at 11:00 AM, observation revealed R1 lay in bed with his pants off. LN H and Administrative Nurse D performed R1's dressing change to his right inner thigh. The wound to R1's right inner thigh was approximately 3 cm by 0.5 cm and covered with eschar (dead tissue) with redness around the peri-wound (skin around the wound). R1 tolerated the treatment well. On 12/10/24 at 10:00 AM, R1 stated he did not remember spilling his coffee on his lap. R1 stated lids were used on his coffee cups. R1 could not answer when asked if his wound caused him pain he just stared straight ahead. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/10/24 at 10:30 AM, LN H stated that R1's burn to his right inner thigh was completely healed and the facility continued to perform the dressing change for prophylaxis. LN H stated she would not perform R1's dressing change until after he returned from his appointment. On 12/10/24 at 11:00 AM, LN H found the surveyor and stated she told the surveyor the wrong information about R1's right inner thigh wound, and the wound was not healed. LN H said she could perform the dressing change at that time before R1 went to his appointment. On 12/10/24 at 11:30 AM, CNA M stated R1 required assistance from staff for eating his meals at all times because of his continued weakness since his stroke. CNA M stated R1 required a lid on his coffee cup at all times. On 12/10/24 at 09:45 AM, Administrative Nurse D stated the coffee temperature that was served to R1 had not been checked before the coffee was served. Administrative Nurse D verified R1 required assistance with meals at times. The facility's Hot Beverage Service in Senior Dining, documented that coffee or hot beverages may be brewed in the dining rooms and offered to each resident with their meals. Licensed areas must serve hot beverages at no greater than 140 degrees F. Record the time that the coffee or hot beverage was brewed using the log provided. The temperature of the coffee or hot beverage should be taken using a clean and sanitized digital instant-read thermometer. Following the reading the thermometer should be wiped using alcohol wipes provided. If the temperature is above the required temperatures, allow it to cool for a while longer and check the temperature again. Record the temperature when the coffee or hot beverage has reached the appropriate temperature using the log provided. Once the temperature is appropriate based on the above guidelines, the coffee or hot beverage can be served. The facility failed to identify risk and implement appropriate interventions and assistance with eating to prevent a hot liquid spill and further failed to assess the temperature of hot liquids prior to serving to ensure safe temperatures which resulted in a second-degree burn for R1. This deficient practice also placed R1 at risk for pain and prolonged healing. - R2's Electronic Medical Record (EMR) documented R2 had diagnoses of peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), hypertension (high blood pressure), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R2 required moderate staff assistance for bathing, bathing, dressing, and bed mobility. R2 was dependent on staff for all transfers and putting and taking off her footwear. The MDS documented R2 was independent for eating. The MDS documented R2 had no skin impairment. R2's Care Area Assessments (CAA), dated 12/18/23, lacked analysis. R2's Care Plan documented R2 ate in her room for all meals and was able to feed herself once the tray was delivered (08/22/24). R2 required assistance from one staff for bathing dressing and toileting, one to two staff for bed mobility, and assistance from two staff for transfers (08/22/24). The care plan documented R2 enjoyed tomato soup and liked to eat it several times a week (09/06/24). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R2's Care Plan was updated after the incident and directed staff R2's primary care physician prescribed Silvadene (a topical antibiotic used in partial thickness and full thickness wounds to prevent infection) to treat the burn injuries to R2's left thigh. The plan directed staff to administer the ointment as prescribed and notify R2's primary care physician of any concerns. The care plan directed staff to monitor R2's burn injury sites to her left thigh every shift until healed (12/04/24). The Skin/Wound Note, dated 12/03/24, documented CNA N called Licensed Nurse (LN) I into R2's room during supper. CNA N stated that Student CNA GG had accidentally knocked over R2's table that had her coffee and tomato soup on it. The coffee and soup spilled on R2's legs, mostly landing on her left thigh. The area appeared red and had no blistering. CNA N, who had witnessed this, stated Student CNA GG took R2's supper into her room and was readjusting the height on her table. Instead of adjusting the height, Student CNA GG accidentally tilted the table, causing the tomato soup and coffee to spill. R2 stated, I have no idea what happened, it all happened so fast. It hurt so bad it brought tears to my eyes. I know it was an accident, so I hope she is not in trouble. Staff removed R2's clothing and cleaned the coffee and soup. LN I applied a cold washcloth and a towel-wrapped ice pack to the site. LN I completed a skin assessment and obtained vital signs. R2's vital signs were within normal limits for her. After the skin assessment was completed, R2 was dressed in clean, dry clothes. LN I notified the on-call nurse of what happened. Approximately an hour later, LN I and CMA R assisted R2 to the bathroom to reassess her left thigh. The area appeared to be less red and still had not blistered. LN I advised R2 to keep her pants off and R2 refused. LN I provided R2 education that the heat from her burn could be trapped by keeping the pants on and the pants rubbing against her skin could cause further irritation. Student CNA HH's Witness Statement, dated 12/03/24, documented Student CNA HH walked by R2's room and saw a cup of soup get spilled on R2's lap as the table tipped over toward her. R2 was in a lot of pain. The CNAs in the room at the time poured water over R2's legs. A family member of R2 asked for help so a charge nurse was called. The nurse went into R2's room and provided care. Student CNA GG's Witness Statement, dated 12/03/24, documented Student CNA GG gave R2 dinner. There were two mugs with liquids in them on the tray. Student CNA GG moved the tray closer to R2. The side lever was pushed to adjust the tray. The tray was stable. A few minutes later the tray tilted, and the mugs spilled off the tray. The mug with soup spilled on R2. R2's responsible party poured cold water on her lap immediately. Staff lifted R2 up and her wet pants were pulled down. The nurse was informed immediately and went into R2's room. The tray table was very unstable and wobbled when maneuvered. CNA N's Witness Statement, dated 12/03/24, documented Student CNA GG brought R2 tomato soup and coffee and went to adjust the height of the table but grabbed the wrong thing and tilted the table towards R2. The tomato soup and coffee spilled on R2's left upper thigh. The skin appeared red with no blisters on it. CNA N stated they removed R2's clothes to get the hot soup and coffee off her, dried her leg, and gave her a cool rag and ice pack. Staff then put dry clothes on R2. The staff took that tray out and brought in another tray that did not tilt. The Progress Note, dated 12/04/24, documented R2's left thigh was checked related to the coffee spill on 12/03/24. The note documented two raised welts and two red areas to R2's inner and top of the thigh. The sites were measured by Administrative Nurse D that morning. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Communication with Physician Note, dated 12/04/24, documented that staff placed a call to R2's primary care physician about getting an appointment for R2 to have her leg looked at related to a soup burn she received on 12/03/24 and asked to have a physician's assistant come in-house to see R2. The Skin Wound Note, dated 12/04/24, documented a skin assessment was completed to R2's left thigh post hot liquid spill. The note documented two reddened areas that were non-blanchable, and non-blistered. Site A measured 4 centimeters (cm) by 1.4 cm and site B measured 3.6 cm by 1.5 cm. There was no depth noted. The peri-wound (skin around the wound) was light pink without warmth. Staff updated R2's primary care physician and responsible party. The Communication with Physician Note, dated 12/04/24, documented R2's primary care physician wanted to see R2 via virtual medical appointment in the afternoon related to the burn site on her left thigh. The Health Status Note, dated 12/04/24, documented R2 had a virtual medical appointment with her primary care physician related to the burn on R2's left thigh. R2 received a new order for Silvadene external cream topically to the left thigh twice a day for ten days. The Administration Note, dated 12/05/24, documented the red area remained. R2 voiced no pain at the site during the assessment. R2 wore pants with no difficulties or irritation voiced. The Skin/Wound Note, dated 12/06/24, documented R2's old bedside table had been removed from R2's room and replaced with one that did not tilt related to the soup spill. R2's responsible party told the nurse she was putting the old bedside table back in R2's room because R2 did not like the new table and preferred her old table. The nurse educated R2's responsible party on the risks of having the old table with the tilt ability. R2's responsible party stated, She has had this one for a long time and it was never an issue. The nurse taped a sign over the tilt mechanism that stated, Do not adjust. The Facility Incident Report, dated 12/10/24, documented on 12/03/24 at 05:30 PM, LN I was called to R2's room by CNA N. CNA N stated Student CNA GG had taken R2's supper to her room and was readjusting the height on her bedside table. Instead of adjusting the height, Student CNA GG adjusted the tilt of the table accidentally causing R2's bedside table to tilt and spilled R2's coffee and tomato soup onto R2's legs; most of the spill landed on R2's left thigh. CNA N and Student CNA GG immediately assisted R2 in removing her pants, cleaned the liquids, and applied cool compresses to the site. The areas appeared red and had no blistering upon initial observation. Cool compresses remained in place through the evening over the next two hours. Assessments remained unchanged. After the skin assessment was completed, R2 was dressed in clean, dry clothes. At 06:19 PM, LN I and Certified Medication Aide (CMA) R assisted R2 to the bathroom and the areas appeared to be less red and had still not blistered. LN I advised R2 to keep her pants off to decrease discomfort and the potential for injury. R2 refused to allow her pants to be off and was redressed in her pants upon her request. On 12/04/24 at 07:30 AM, the exam revealed R2 had two reddened areas on her left thigh that were non-blanchable and non-blistered. The first site measured 4 cm by 1.4 cm. The second site measured 3.6 cm by 1.5 cm. The peri-wound was light pink with no warmth. R2 did not report pain in the areas. R2's primary care provider updated and ordered Silvadene cream twice a day and measured weekly until healed. R2 had no complaints and resumed her usual routine. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/10/24 at 10:15 AM, observation revealed R2 sat in her wheelchair, which was pushed up to her tray table and she was reading the paper. R2's tray table had a note over one of the levers that stated, Do Not Adjust. R2 pulled down the left side of her pants to show her burn sites. Observation revealed R2 had two burn sites that were dark pink on her left upper thigh. The first area measured approximately 4 cm by 0.6 cm and the second area measured approximately 4 cm by 0.7 cm. On 12/10/24 at 09:30 AM, Administrative Nurse D stated the facility had CNA students training on the day the accident happened. Administrative Nurse D stated Student CNA GG accidentally engaged the tilt function of R2's tray table and the soup and coffee had spilled on R2. Administrative Nurse D revealed Student CNA GG had warmed up R2's soup and coffee in the microwave in the dining room and had not assessed the temperature of the hot liquids for an appropriate temperature prior to serving. Administrative Nurse D stated all the microwaves in the three dining rooms had been removed and that from now on if any food or drink items needed to be warmed, the items would be taken to the kitchen for kitchen staff to warm the items and check temperature to make sure they were the appropriate temperature. Administrative Nurse D stated nursing staff had been educated regarding the new procedure. On 12/10/24 at 10:15 AM, R2 stated that when the student spilled the coffee and soup on her it hurt so bad. R2 stated she screamed in pain. R2 stated she knew it was an accident and the student did not mean for it to happen. R2 stated her left thigh hurt so bad that she had not been able to get a good night's sleep since the accident happened until last night and she was finally able to sleep. R2 stated they had taken her old tray table out of her room, but she did not like the new tray table, so her daughter went and got the old tray table back. R2 stated this tray table had a ledge around it that prevented her things from falling off her table. On 12/10/24 at 10:40 AM, LN J stated R2's left thigh burn sites were still red and the Silvadene was scheduled to be continued to be applied twice a day until 12/14/24. LN J stated she had not performed R2's treatment with Silvadene yet because she had been at a hair appointment. LN J said R2 had not reported any pain at her burn sites. The facility's Hot Beverage Service in Senior Dining, documented that coffee or hot beverages may be brewed in the dining rooms and offered to each resident with their meals. Licensed areas must serve hot beverages at no greater than 140 degrees F. Record the time that the coffee or hot beverage was brewed using the log provided. The temperature of the coffee or hot beverage should be taken using a clean and sanitized digital instant-read thermometer. Following the reading the thermometer should be wiped using alcohol wipes provided. If the temperature is above the required temperatures, allow it to cool for a while longer and check the temperature again. Record the temperature when the coffee or hot beverage has reached the appropriate temperature using the log provided. Once the temperature is appropriate based on the above guidelines, the coffee or hot beverage can be served. The facility failed to provide adequate supervision and failed to assess the temperature of hot liquids prior to serving to ensure safe temperatures to prevent R2 from sustaining a hot liquid burn. This deficient practice resulted in a burn which caused excruciating pain which impacted R2's ability to sleep and placed R2 at risk for ongoing pain and impaired psychosocial wellbeing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175300	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salina Presbyterian Manor	2601 E Crawford 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 0689 Level of Harm - Actual harm Residents Affected - Few	The facility completed corrective actions to correct the deficit practice, which were completed by 12/06/24. The actions included assessing R1's safety with hot liquids and updating his care plan accordingly to ensure he always received a lid on hot beverages. Dietary staff would assess the temperature of the coffee carafes to ensure temperatures were in the appropriate range. The microwaves were removed from the dining rooms and staff must take all food and beverages to the dietary staff for reheating so temperatures can be assessed and ensured in the appropriate range. R2's tray table was switched out then later returned at her request and marked for increased staff awareness regarding the tilt function. Staff received education on the new processes and accident prevention. Since all corrective actions were completed before the onsite survey, the deficient practice was deemed past noncompliance and remained at G to represent the actual harm to R1 and the psychosocial harm to R2.