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	01/15/2025

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 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** 43204 The facility identified a census of 56 residents with three residents reviewed for abuse and neglect. Based on record review, observation, and interview, the facility failed to ensure Resident (R) 1, R2, and R3 remained free from abuse. On 12/17/24 at 05:00 AM, Licensed Nurse (LN) G and Certified Nurse Aide (CNA) N received a report from R1 that CNA M had shoved her hard into the wall when turning to change her and slapped her buttocks. During the night shift, LN G removed CNA M from another hall, due to the mistreatment of R2 and R3. R2 stated CNA M would not listen to her about a transfer and hurt her arm during the transfer, which caused her to have tremors. R3 stated that CNA M came into his room, throwing and slamming things around, and would not provide him assistance to the bathroom. This deficient practice placed R1, R2, and R3 at risk for negative psychosocial impact including fear, anxiety, and neglect. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, psychosis (any major mental disorder characterized by a gross impairment in reality perception), and obsessive-compulsive disorder (anxiety disorder characterized by recurrent and persistent thoughts, ideas and feelings of obsessions severe to cause marked distress, consume considerable time or significantly interfere with the resident's occupational, social or interpersonal functioning). The Annual Minimum Data Set (MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status score of 12, which indicated moderately impaired cognition. The MDS documented R1 required moderate to substantial staff assistance for all activities of daily living (ADL), was frequently incontinent of urine and occasionally incontinent of bowel, and lacked documentation of behaviors. The Functional Abilities Care Area Assessment (CAA), dated 11/25/24 documented R1 required assistance with all ADLs, except eating. The CAA documented R1 could make her needs known. The Urinary Incontinence CAA, dated 11/25/24, documented R1 was frequently incontinent of bladder and required assistance to the toilet, required check and change at night, and needed assistance with peri care and moisture barrier protectant. The Care Plan documented R1 could be interviewed and could respond verbally (08/26/24). The care plan documented R1 required assistance with toileting, bathing, ambulation, transfers, locomotion, and transfers (08/26/24). The care plan included R1 used incontinence products and staff needed to ensure the incontinence products were on appropriately and changed when soiled (08/26/24). (continued on next page)

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	R2's EMR documented R2 had diagnoses of chronic pain, chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), presence of artificial right knee joint, presence of artificial left knee joint, and osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk). The Admission MDS, dated [DATE], documented R2 had a BIMS score of 13 which indicated intact cognition. The MDS documented R2 required moderate to maximum assistance with her ADLs. The MDS lacked any documentation of behaviors. The Functional Abilities CAA, dated 11/25/24, documented R2 had weakness and was unable to care for herself. R2 required assistance with ADLs. The Care Plan documented R2 had depression related to a new move to health care from her independent apartment and directed staff to encourage and provide R2 with opportunities for exercise, and physical activity. R2 preferred to remain in her room with her legs elevated in her recliner and watch TV. (11/25/24) The care plan lacked any documentation or directives regarding R2's ADLs or preferences. R3's EMR documented R3 had diagnoses of acute kidney failure (inability of the kidneys to excrete wastes, concentrate urine, and conserve electrolytes), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and atrial fibrillation (fast, irregular heartbeat). The Admission MDS, dated [DATE], documented R3 had a BIMS score of 13 which indicated intact cognition. The MDS documented R3 required substantial staff assistance for his ADLs. The MDS lacked any documentation of behaviors. The Care Plan directed staff R3 required one to two staff assistance for his ADLs. The care plan documented R3 was a short-term placement and planned on returning home after his stay. (11/26/24) The EMR for R1, R2, and R3 lacked any progress notes regarding the incident on 12/17/24. The Facility Incident Report, dated 12/31/24 (14 days after the incident), documented on 12/17/24 at approximately 05:00 AM, R1 reported to LN G that CNA M had hit her bottom while assisting R1 with incontinent care in bed through the night. R1 stated CNA M just pushed me hard against the wall as she swatted me wanting me to turn. Please don't say anything to her. LN G reported she performed an immediate skin examination and did not find any type of redness or bruising. LN G reported the situation to Administrative Nurse D. Administrative Nurse D examined R1 after her shower and revealed no visible signs of being hit or swatted. R1 did have a chem strip completed and was noted to have symptoms of a urinary tract infection. CNA M was immediately removed from the schedule and informed she was suspended. Administrative Nurse D conducted interviews with eight other residents. Six of those residents reported no concerns. Two residents reported concerns. The first reported concern, from R2, stated CNA M had come in to assist her to the toilet. R2 tried to explain to CNA M how she would like to be transferred, and R1 reported CNA M tried to pull her hard from the left side, while stating I am not going to sacrifice my back, during the transfer. R2 reported CNA M pulled from the wrong side and caused her to have knee pain and spasms. R2 reported CNA M was being mean to her and raised her voice. R2 voiced that she did not want CNA M to provide care to her in the future. The second concern was from R3. R3 reported he had the opportunity to be cared for by CNA M on two separate occasions. On one occasion, CNA M came into his room, did not turn the lights on, demonstrated erratic behavior, slammed things around in his room, and did not appear right. R3 reported he asked CNA M if he could help her with anything and CNA M was flippant with him. CNA M then refused to provide R3 assistance to the bathroom because he didn't need to go to the bathroom. R3 tried to explain to CNA M he no longer had a catheter and CNA M again refused and walked out of the room leaving R3 to transfer himself to the bathroom. R3 stated when CNA M came back to his room, R3 told CNA M to get out of his room and not come back. R3 stated he did not want CNA M to provide care to him. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA M's Witness Statement, dated 12/17/24, documented R1 turned on her call light at about 05:45 AM. CNA M went to R1's room and gathered supplies to change R1's brief. CNA M stated she changed R1's brief and provided peri care. R1 then told CNA M she wanted to get up for the day. CNA M stated she informed R1 that she would need help to transfer R1 and she would need to wait. CNA M stated R1 was upset CNA M could not get her up by herself or get someone right away to help with the transfer. CNA M stated she informed R1 she would get help and walked out the door, partially shutting the door, as R1 wanted to remain uncovered to get up for the day. LN G's Notarized Witness Statement, dated 12/30/24 (13 days after the incident), documented on 12/17/24 LN G had removed CNA M off of the hall CNA M had been assigned, due to R2's complaint regarding CNA M hurting her arm during a transfer. Knowing several residents did not want CNA M in their rooms, LN G stated she decided to move CNA M to another hall. On 12/17/24 at 05:00 AM, LN G entered R1's room to administer her 05:00 AM medication. R1 told LN G That girl hit me. R1 stated the girl [CNA M] was trying to get her up and rolled R1 over, and was pushing on R1's hip quite hard. R1 stated she told CNA M to leave and CNA M said, Fine, and hit R1. LN G asked R1 where CNA M had hit her and R1 stated My butt. LN G reported the incident to Administrative Nurse D. CNA N's Notarized Witness Statement, dated 12/31/24 (14 days after the incident), documented R1 was yelling for help. CNA N went into R1's room and R1 was uncovered with her brief halfway pulled on and her bottom still not cleaned. CNA N asked R1 what she could do to help, and R1 stated, Look how I was left. R1 proceeded to tell CNA N she had not had a good morning so far and the aide that was helping her had been rough and had hit her on the bottom. CNA N stated she helped R1 get dressed and comfortable and then reported the situation to the nurse. During an observation on 01/15/24 at 10:30 AM, R1 sat in her wheelchair in her bathroom. R1 was going to wash her hands after participating in the activity. R1 was dressed and groomed neatly. R2 was unavailable for observation due to hospitalization . During an observation on 01/15/24 at 11:00 AM, R3 walked out of his bathroom with his walker, went to his lift recliner, and sat down. R3 was neatly dressed and groomed. During an interview on 01/15/24 at 10:30 AM, R1 stated she remembered CNA M hitting her bottom very well. R1 became teary-eyed and stated she had feared CNA M when the incident happened. R1 stated she had been told CNA M would never take care of her again. R1 stated she never had anyone treat her so poorly in her life. R1 stated she had not had any other problems with staff. During an interview on 01/15/24 at 10:45 AM, CNA N stated she was the one to initially find R1 the morning of 12/17/24. CNA N stated when she walked into R1's room R1 was completely uncovered with her brief half off and her buttocks covered in BM. CNA N stated R1 was visibly upset and told her CNA M had smacked her butt and just left her like this. CNA N stated R1 did not want to get CNA M in trouble and CNA N assured R1 she should not have been treated that way. CNA N stated she had received re-education regarding abuse and neglect. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 01/15/24 at 11:00 AM, R3 stated CNA M had really upset him. R3 stated he felt unsafe with CNA M in his room and that is why he asked her to leave and not come back. R3 stated he thought CNA M was on something because her behavior was so erratic. R3 stated people like CNA M should not be in healthcare taking care of people because he was able to stand up for himself, but others might not be able to do the same. On 01/15/24 at 11:30 AM, Administrative Nurse D stated during the investigation, and with three residents revealing CNA M had treated them badly in some way or another, there was no disputing the incidents had occurred. Administrative Nurse D stated she expected all staff working at the facility to understand and follow the ANE [Abuse, Neglect, and Exploitation] policy and treat residents with dignity and respect. Administrative Nurse D stated she happened to come in early that morning and LN G informed her of what was reported. Administrative Nurse D stated she went directly to the shower, where R1 was, and examined her skin and did not find any marks or bruises. Administrative Nurse D stated she then went to the service corridor to wait for CNA M to come back in the facility from taking trash out and then Administrative Nurse D accompanied CNA M to her office and had her fill out witness statements, suspended her pending investigation, and after the investigation terminated CNA M. The facility's ANE: Abuse Prevention, Intervention, Reporting, and Investigation - Staff Treatment of Residents Policy, revised 10/11/21, documented that Residents had the right to be free from verbal sexual, and mental abuse, corporal punishment, exploitation, and involuntary seclusion. It is the responsibility of the employees to promptly report to the community management any occurrence or suspected occurrence of neglect or resident abuse from other residents, staff, family, or visitors including injuries of unknown source and theft or misappropriation of resident property. Staff are mandated reporters and must comply with state and federal regulations regarding reporting suspected occurrences of neglect or resident abuse or unauthorized photographs or video recordings. All reports of ANE are promptly and thoroughly investigated by community management. Employees will receive training regarding abuse, neglect, protection of resident privacy, and misappropriation of resident property at initial orientation and at least annually. Prevention measures will be in place which provide residents, families, and staff related to reporting and handling concerns and grievances. Prevention will include identifying, correcting, and/or intervening in situations in which abuse and neglect are likely to occur. The resident will be protected from harm during the investigation. On 01/14/25 at 01:30 PM, Administrative Staff A and Administrative Nurse D were provided a copy of the IJ template and notified of the facility failure to ensure R1, R2, and R3 remained free from abuse from CNA M, which placed the residents in immediate jeopardy. The facility identified and implemented the following corrective measures provided education to all staff regarding Abuse, Neglect, and Exploitation on 12/17/24. Head-to-toe assessment completed on R1 without any signs of redness or bruising noted. All three residents were placed on monitoring for signs of psychosocial concerns. Interviews were completed with all other alert and oriented residents regarding any concerns with safety in the facility. The surveyor verified the implemented corrective actions on 01/15/25 at 01:00 PM. Due to the facility's corrective actions completed prior to the surveyor's arrival onsite, the deficient practice was deemed past non-compliance at a J scope and severity following removal of the immediacy.