STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175423	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holiday Resort of Salina	2825 Resort Drive 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review, observation, and interview, the facility failed to develop and implement a comprehensive care plan for Resident (R) 1 to direct staff to provide R1 services for R1 to attain or maintain her highest practicable physical, mental, and psychosocial well-being. Findings included:- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of hemiparesis (muscular weakness of one half of the body) and hemiplegia (paralysis of one side 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), urinary tract infection (UTI-an infection in any part of the urinary system), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The admission Minimum Data Set (MDS) 04/09/26, documented R1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R1 had impairment on both sides of her upper and lower extremities and was dependent on staff for all activities of daily living (ADLs). The MDS documented R1 was frequently incontinent of bladder and bowel. The MDS documented R1 had a urinary tract infection in the last 30 days. The Functional Abilities Care Area Assessment (CAA) dated 04/09/26, documented R1 had diagnoses that made ADLs difficult or impossible for R1 to do by herself, and staff would assist R1 with her ADLs. R1's Care Plan, initiated 03/02/26, lacked any direction regarding R1's ADLs and care needs. The care plan only had three areas addressed in the care plan: advanced directives, black box warnings, and discharge. On 04/22/26 at 11:00 AM, observation revealed R1 had greasy, oily hair and a distinct odor about her. R1 lay in bed and was turned on her right side. On 04/22/26 at 11:00 AM, R1 stated that she did not think staff knew how to take care of her. R1 stated she would ask staff to turn her in a different direction because she got so sore staying in one position. R1 stated staff would come into her room, and she would ask to be turned, and they would say, Not right now. R1 stated she did not know what days her showers were supposed to be because no one had told her. R1 stated she would like to be turned towards the door. On 04/22/26 at 01:00 PM, Administrative Nurse D stated he was aware R1 did not have a complete care plan, and that was his fault. Administrative Nurse D stated he expected residents to have a comprehensive care plan in place a month and a half after admission to the facility. The facility's Care Plan Policy, dated 03/21/24, documented a care plan will be developed for each resident that includes measurable objectives to meet a resident's medical, nursing, mental, and psychosocial needs and is consistent with the resident's desires and preferences. A comprehensive care plan must be developed within seven days of completion of the MDS and CAAs or within 21 days after admission, whichever comes first. The care plan should reflect individualized problems, goals, and interventions based on the resident's preferences and wishes.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, and interview, the facility failed to ensure staff provided consistent bathing and/or showers for five sampled residents who were dependent on staff for activities of daily living (ADL), Resident (R) 1, R2, R3, R4, and R5. Findings included:- 1. R1's Electronic Medical Record (EMR) documented R1 had diagnoses of hemiparesis (muscular weakness of one half of the body) and hemiplegia (paralysis of one side 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), urinary tract infection (UTI-an infection in any part of the urinary system), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The admission Minimum Data Set (MDS) 04/09/26, documented R1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R1 had impairment on both sides of her upper and lower extremities and was dependent on staff for all ADL. The Functional Abilities Care Area Assessment (CAA) dated 04/09/26, documented R1 had diagnoses that made ADLs difficult or impossible for R1 to do by herself, and staff would assist R1 with her ADLs. R1's Care Plan lacked any direction regarding R1's ADLs. The Bathing Schedule Sheets in the EMR documented R1 was scheduled to have showers every Tuesday and Saturday. R1's EMR documented R1 only had four showers from 03/24/26 through 04/22/26. On 04/22/26 at 11:00 AM, observation revealed R1 had greasy, oily hair and a distinct odor about her. On 04/22/26 at 11:00 AM, R1 stated that she had not been getting her showers the way she was scheduled, and she felt dirty and unclean. R1 stated she was used to showering every day, and waiting 7-10 days for a shower was not acceptable to her. 2. R2's EMR documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (high blood pressure), depression, and chronic kidney disease (long-term progressive loss of kidney function). The Comprehensive MDS, dated 04/14/26, documented a BIMS score of 15, which indicated intact cognition. The MDS documented R2 had impairment on both sides of his lower extremities and was dependent on staff for all his ADLs. The Functional Abilities CAA dated 04/14/26, documented R2 had diagnoses that made it difficult for R2 to complete most of his ADLs, and staff would assist R2 with his ADLs. R2's Care Plan documented R2 preferred to shower two times a week. The care plan lacked any direction on the assistance R2 needed for bathing. The Bathing Schedule Sheet in the EMR documented R2 was to have baths/showers every Sunday and Thursday. The EMR documented R2 only had 6 baths from 03/24/26 through 04/22/26. On 04/22/26 at 10:00 AM, observation revealed R2 had an overgrowth of gray beard on his face, and R2 had a distinct body odor about him. On 04/22/26 at 10:00 AM, R2 stated he wrote everything down in his notebook that the staff did and did not do for him. R2 stated he had only had three baths in the last 30 days, and if his EMR said anything different, the staff were lying. R2 stated he preferred to be showered three days a week, but the facility would only offer two showers a week. R2 stated the facility could not even give him two showers a week. R2 stated he felt neglected when he did not get cleaned up.3. R3's EMR documented R3 had diagnoses of multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord), heart failure (a condition with low heart output and the body becomes congested with fluid), and depression. The Quarterly MDS dated 03/31/26, documented R3 had a BIMS score of 15, which indicated intact cognition. The MDS documented R3 had impairment on both sides of her lower extremities. The MDS documented R3 was dependent on staff for transfers and required substantial staff assistance for showering. The Functional Abilities CAA dated 12/12/25, documented R3 had a progressive decline in her physical abilities to perform her ADLs. R3's Care Plan documented R3 preferred to have two showers a week. The Bathing Schedule Sheet in the EMR documented R3 was to receive showers/bathing every Monday and Thursday. The EMR documented R3 had only received two (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showers from 03/24/26 through 04/22/26. On 04.22.26 at 10:15 AM, observation revealed R3 up in a motorized scooter. R3 had unkempt hair, which was greasy and oily. R3 had a distinct odor of urine about her. On 4/22/26 at 10:15 AM, R3 stated she had not been getting her showers the way she was supposed to. R3 got tears in her eyes and stated she had not had a shower in two weeks. R3 stated she felt dirty and smelly. R3 stated staff did not have enough time to get her in the shower for bathing. 4. R4's EMR documented R4 had diagnoses of gout (inflammation of the joints), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and severe obesity. The Comprehensive MDS, dated 03/27/26, documented R4 had a BIMS score of 15, which indicated intact cognition. The MDS documented R4 was dependent on staff for toileting hygiene, lower body dressing, and transfer, and required substantial staff assistance with bathing/showering and bed mobility. The Functional Abilities CAA, dated 03/27/26, documented R4 had diagnoses which made it difficult for her to assist in transfers and bathing, and staff would provide R4 assistance with ADLs. The Bathing Schedule Sheet in the EMR documented R4 was scheduled to receive showers/baths every Monday and Wednesday. The EMR documented R4 had only received four showers from 03/24/26 through 04/22/26. On 04/22/26 at 10:30 AM, observation revealed R4 sat up in her wheelchair and waited for her care plan meeting. R4's hair was unkept and oily. On 04/22/26 at 10:30 AM, R4 stated she had not been receiving her showers/baths the way she was supposed to. R4 stated she felt neglected and uncared for by facility staff because staff did not care if she was clean or not. R4 blamed lack of staffing for not getting showers.5. R5's EMR documented diagnoses of hemiplegia and hemiparesis following a cerebral infarction, anxiety, and depression. The Quarterly MDS dated 08/16/24, documented R5 had a BIMS score of 14, which indicated intact cognition. The MDS documented R5 had impairment on one side of her upper and lower extremities. The Functional Abilities CAA dated 04/11/25, documented R5 had difficulty performing ADLs, and staff would assist her with ADLs. R5's Care Plan directed staff to help R5 wash her hair and her back during her showers. The Bathing Sheet Schedule in the EMR documented R5 was scheduled to receive showers/baths every Wednesday and Friday. The EMR documented R5 had only received five showers from 03/24/26 through 04/22/26. On 04/22/26 at 10:30 AM, observation revealed R5 up in her wheelchair. R5 had contractures of her left hand and foot. R5 had a distinct odor of urine about her, and her hair was oily. On 10/02/24 at 10:30 AM, R5 stated she was not getting her showers the way she was scheduled to and blamed the lack of staffing. R5 stated she felt smelly and gross due to the lack of showers. On 04/22/26 at 11:00 AM, Certified Medication Aide (CMA) R stated the staff was not taking care of the residents the way they were supposed to be taken care of. CMA R stated the residents were not getting showered and bathed, and were lucky if they got one every ten days. CMA R stated low staffing as the reason for the lack of care. On 04/22/26 at 01:00 PM, Administrative Nurse D stated he knew there had been some problems with baths getting done and he was currently going through bathing sheets to assess whether showers were not getting done or not getting charted. He stated he knew R3 had not had a bath in two weeks, and he had apologized to her and had staff get her in the shower right away. The facility's Activities of Daily Living Policy revised 04/27/18, documented the residents will be given the appropriate treatment and services to maintain or improve his/her ability to carry out the activities of daily living. The facility will provide care and services based on the comprehensive assessment of the resident and consistent with his/her needs or choices for the following: Hygiene (bathing, dressing, grooming, and oral care), Mobility (transfer and ambulation), Elimination (toileting), Dining (eating, including snacks and meals), and Communication (speech, language, functional communication systems). Residents who are unable to carry out activities of daily living and are dependent on if staff will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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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. Based on record review, observation, and interview, the facility failed to follow R1's primary care physician's orders to obtain a straight catheterization urine specimen to assess for a urinary tract infection. Findings included:- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of hemiparesis (muscular weakness of one half of the body) and hemiplegia (paralysis of one side 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), urinary tract infection (UTI-an infection in any part of the urinary system), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The admission Minimum Data Set (MDS) 04/09/26, documented R1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R1 had impairment on both sides of her upper and lower extremities and was dependent on staff for all activities of daily living (ADLs). The MDS documented R1 was frequently incontinent of bladder and bowel. The MDS documented R1 had a urinary tract infection in the last 30 days. The Functional Abilities Care Area Assessment (CAA) dated 04/09/26, documented R1 had diagnoses that made ADLs difficult or impossible for R1 to do by herself; staff would assist R1 with her ADLs. R1's Care Plan initiated 03/02/26, lacked any direction regarding R1's ADL and care needs. The care plan only had three areas addressed in the care plan: advanced directives, black box warnings, and discharge. The Nurses Note dated 03/11/26 at 11:31 AM, documented when changing R1 and providing peri care, staff noted blood in R1's brief and while wiping. R1 had increased urinary frequency, decreased urine output at times, and appeared to have bladder spasms. Staff notified R1's primary care physician and received an order to perform a straight catheterization to obtain a urine sample. The Nurses Note dated 03/11/26 at 04:53 PM, documented R1's primary care physician had faxed back an order to obtain a straight catheterization urine specimen and send for culture and sensitivity if indicated. The March 2026 Treatment Administration Record (TAR) documented a new order for a straight catheterization urine specimen to be obtained. The TAR lacked any documentation the order had been completed. R1's EMR lacked any urine specimen results. R1's Hospital Health and Physical (H&P) dated 03/13/26, documented R1 had been admitted to the hospital with hypoxia (low oxygen saturation), and no source for the hypoxia was found. A straight catheterization had been completed, and R1 had a UTI and was placed on an intravenous antibiotic and admitted to the hospital. On 04/22/26 at 11:00 AM, observation revealed R1 had greasy, oily hair and a distinct odor about her. R1 lay in bed and was turned on her right side. On 04/22/26 at 11:00 AM, R1 stated that she had to be admitted to the hospital and had a urinary tract infection. R1 stated her granddaughter had told her the facility did not obtain a urine specimen when it had been ordered by her doctor. R1 stated she could remember staff telling her she had blood in her urine but did not remember staff obtaining a urine sample. On 04/22/26 at 01:00 PM, Administrative Nurse D stated he was unaware of any straight catheterization order being missed for R1. Administrative Nurse D reviewed R1's EMR, and he verified the order had not been completed by staff. Administrative Nurse D stated all physician orders needed to be completed by the nursing staff, and it was unacceptable this order had not been followed. The Physician Order Policy, dated 09/21/21, documented physician orders will be followed related to the care needs of individual residents. Physician orders may be received verbally, via telephone or fax communication, or written orders in the clinical record progress note or other written forms. A licensed nurse must note all physician orders and process them as indicated, which includes entering the order into the electronic medical record.