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	05/27/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interviews and record review, the facility failed to ensure Resident (R) 3 received quality treatment and care in accordance with professional standards of practice. On 04/27/26, Licensed Nurse (LN) G failed to follow wound vac (a vacuum-assisted wound treatment that applies gentle suction to a wound to help it heal) treatment orders for the treatment of R3's third, fourth and fifth right toe amputations (surgical removal of a body part), which caused R3's surgical wound to worsen and require intravenous (IV-administered directly into the bloodstream via a vein) antibiotic administration. Findings included:- R3's Electronic Medical Record (EMR) documented R3 had diagnoses of peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), osteomyelitis (local or generalized infection of the bone and bone marrow) of the right foot, and surgical aftercare for amputation of the third, fourth, and fifth toes. R3's admission Minimum Data Set, dated 04/06/26, documented R3 had a Brief Interview for Mental Status score of 15, which indicated intact cognition. The MDS documented R3 required substantial assistance for toileting, bathing, transfer, and bed mobility. The MDS documented R3 had a surgical wound and received dressing changes. The Functional Abilities Care Area Assessment (CAA), dated 04/10/26, documented R3 required staff assistance with activities of daily living (ADLs) due to impaired balance and transitions during transfers and functional impairment with activity. The CAA documented R3 had generalized weakness and decreased safety awareness. R3's Care Plan, initiated 04/06/26, directed staff to encourage R3 to elevate her legs, notify the provider if there is no sign of improvement on the current wound regimen, and provide wound care per treatment orders (04/06/26). The care plan documented R3 had a surgical wound related to the surgical amputation of toes. The plan directed staff to provide education to R3 and her family regarding the wound and treatment plan, and R3's wound would be assessed weekly by the wound care nurse (04/12/26). The plan documented R3 had osteomyelitis in her right foot and ankle and directed staff to administer IV antibiotics as ordered, administer antipyretics (medication used to prevent, reduce, or relieve a fever) per orders, monitor R3's temperature and pulse three times a day, and monitor R3's mental status and cognitive function throughout the day and communicate any decline (04/29/26). The admission Summary Note, dated 04/06/26, documented the incision site to R3's right foot, which measured eight centimeters (cm) in length and had eight sutures. Toes three, four, and five were amputated. A wound vac was applied on admission after the wound nurse took photos of the wound before the wound vac placement. The Treatment Administration Record (TAR), dated April 2026, documented the wound vac dressing change: cleanse right foot with wound cleanser and pat dry, apply skin prep (liquid skin protectant) to peri (area around)-wound tissue, apply wound vac drape (an airtight adhesive film used in negative pressure wound therapy) to dorsal (back) foot and around surgical incision, cover surgical incision with Adaptic (a non-adhering dressing that helps protect regenerating skin), cover incision covered with Adaptic with small foam tracking onto the dorsal foot, cover with wound vac drape and apply track pad (connects the wound dressing to the vacuum machine) to dorsal foot, cover with multi-layer foam, secure tubing with kerlix (stretchy gauze bandage)and Ace wrap (a stretchable wrap used to apply localized stable pressure to a body part) every Monday, Wednesday, and Friday. Call if the wound deteriorates or shows signs and symptoms of infection. The wound vac should have (continued on next page)

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

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	negative 125 milligrams of Mercury (mmHg) continuous suction, medium intensity. The order was started on 04/08/26 and discontinued on 04/09/26. The Health Status Note, dated 04/08/26, documented R3 left the facility for a wound care clinic appointment and returned at 01:30 PM with no new orders. The Skin/Wound Note, dated 04/09/26, documented the facility received the wound care clinic progress note. The note documented the wound vac stopped. And staff implemented daily dressing changes. R3's orders were updated to reflect this, and the wound vac was placed in the mail room to be returned. The April 2026 TAR documented an order dated 04/09/26 (discontinued on 04/16/26) for wound care for the ulcer to the right foot: Apply Normlgel Ag (an antimicrobial silver wound gel) to the wound bed, apply slightly moistened Aquacel AG (a soft, sterile dressing), Adaptic, and an ABD Pad (thick absorbent dressing). Roll with gauze and secure with tape. Change Daily and as needed (PRN) if soiled or dislodged in the morning for the right foot ulcer. Call [hospital] if wound deteriorates or shows s/s of infection The April 2026 TAR documented a start date of 04/17/26 for wound care for R3's right foot. Cleanse with Hibiclens (antiseptic skin cleanser) using gentle flush and scrub method, apply skin sealant topically to skin, apply Normgel Ag to the wound bed, place hydrocolloid (waterproof, self-adhesive medical dressing) to the peri wound and dorsal foot for redness, apply wound vac to continuous at negative 125 mmHg, apply offloading shoe, change every Monday, Wednesday, and Friday. This order was discontinued on 04/23/26. The April 2026 TAR documented a start date of 04/24/26 for wound care for R3's right foot. Cleanse with Hibiclens using gentle flush and scrub method, apply skin sealant topically to skin, apply a nickel size amount of Normgel Ag to the wound bed, apply Adaptic over the bone, place a thin hydrocolloid to the peri wound and dorsal foot for redness, apply wound vac to continuous at negative 125 mmHg, apply offloading shoe, change every Monday, Wednesday, and Friday. The Health Status Note, dated 04/27/26, documented R3 had the wound vac to her right foot changed. R3 tolerated the dressing change well with minimal discomfort noted during the wound care. R3 complained about a lot of pain after the wound care was completed. The old dressing was removed without difficulty. The wound bed had a large amount of slough (dead tissue, usually cream or yellow in color) and a small amount of granulation tissue (new tissue formed during wound healing). No foul odor was noted. The peri wound was slightly macerated (softening and breaking down of skin because of prolonged exposure to moisture). The wound was cleansed as ordered and staff applied a new foam dressing and secured with occlusive drape. The wound vac tubing connected without an air leak and negative pressure therapy resumed at 125 mmHg continuous pressure per provider order. The Wound Care Clinic Progress Note, dated 04/29/27, documented upon initial assessment R3's wound measured 6.1 cm by 4.6 cm by 1.5 cm. The wound was deep to the bone. Upon removal of the dressing, the wound clinic identified that Aquacel AG had been placed underneath the wound vac. The note documented the facility needed to be educated. The note documented that overall, the area had deteriorated and increased in size since R3's last appointment. R3 had increased fascial necrosis (premature, irreversible death of cells and living tissue) and noted that R3 reported significantly increased pain to the area. The clinic completed debridement (medical removal of dead, damaged, or infected tissue to improve the healing potential for the remaining healthy tissue) of some of the necrotic (dead tissue) tissue was completed but due to pain some of the necrotic tissue remained; a bone and wound culture was obtained. Due to the presentation of the wound, the wound was covered with Dakin's (a diluted, antiseptic sodium hypochlorite solution used to clean wounds, prevent infections, and manage odors) soaked gauze, and R3 was sent to the emergency department for further evaluation/treatment/possible admission. The Health Status Note, dated 04/29/26, documented the facility received a call from the wound care clinic, which reported R3 was being transferred to the emergency room for evaluation. The Health Status Note, dated 04/30/26, documented R3 was very shaky and reported being warm. R3 was confused during the conversation about her appointment with the wound care clinic and her visit to the emergency room. The wound care clinic called and ordered the facility to make an appointment with a vascular surgeon in one week for magnetic resonance (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	imaging (MRI-medical imaging used to view soft tissue) with and without contrast, peripherally inserted central catheter (PICC-a thin, flexible tube that is inserted into a vein in the upper arm and threaded into a large vein above the heart) at the hospital for IV vancomycin (antibiotic) and wound care of 1one-quarter percent Dakin's solution to gauze to wound bed, calmoseptine or zinc to peri-wound, cover with ABD pad, wrap with gauze, secure with tape, and change three times a day. The Health Status Note, dated 04/30/26, documented a nurse from the hospital called, and the MRI showed osteomyelitis in the right foot. The hospital had administered two grams of cefepime (antibiotic) and 800 mg of daptomycin (antibiotic) through the port on R3's chest port. A PICC line is not needed. New orders were received for the facility to infuse IV antibiotics. The Medication Discrepancy IDT Review Note, dated 05/05/26, documented on 04/29/26 at 04:30 PM, a nurse from the wound care clinic called and reported R3 was being transferred to the ER. At 08:23 PM, the wound care clinic called the facility to report R3 had Aquacel AG placed in her wound bed. The Aquacel AG had clogged the wound vac, and the right foot wound had deteriorated. On 04/30/26 at 01:05 AM, the hospital called to say R3 was ready to return to the facility; the hospital was waiting for the scan results. A wound culture had been obtained, and a wet-to-dry dressing had been applied. The note documented that the identified nurse, LN G, may not perform wound dressing changes independently and will complete wound care competency validation prior to resuming independent wound care responsibilities. All facility nurses complete wound vac competencies prior to changing wound vac dressings. R3 was unavailable for observation or interview. On 05/27/26 at 12:30 PM, LN G stated there were two different orders, one on the TAR and one on the 24-hour shift sheet. The order on the 24-hour sheet said to take moistened Aquacel AG and place it on the wound bed. She did not double-check with anyone on the correctness of the 24-hour shift sheet. LN H started crying and stated she had been a nurse for 29 years and had never had anything like this happen, and she could not stop thinking about it. On 05/27/26 at 03:00 PM, Administrative Nurse D stated she expected nurses to follow the orders in the TAR and, if there were discrepancies, to double-check the order and clarify. The facility's Negative Pressure Wound Therapy Checklist Policy, dated 02/26/26, documented nurses would review the medical order for the application of the wound vac therapy, including the ordered pressure settings for the device. The facility identified and implemented immediate corrective actions which included: LN G, may not perform wound dressing changes independently and will complete wound care competency validation prior to resuming independent wound care responsibilities. All facility nurses completed wound vac competencies prior to changing wound vac dressings. All corrective actions were completed prior to the onsite survey therefore the deficient practice was deemed past noncompliance at the scope and severity of a G (actual harm, isolated).

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure Resident (R) 2 received the necessary care, consistent with professional standards of practice, to prevent a pressure injury from developing when staff failed to identify and implement preventative measures such as heel offloading or repositioning to address R2's risk for pressure risk related to friction and shear and very limited ability to reposition. This failure resulted in an unstageable pressure injury unstageable (depth of the wound is unknown due to the wound bed being covered by a thick layer of other tissue and pus). Findings included:- R2's Electronic Medical Record (EMR) documented he admitted to the facility on [DATE]. The EMR documented diagnoses of displaced fracture of the base of the neck of the right femur (right hip fracture), artificial right hip joint replacement, heart failure (a condition with low heart output and the body becomes congested with fluid), atrial fibrillation (rapid, irregular heart beat), dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and major depressive disorder(major mood disorder that causes persistent feelings of sadness). R2's admission Minimum Data Set (MDS), dated 11/09/25, documented he had a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderately impaired cognition. The MDS documented R2 did not have a pressure ulcer on admission. The MDS documented R2 required maximum staff assistance with all activities of daily living (ADLs) except eating. The Functional Abilities Care Area Assessment (CAA), dated 11/09/25, documented R2 had impaired balance and transition during transfers and functional impairment in activity. R2 had generalized weakness and decreased safety awareness. The Pressure Ulcer/Injury CAA, dated 11/09/25, documented R2 had the potential for pressure ulcers due to ADL functional/mobility impairment and incontinence. The CAA documented a licensed nurse would assess R2's skin each week and put in proper interventions in place to prevent skin breakdown. R2's Care Plan, initiated 11/07/25, lacked any focus, goals, or intervention regarding any staff assistance R2 required for ADLs. The care plan lacked any focus, goals, or interventions related to the assessment of R2's skin or the prevention of skin alterations or pressure ulcers until 11/26/25, after development of the deep tissue injury (DTI- purple or maroon localized area of discolored intact skin or blood^filled blister due to damage of underlying soft tissue from pressure and/or shear). R2's Care Plan dated 11/26/25 documented R2 had impaired tissue integrity related to pressure and shear forces and noted he had a DTI on his right heel. The plan directed staff to assess his nutritional status and consult the dietician if needed. An intervention dated 11/26/26 directed staff to check R2's dressing each shift and follow his treatment plan as directed by the primary care physician. The plan documented R2 would receive adequate pain control. Interventions dated 11/26/26 documented staff would teach R2 and his representatives about pressure injury prevention and directed staff to offload R2's heels by using Prevalon boot (special pressure-reducing heel protectors). The QA admission SKIN ASSESSMENT, dated 11/04/25 at 02:06 PM, documented R2's skin was warm and dry. He had purple discoloration noted on his bilateral arms, an abrasion noted on the right elbow, and a skin tag noted on the left inner arm. He had no redness noted on his heels or groin. There was slight redness to his inner buttocks, and barrier cream was encouraged. He had a skin tag noted on his mid back. He had a surgical incision to his right hip; the dressing was dry and intact and was supposed to stay in place until his orthopedic (medical specialty focused on bones) appointment. He had trace edema to both lower extremities and had a purple-colored area on his right lower leg from his fall; he had spider veins observed on his ankles. He was missing his right great toenail and the nail next to it. He was also missing his great left toenail. His feet were dry, and lotioning was encouraged. He had age spots noted on his face. The Braden Scale Evaluation, dated 11/04/25, documented R2 was occasionally moist, walked occasionally, had very limited bed mobility, and was only able to make occasional, slight changes in body or extremity position but was unable to (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	make frequent or significant changes independently. The evaluation documented of R2's nutrition was probably inadequate. The N Adv - Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated 11/11/26 documented R2 had no sensory perception impairment, was occasionally moist, and walked occasionally. The assessment noted R2 was very limited in mobility and made occasional slight changes in body or extremity position but was unable to make frequent or significant changes independently. His nutrition was marked as probably inadequate. The assessment noted friction, and shearing was a potential problem. The Braden score was 16, which indicated mild risk (but requires preventative measures). R2's EMR lacked evidence that preventative measures to avoid pressure injuries were implemented. The N Adv - Skin Check note dated 11/20/25 at 05:14 AM documented R2's skin was warm and dry. R2's skin color was within normal limits. His skin turgor (the degree of elasticity of the skin, which shows hydration levels) was normal. No new skin issues identified. The note documented a foot evaluation was completed. R2 had an incision to his right hip that was healing nicely with no redness, swelling, or drainage noted. The N Adv - Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated 11/20/26 at 05:20 AM documented R2's sensory perception was slightly limited. He was occasionally moist and walked occasionally. The assessment noted R2 was very limited in mobility and made occasional slight changes in body or extremity position but was unable to make frequent or significant changes independently. His nutrition was marked as probably inadequate. The assessment noted friction, and shearing was a potential problem. The Braden score was 16 which indicated. R2's EMR lacked evidence that preventative measures to avoid pressure injuries were implemented. The Skin/Wound Note, dated 11/24/25, documented the nurse was notified by nursing staff R2 had a sore on his right heel. R2's heel presented with eschar (dead tissue) and an open blister, which measured 1.5 cm by 1.75 cm. No drainage was noted. The area was cleansed and covered with protective dressing. Staff left a message with R2's responsible part and sent a message to the wound care nurse for further treatment recommendations and staff elevated R2's heels at that time. The Skin Issues Note dated 11/26/26 documented R2 had a new DTI to his right heel acquired in-house. The note documented that the wound was painful and burning. The wound measured 3.66 cm in length by 3.02 cm in width, and 0.1 cm in depth. The wound bed had 60% eschar with light sanguinous (bloody drainage) exudate (a fluid that leaks out of body vessels and tissues). The new interventions included repositioning. The dressing change directions were to cleanse the area with wound cleanser and pat dry, apply skin prep to the peri-wound tissue, apply betadine to the wound bed, apply a foam dressing, change every three days and as needed. Under additional care, the note directed to apply Prevalon boots while in bed. Staff faxed the skin update to R2's primary care physician. The Skin/Wound Note, dated 12/10/25, documented R2 continued with the DTI of his right heel related to pressure and shear forces while in bed. The wound bed measured 2.67 cm by 3.54 cm by 0.1 cm. The wound bed had 80% eschar, and the surrounding tissue had erythema (redness or inflammation of the skin). Continued the previous dressing change. The note documented that R2 often took off Prevalon boots while in bed. Skin update was faxed to R2's primary care physician. The Skin Issue Note, dated 12/16/25, documented R2's right heel DTI measured 2.81 cm by 3.6 cm by 0.1 cm. The wound bed had 90% eschar with light sanguinous exudate. Called R2's primary care physician regarding wound care referral. The Skin Issue Note, dated 12/23/25, documented R2's right heel DTI measured 1.99 cm by 2.53 cm by 0.1 cm. The note lacked any other wound documentation. The Discharge Summary, dated 12/31/25, documented R2 was to be discharged to his previous assisted living home with home health services. R2 had multiple falls while at the facility. R2 had an ulcerated area on his right heel. Cleansed and border dressing changed every three days and as needed. On 05/27/26 at 12:30 PM, Licensed Nurse (LN) G said she remembered R2 but could not remember if there had been any interventions in place to prevent pressure ulcer development. LN G stated that new admissions who are at risk should have pressure ulcer prevention interventions added and implemented. On 05/27/26 at 03:00 PM, Administrative Nurse D stated she remembered R2, but she did not remember that R2 had a DTI. Administrative Nurse D agreed preventative measures should (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	have been put in place to try to prevent R2 from obtaining a DTI on his right heel. The facility's Skin Integrity Pressure Ulcer/Injury Prevention Policy, revised 03/20/26, documented all residents are considered to have a potential risk for the development of pressure ulcers. Nursing staff will evaluate skin integrity, implement preventative measures as indicated, and treat skin breakdown. The primary care provider's admission orders will authorize approval to begin using established skin and wound treatment guidelines. Dressing changes are performed by a licensed nurse.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on interviews and record review, the facility failed to provide adequate supervision to prevent a fall with serious injury for Resident (R) 1, who was at high risk for falls, received an anticoagulant (a class of medications used to prevent the blood from clotting), and required assistance with activities of daily living. On [DATE], Certified Nurse Aide (CNA) M assisted R1 into the bathroom in his room, sat R1 on the toilet, then left R1 alone in the bathroom. CNA M alerted Licensed Nurse (LN) G that R1 was in the bathroom. At 10:55 AM, CNA N entered R1's room and found R1 on the floor of the bathroom. R1 had hematoma (a collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) on the right side of his head. Emergency Medical Services (EMS) transported R1 to the hospital, where he was diagnosed with a subarachnoid bleed (a serious condition, typically caused by head injury, where blood collects between the skull and the surface of the brain). R1 died on [DATE] in the hospital. The facility's failure to provide adequate supervision for R1 placed him in immediate jeopardy. Findings included:- R1's Electronic Medical Record (EMR) documented he had diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following a 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 the dominant right side, atrial fibrillation (rapid, irregular heart beat), aphasia (condition with disordered or absent language function), and transient ischemic attacks (TIA- temporary episode of inadequate blood supply to the brain). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognitive function. The MDS documented R1 required moderate to substantial assistance with all activities of daily living (ADLs), except eating. The MDS documented R1 had three falls during the look-back period. Both the Functional Abilities Care Area Assessment (CAA) and the Falls CAA dated [DATE] documented R1 required assistance with ADLs, R1 had impaired balance and transition during transfers, functional impairment during activities, and inability to move his right lower extremity. The CAA documented R1 had generalized weakness and decreased safety awareness. R1's Care Plan, initiated [DATE], lacked any focus, goals, or interventions related to R1 requiring assistance with ADLs. The care plan documented R1 would try to get up in the bathroom by himself and directed staff to ensure R1 had his pendant call light, and documented R1 was educated to pull the cord when he was finished ([DATE]). The care plan documented R1 had expressive aphasia (a communication disorder where you know exactly what you want to say but struggle to get the words out) and receptive aphasia (a language disorder where people have severe difficulty understanding written and spoken language) ([DATE]). The care plan directed staff to be conscious of R1's position in groups, activities, and the dining room to promote proper communication with others ([DATE]). The care plan documented R1 was a high fall risk related to gait and balance problems, incontinence, poor communication/comprehension, and vision and hearing problems. The care plan documented R1 was non-compliant with using his call light and often attempted to complete his ADLs independently [DATE]). The Fall Risk Assessment, dated [DATE], documented R1's fall risk score was 22.0, which indicated R1 was a high fall risk. The Medication Administration Record (MAR), dated [DATE], documented R1 was taking Eliquis (an anticoagulant medication) 5 milligrams (mg) daily and aspirin (a low daily dose of an anti-inflammatory drug thins the blood, making it highly effective in preventing heart attacks and strokes) 81 mg daily. The Health Status Note, dated [DATE], documented R1 left the facility via the facility van to go to the hospital for an echocardiogram. The Health Status Note, dated [DATE] at 10:35 AM, documented R1 returned to the facility from his echocardiogram (a graphic outline of the movements of the heart structures produced by ultrasound). The Health Status Note, dated [DATE] at 10:45 AM, documented staff alerted LN G (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	that R1 was on the floor in his bathroom. LN G observed R1 lying on his buttocks on the floor with his head resting against the metal toilet paper holder. R1 was alert and oriented to person, place, time, and situation. R1 had his pants pulled up, but they were urine-soaked. Urine was found on the floor in front of the toilet. R1 had a small hematoma to the right back side of his head with a small amount of dried blood noted in the area. Active range of motion was noted in all extremities. R1 denied pain. Four staff assisted R1 from the floor to a standing position with a gait belt and assisted him into his wheelchair. R1's primary care physician was called, and they gave an order to send R1 to the emergency room via EMS for evaluation and treatment. A call was placed to R1's daughter to inform her of R1's status. Staff called 911 to have R1 transported to the emergency room. The Radiology Report, dated [DATE] at 12:09 PM, documented R1 had an acute subarachnoid bleed along the right side of his head, with the widest point measuring 2.5 cm. The Health Status Note, dated [DATE] at 12:49 PM, documented a call was placed to the hospital to check on the status of R1. The hospital nurse reported R1 had a bleed in his head and would possibly be transported to a higher level of care as the 2 cm bleed was pushing on R1's brain. The Health Status Note, dated [DATE] at 02:03 PM, documented a call was placed to the hospital to check on R1. The emergency room doctor informed facility staff that R1 had a 2 cm bleed in his head and was choosing to go on comfort measures. The hospital would keep R1 until R1 was able to get started on hospice and comfort care. The Health Status Note, dated [DATE] at 11:33 PM, documented the facility was informed by the hospital R1 had passed away there.CNA M's Notarized Witness Statement, dated [DATE], documented CNA M stated she brought R1 back to the facility from his appointment. She noted R1 told her they needed to hurry because he needed to go to the bathroom. CNA M documented she got R1 to his room so he could go to the bathroom, and R1 stood up with the grab bar and got on the toilet. CNA M said she went and told LN G that R1 was on the toilet. LN G's Notarized Witness Statement, dated [DATE], documented transportation staff notified her R1 was back and was using the bathroom. CNA N entered R1's room to get R1's lunch order then alerted LN G that R1 was on his bathroom floor. LN G stated upon entering R1's bathroom, R1 lay on his buttocks on the floor with his head resting against the metal toilet paper holder. R1 was fully dressed in blue jeans that were unzipped and buttoned. R1's jeans were urine-soaked. R1 had a shirt and tennis shoes on. R1 was alert and oriented. Urine was found on the floor in front of the toilet. R1 had a small hematoma to the back right side of his head with a small amount of blood, which appeared to be dry. Vital signs were obtained and were within normal limits for R1. A neurological assessment was completed. R1 had an active range of motion to all extremities. Administrative Nurse D and R1's daughter were notified. CNA N's Notarized Witness Statement, dated [DATE], documented CNA N entered R1's room to get his lunch order and found R1 lying on the bathroom floor. The CNA then went to the door, called for LN G, and informed her of the fall. R1 told CNA N he fell trying to clean up where he urinated on the floor. R1 stated he hit his head on the toilet paper holder. It took CNA N, a CNA from another hall, and the Certified Medication Aide (CMA) to help R1 up off the bathroom floor. The bathroom light was on. R1 laid on his back, his head was on the wall, and his feet were at the door. R1 was dressed in shoes, socks, jeans, and a shirt. R1 had his call pendant on, but he did not use it or his call light. R1 did not present with any pain when he stood up, other than where he hit his head. On [DATE] at 01:20 PM, CNA M stated after she and R1 got back from the hospital and out of the van, R1 said she needed to hurry because he really had to use the bathroom. CNA M stated she hurried and pushed R1 in his wheelchair to his room, got him in the bathroom, and helped him sit on the toilet. CNA M stated she thought she had given R1 his call light but could not remember. CNA M stated she told LN G R1 was back, and he was on the toilet and then she left the unit. CNA M stated she had been unaware R1 was non-compliant with using his call light when in the bathroom to call for help and said she did not know what amount of assistance R1 required. On [DATE] at 03:00 PM, Administrative Nurse D stated residents returning from an appointment after a procedure should not be left alone in the bathroom due to possible occurrences of weakness, fatigue, confusion, or anxiety. Staff should assist the residents with their needs (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	05/27/2026

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	immediately, remain present with them if they are in the bathroom, and ensure they are comfortable and in their bed or chair before leaving them. The facility's Falls Policy, revised [DATE], documented residents would be identified for risk of falls and interventions implemented to reduce risk. A Fall Risk Evaluation Tool is completed on admission, quarterly, when there is a significant change, and after a fall. A resident's high-risk status will be documented on the comprehensive plan of care or service plan. Review of the fall prevention reference sheet for ideas to implement and document in the care plan. On [DATE] at 03:30 PM, Administrative Staff A and Administrative Nurse D were provided the Immediate Jeopardy [IJ] Template and were notified the facility's failure to provide adequate supervision and assistance for R1 placed R1 in immediate jeopardy. The facility implemented education and retraining to staff regarding providing the appropriate level of staff assistance and supervision. The corrections were completed on [DATE], prior to the onsite survey therefore, the deficient practice was deemed past non noncompliance and remained at a scope and severity J (immediacy, isolated).