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	07/09/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 45 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure one resident, Resident (R) 5 was free from antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication without an appropriate indication for use. The facility failed to ensure the physician provided the risk versus benefit for the continued use of antipsychotic medications. This placed R5 at risk of unnecessary medication administration and related complications.Findings included:- The Electronic Medical Record (EMR) for R5 documented diagnoses of dementia without behavioral disturbances (a progressive mental disorder characterized by failing memory and confusion), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).The Quarterly Minimum Data Set (MDS), dated [DATE], documented R5 had severely impaired cognition. The MDS documented R5 required substantial staff assistance for toileting, upper body dressing, personal hygiene, mobility, transfer, and did not ambulate. The MDS further documented R5's preferred language was Spanish, did not reject care, and had other behaviors for one to three days. R5 received antipsychotic, antianxiety (a class of medication that calms and relaxes people), antidepressant (a class of medications used to treat mood disorders), and diuretic (a medication to promote the formation and excretion of urine) medication daily. R5's Care Plan, dated 06/12/25, lacked a care area for antipsychotic medications to direct staff of the indications for the use of the medications, as well as what signs and symptoms to look for.The Physician's Order, dated 06/27/25, directed staff to administer Seroquel (an antipsychotic medication), 25 mg, two tablets, by mouth, twice daily, for major depressive disorder. This was discontinued on 06/03/25.The Physician's Order, dated 07/01/25, directed staff to administer Seroquel, 25 mg, two tablets, by mouth, three times daily for major depressive disorder.The Physician's Order, dated 07/03/25, directed staff to administer Compound Medication (lorazepam, one mg, diphenhydramine (an antihistamine medication) 25 mg, and Haldol (an antipsychotic medication), 1 mg, apply to inner wrist topically, every two hours, as needed for anxiety, restlessness, and agitation. This is to be discontinued on 07/14/25.The EMR lacked documentation of R5's family receiving a risk versus benefit or any other treatment alternatives.The Nurse's Note, dated 03/19/25, documented R5 sat on the side of her bed, speaking and pointing to the room across the hall, asking if there was a problem in that room. R5 began to speak faster Spanish, then leaned forward and went down onto the mat on her knees. R5 stated she was looking for something. The note documented staff called R5's family and was advised to administer Ativan to R5.The Nurse's Note, dated 04/20/25, documented R5 had multiple behaviors today, attempted to stand up from her wheelchair, and then walk. The note further documented R5 also bothered her daughter in her room.The Nurse's Note, dated 06/22/25, documented R5 was very agitated, restless, yelled, and cried that she wanted to go home. Staff asked R5 if she wanted to go to her room to be near her daughter, and she stated yes. The note documented staff were able to medicate R5 for her agitation.The Hospice Note, dated 06/30/25, documented during a routine visit, facility staff attempted to keep R5 in her wheelchair as R5 was agitated and attempted to stand up. R5 spoke very rapidly in Spanish and allowed a Spanish-speaking employee to wheel her into her room. The note further documented R5 hit, screamed, and bit at staff during the day, and an order to increase R5's Seroquel was obtained.On 07/08/25 at 01:08 PM, R5 hollered out in Spanish, cried, and Licensed Nurse (LN) G told her she needed to speak in English. R5 stated 'I don't want to speak English. R5 continued to cry, and LN G asked R5 if she could take R5 to R5's room to be close to her daughter. LN G pushed R5 to her room.On 07/08/25 at 09:40 AM, Certified Nurse Aide (CNA) M stated that R5 liked to be close to her daughter as they are in the same room. CNA M further stated she can understand English some of the time, but when she was frustrated and mad, she spoke in Spanish. CNA M stated she does not always know what she wants or what she is saying. CNA M stated there were a couple of Spanish-speaking staff members, but they were not always in the building to assist with R5.On 07/08/25 at 10:45 AM, Certified Medication Aide (CMA) R stated R5 would often become anxious and agitated and would speak mostly in Spanish. CMA R further stated that Seroquel was given because R5 would get frustrated when staff did not know what she was saying or what she wanted. CMA R stated there was at least one Spanish-speaking staff member, but she was not always

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 45 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to provide a Bed Hold Notification and State Ombudsman Agency notification of Resident (R) 32's discharge from the facility. This placed R32 at risk for being uninformed.Findings included:- R32's Electronic Medical Record (EMR) documented diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following 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 left non-dominant side, chronic kidney disease, diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), obesity (excessive body fat), nicotine dependence, cigarettes, lymphedema (tissue swelling caused by accumulation of protein rich fluid), polyarthritis, chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and chronic respiratory failure with hypoxia (inadequate supply of oxygen).R32's Quarter Minimum Data Set (MDS), dated [DATE], documented that the resident had intact cognition, had verbal symptoms directed toward others, and rejected care occurred one to three days of the look-back period. R32 used a wheelchair for mobility, required setup or clean-up assistance with eating, substantial/maximal assistance with oral hygiene, upper body dressing, and dependent with toileting hygiene. The MDS further documented R32 required partial/moderate assistance with transfers, frequently incontinent of urine, no pain or falls. R32 received insulin (a hormone that lowers the level of glucose in the blood), a diuretic (a medication to promote the formation and excretion of urine), an antiplatelet (a medication used to prevent blood components from clumping together), a hypoglycemic (a medication used to lower blood sugar), and an anticonvulsant (medication used to prevent seizures).R32's MDSs recorded:On 12/11/24, a Discharge Return Anticipated.On 12/16/24, an Entry into the facility.On 12/30/24, a Discharge Return Anticipated.On 01/03/25, an Entry into the facility.On 01/08/25, a Discharge Return Anticipated.On 02/03/25, an Entry into the facility.The EMR documented a Bed Hold Notification was provided to R32 or the resident representative on 12/30/25 and 01/08/25. The EMR lacked a Bed Hold Notification for the discharge on [DATE].On 07/08/25 at 12:06 PM, Social Services Staff X stated she was responsible for providing the residents who were discharged to the hospital with the facility's bed hold policy and notifying the State Ombudsman's Agency department also of discharges. Social Services X stated she had failed to provide this information as related to R32's hospitalizations and must have slipped through the cracks. The facility's Bed-Hold Policy Notice dated 11/28/17 documented that a written notice will be issued to the resident or resident representative upon transfer to a hospital or therapeutic leave. The notice will specify the duration of the bed-hold policy.

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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 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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 45 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan with individualized, resident-centered interventions for dementia (a progressive mental disorder characterized by failing memory and confusion) care, behaviors, and communication for one resident, Resident (R) 5. This placed the resident at risk for unmet care needs.Findings included:- The Electronic Medical Record (EMR) for R5 documented diagnoses of dementia without behavioral disturbances (a progressive mental disorder characterized by failing memory and confusion), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made or the boy cannot respond to the insulin).The Quarterly Minimum Data Set (MDS), dated [DATE], documented R5 had severely impaired cognition. The MDS documented R5 required substantial staff assistance for toileting, upper body dressing, personal hygiene, mobility, transfer, and did not ambulate. The MDS further documented R5's preferred language was Spanish, did not reject care, and had other behaviors one to three days. R5 received antipsychotic (a class of medication used to treat major mental conditions that cause a break from reality), antianxiety (a class of medication that calms and relaxes people), antidepressant (a class of medications used to treat mood disorders), and diuretic (a medication to promote the formation and excretion of urine) medication daily.R5's Care Plan, dated 06/12/25, lacked an individualized care area for dementia care, behaviors, and communication.The Physician's Order, dated 03/03/25, directed staff to administer trazodone (an antidepressant medication), 150 milligrams (mg), by mouth, at bedtime, for depression.The Physician's Order, dated 03/19/25, directed staff to administer venlafaxine hci (an antidepressant medication), 75 mg, by mouth, twice a day, for depression.The Physician's Order, dated 05/02/25, directed staff to administer sertraline hci (an antidepressant medication), 5 milliliters (ml), by mouth, daily, for major depressive disorder.The Physician's Order, dated 06/06/25, directed staff to administer Ativan (an antianxiety medication), 0.5 mg, by mouth, twice daily for agitation and anxiety.The Physician's Order, dated 06/27/25, directed staff to administer Seroquel (an antipsychotic medication), 25 mg, two tablets, by mouth, twice daily, for major depressive disorder. This was discontinued on 06/30/25The Physician's Order, dated 07/01/25, directed staff to administer Seroquel, 25 mg, two tablets, by mouth, three times daily for major depressive disorder.The Physician's Order, dated 06/30/25, directed staff to administer Compound Medication (lorazepam, one mg; diphenhydramine (an antihistamine medication) 25 mg, and Haldol (an antipsychotic medication), 1 mg, apply to inner wrist topically, every two hours, as needed for anxiety, restlessness, and agitation. This was discontinued on 07/03/25.The Physician's Order, dated 07/03/25, directed staff to administer Compound Medication (lorazepam, one mg, diphenhydramine (an antihistamine medication) 25 mg, and Haldol (an antipsychotic medication), 1 mg, apply to inner wrist topically, every two hours, as needed for anxiety, restlessness, and agitation. This is to be discontinued on 07/14/25.The EMR lacked documentation of R5's family receiving a risk versus benefit or any other treatment alternatives.The Nurse's Note, dated 03/19/25, documented R5 sat on the side of her bed, speaking and pointing to the room across the hall, asking if there was a problem in that room. R5 began to speak faster Spanish, then leaned forward and went down onto the mat on her knees. R5 stated she was looking for something. The note documented that staff called R5's family and was advised to administer Ativan to R5.The Nurse's Note, dated 04/20/25, documented R5 had multiple behaviors today, attempted to stand up from her wheelchair, and then walk. The note further documented R5 also bothered her daughter in her room.The Nurse's Note, dated 06/22/25, documented R5 was very agitated, restless, yelled, and cried that she wanted to go home. Staff asked R5 if she wanted to go to her room to be near her daughter, and R5 stated yes. The note documented staff were able to medicate R5 for her agitation.The Hospice Note, dated 06/30/25, documented that, during a routine visit, facility staff attempted to keep R5 in her wheelchair as R5 was agitated and attempted to stand up. R5 spoke very rapidly in Spanish and allowed a Spanish-speaking employee to wheel her into her room. The note further documented R5 hit, screamed, and bit at staff during the day, and an order to increase R5's Seroquel was obtained.On 07/07/25 at 02:01 PM, R5 spoke in Spanish as an unidentified Certified Nurse Aide (CNA) tried to assist her further back into her wheelchair. R5 continued to speak Spanish when the CNA stated, I don't speak Spanish. At that time, three other staff

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 45 residents. The sample included 12 residents, with one reviewed for communication. Based on observation, record review, and interview, the facility failed to implement alternative communication methods for one resident, Resident (R) 5, who spoke Spanish. This placed the resident at risk for unmet needs, frustration, and agitation.Findings included:- The Electronic Medical Record (EMR) for R5 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) without behavioral disturbances, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the boy cannot respond to the insulin).The Quarterly Minimum Data Set (MDS), dated [DATE], documented R5 had severely impaired cognition. The MDS documented R5 required substantial staff assistance for toileting, upper body dressing, personal hygiene, mobility, transfer, and did not ambulate. The MDS further documented that R5's preferred language was Spanish.R5's Care Plan, dated 06/12/25, lacked an individualized care area for communication.On 07/07/25 at 02:01 PM, R5 spoke in Spanish as an unidentified Certified Nurse Aide (CNA) tried to assist her further back into her wheelchair. R5 continued to speak Spanish when the CNA stated, I don't speak Spanish. At that time, three other staff members approached R5 and surrounded her to get her further back into her wheelchair. R5's Spanish because faster and louder when a staff member went up to her and was able to speak to her in Spanish, and R5 was less agitated and even laughed at something the staff said to her.On 07/08/25 at 10:00 AM, a Certified Medication Aide (CMA) R administered medications to R5. R5 spoke in Spanish, and CMA R made a drinking motion with her hand. R5 said something again in Spanish. CMA R continued to make the drinking motion, and R5 drank her water.On 07/08/25 at 01:08 PM, R5 hollered out in Spanish, cried, and Licensed Nurse (LN) G told her she needed to speak in English. R5 stated 'I don't want to speak English. R5 continued to cry, and LN G asked R5 if she could take R5 to R5's room to be close to her daughter. LN G pushed R5 to her room.On 07/08/25 at 09:40 AM, Certified Nurse Aide (CNA) M stated that R5 liked to be close to her daughter as they were in the same room. CNA M further stated she could understand English some of the time, but when she was frustrated and mad, she spoke in Spanish. CNA M stated she does not always know what she wants or what she is saying. CNA M stated there were a couple of Spanish-speaking staff members, but they were not always in the building to assist with R5.On 07/08/25 at 10:45 AM, Certified Medication Aide (CMA) R stated R5 would often become anxious and agitated and would speak mostly in Spanish. CMA R further stated that Seroquel was given because R5 would get frustrated when staff did not know what she was saying or what she wanted. CMA R stated there was at least one Spanish-speaking staff member, but she was not always working.On 07/08/25 at 10:45 AM, LN G stated R5 could speak some English and could understand what the staff were saying. LN G stated R5 would get agitated, refuse medications, and care. LN G stated R5 received medication for her agitation.On 07/08/25 at 12:36 PM, Administrative Nurse D stated that there should be an application on the staff's IPAD (a portable device with a touchscreen, designed for various tasks) that would assist them to understand R5, but stated the application had not been downloaded yet. Upon request, a policy for communication was not provided by the facility.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 45 residents. The sample included 12 residents, with 4 reviewed for bathing. Based on observation, record review, and interview, the facility failed to provide consistent bathing services for two residents, Resident (R) 6 and R8. This placed the residents at risk for complications related to poor hygiene. Findings included:- The Electronic Medical Record (EMR) for R6 recorded diagnoses of multiple sclerosis (MS - progressive disease of the nerve fibers of the brain and spinal cord), heart failure, dementia without behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) The Quarterly Minimum Data Set (MDS), dated [DATE], documented R6 had moderately impaired cognition. R6 was independent for eating, oral hygiene, dressing, personal hygiene, mobility, and transfers. R6 required substantial staff assistance with bathing. R6's Care Plan, dated 06/26/25, initiated on 06/12/19, directed staff to assist her to wash her back and hair during showers and allow her to wash the rest of herself with a washcloth. The update, dated 11/28/22, documented R6 preferred to take two showers or whirlpools per week. The June and July 2025 Bathing Record documented R6 requested showers on Monday and Thursday, and documented R6 had not received a shower during the following days:06/25/25 - 0707/25 (13 days) The EMR lacked documentation R6 refused her showers. On 07/07/25 at 09:29 AM, R6's hair was greasy, and she stated she did not get a shower very often. R6 stated she was supposed to get one twice per week. On 07/08/25 at 10:00 AM, Certified Medication Aide (CMA) R stated R6 did not refuse her baths, and staff filled out bathing sheets and turned them into the nurse. On 07/08/25 at 10:45 AM, Licensed Nurse G stated that if a resident refused her bath, they would reapproach later and try again. If the resident still refused, they would be put on the schedule for the following day, but R6 did not refuse her baths. On 07/09/25 at 10:39 AM, Administrative Nurse G stated she would be doing more bathing audits to make sure residents received their baths. The facility's Bath and Shower policy, dated 11/28/17, documented that the facility ensured the residents' baths and showers were performed and documented as scheduled according to resident preferences to maintain each resident's hygiene and dignity. The Director of Nursing or designated personnel would review the Bathing Report to ensure each resident received a bath/shower and hair care as required. - R8's EMR documented R8 had diagnoses of intellectual disabilities (a significantly below-average score on a test of mental ability or intelligence and limitations in the ability to function in areas of daily life) and vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R8's Quarterly MDS, dated [DATE], documented R8 had a Brief Interview of Mental Status (BIMS) score of eight, which indicated severe cognitive impairment. The MDS documented R8 was dependent on the staff for showering. R8's Care Plan, revised 04/23/25, documented R8 would like a bath twice a week, not in the early morning. R8's Bathing Schedule documented R8 received a shower on Wednesday and Saturday evenings. R8's Showering Report documented he had a shower on the following days:May last shower 05/31/2506/18/25, 06/25/25, 06/29/25 (refused 06/04/25, 06/07/25, 06/11/25, 06/14/25, and 06/28/25). 07/03/25 and as of 07/08/25 (5 days without a shower) refused. On 07/07/25 at 02:36 PM, R8 sat in a wheelchair in the small dining room off the main dining room at a ball-hitting activity with greasy hair. On 07/09/25 at 10:14 AM, Consultant GG stated residents should receive their baths as requested. The facility's Bath and Shower Policy, revised 11/28/17, documented to ensure the resident's baths and showers are performed and documented as scheduled according to resident preference to maintain each resident's hygiene and dignity.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 45 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to provide adequate supervision for Resident (R) 32, who smoked and had a staff-assisted descent to the ground while being assisted with a chair-to-chair transfer. This placed R32 at risk for injuries from smoking and falls.Included findings:- R32's Electronic Medical Record (EMR) documented diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following 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 left non-dominant side, chronic kidney disease, diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), obesity (excessive body fat), nicotine dependence, cigarettes, lymphedema (tissue swelling caused by accumulation of protein rich fluid), polyarthritis, chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and chronic respiratory failure with hypoxia (inadequate supply of oxygen).R32's Quarter Minimum Data Set (MDS), dated [DATE], documented the resident had intact cognition, had verbal symptoms directed toward others, and rejected care, which occurred one to three days of the look-back period. R32 used a wheelchair for mobility, required setup or clean-up assistance with eating, substantial/maximal assistance with oral hygiene, upper body dressing, and was dependent with toileting hygiene. The MDS further documented R32 required partial/moderate assistance with transfers, was frequently incontinent of urine, and had no pain or falls. R32 received insulin (a hormone that lowers the level of glucose in the blood), a diuretic (a medication to promote the formation and excretion of urine), an antiplatelet (a medication used to prevent blood components from clumping together), a hypoglycemic (a medication used to lower blood sugar), and an anticonvulsant medication (medication used to prevent seizures). R32's Care Plan, dated 03/31/25, documented that R32 smoked and had been educated on the risks of smoking even with the diagnosis of COPD. The Care Plan documented that R32 could not safely smoke, although he would not give up his smoking materials or allow someone to assist with smoking. R32 signed an informed risk agreement to allow R32 to keep smoking materials on his person and continue to smoke independently against recommendations from the facility. The plan of care documented R32 did not follow directions for the designated smoking area, and staff were to redirect R32 when he went to other areas to smoke. R32's plan of care documented he often fell asleep while smoking and knew the risks associated with this. The plan of care directed staff to set a timer when R32 went outside to check on him. The plan of care documented R32 understood the danger of smoking without assistance. The plan of care documented staff had discussed with R32 where the designated smoking areas were, that he could not smoke in the facility, and how to properly dispose of the cigarette butts. The plan of care directed staff to remind R32 of the need to follow the rules for the safety of himself and others. The facility Smoking Assessment dated 11/14/24, documented R32 reported he would put cigarettes out and put them back into his pack. The assessment documented R32 put a cigarette out in a Styrofoam cup that was located in his room and noted the resident had not safely disposed of cigarettes.The facility's Smoking Assessment dated 12/26/24, documented R32 experienced a recent illness and dozed off when attempting to light and smoke cigarettes. R32 was no longer safe to smoke alone.The Progress Note dated 12/26/24 at 03:52 PM documented that the Social Service Designee (SSD) witnessed R32 outside in the smoking area three times throughout the day, falling asleep while smoking, trying to light an already lit cigarette, and dropping cigarettes on himself. The SSD was with the Certified Dietary Manager (CDM) and other residents who also witnessed the event and had concerns.The Progress Note dated 12/26/24 at 04:00 PM, documented R32 was observed outside smoking and sleeping on multiple occasions. R32 was unable to stay awake long enough to finish his cigarette. R32 fell asleep with a cigarette in his mouth, as well as trying to light a cigarette and getting the flame close to his facial hair while falling asleep. Staff woke R32 up on all of the occasions and became upset with the staff.The Progress Note dated 12/27/25 at 07:46 AM documented R32 had had issues with falling asleep while smoking following a recent illness. The facility presented R32 with the smoking policy and he verbalized understanding. R32 had intact cognition and completed a smoking assessment. R32 was notified that due to facility policies and the recent smoking assessment, it was not recommended that he keep smoking materials on his person or smoke independently

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holiday Resort of Salina	2825 Resort Drive 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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. The facility had a census of 45 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to post the actual scheduled hours worked for nursing staff directly responsible for resident care per shift. This placed the residents at risk of being uninformed of nursing staff hours.Findings included:- On 07/07/25 at 08:10 AM, upon entrance into the facility, the Daily Nurse Staffing Report was observed posted on the desk pillars on the North side of the nurse's station, dated 07/06/25 and indicated a census of 45 residents. On 07/08/25 at 07:30 AM, observation revealed the facility lacked a Daily Nurse Staffing Report.On 07/09/25 at 08:10 AM, Nurse Consultant GG verified it was the night shift's responsibility to make sure the Daily Nurse Staffing Report was posted for the current day. Nurse Consultant GG verified on 07/07/25 that the facility had posted a schedule dated 07/06/25, and on 07/08/25, the facility lacked a nursing staffing schedule posting for part of the day. The facility's Daily Nursing Staff Posting policy, dated 11/28/17, documented the facility would post the full-time equivalent number of personnel responsible for providing direct care daily for each shift. At the beginning of each shift, the number of licensed nurses (RNs and LPNs) and the number of unlicensed nursing personnel (CMAs, CNAs, nurse's aide trainees) who provide direct care to the residents would be posted using the Daily Nurse Staffing form. The shift posting information shall include the number of full-time equivalents on duty for that day for that shift. Daily nursing shall be recorded on each facility's Daily Nurse Staff Fork, which will be retained for 18 months.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 45 residents. The sample included 12 residents, with two reviewed for dementia (progressive mental deterioration characterized by confusion and memory failure) care. Based on observation, record review, and interview, the facility failed to develop and implement an individualized dementia treatment plan for one resident, Resident (R) 5, who had dementia and received psychotropic (alters mood or thought) medication. This placed R5 at risk for decreased quality of life.Findings included:- The Electronic Medical Record (EMR) for R5 documented diagnoses of dementia without behavioral disturbances, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).The Quarterly Minimum Data Set (MDS), dated [DATE], documented R5 had severely impaired cognition. The MDS documented R5 required substantial staff assistance for toileting, upper body dressing, personal hygiene, mobility, transfer, and did not ambulate. The MDS further documented R5's preferred language was Spanish, did not reject care, and had other behaviors for one to three days. R5 received antipsychotic, antianxiety (a class of medication that calms and relaxes people), antidepressant (a class of medications used to treat mood disorders), and diuretic (a medication to promote the formation and excretion of urine) medication daily.R5's Care Plan, dated 06/12/25, lacked an individualized care area for dementia care.The Physician's Order, dated 03/03/25, directed staff to administer trazodone (an antidepressant medication), 150 milligrams (mg), by mouth, at bedtime, for depression.The Physician's Order, dated 03/19/25, directed staff to administer venlafaxine hci (an antidepressant medication), 75 mg, by mouth, twice a day, for depression.The Physician's Order, dated 05/02/25, directed staff to administer sertraline hci (an antidepressant medication), 5 milliliters (ml), by mouth, daily, for major depressive disorder. The Physician's Order, dated 06/06/25, directed staff to administer Ativan (an antianxiety medication), 0.5 mg, by mouth, twice daily for agitation and anxiety.The Physician's Order, dated 06/27/25, directed staff to administer Seroquel (an antipsychotic medication), 25 mg, two tablets, by mouth, twice daily, for major depressive disorder. This was discontinued on 06/03/25The Physician's Order, dated 07/01/25, directed staff to administer Seroquel, 25 mg, two tablets, by mouth, three times daily for major depressive disorder.The Physician's Order, dated 06/30/25, directed staff to administer Compound Medication (lorazepam, one mg, diphenhydramine (an antihistamine medication) 25 mg, and Haldol (an antipsychotic medication), 1 mg, apply to inner wrist topically, every two hours, as needed for anxiety, restlessness, and agitation. This was discontinued on 07/03/25.The Physician's Order, dated 07/03/25, directed staff to administer Compound Medication (lorazepam, one mg; diphenhydramine (an antihistamine medication) 25 mg, and Haldol (an antipsychotic medication), 1 mg, apply to inner wrist topically, every two hours, as needed for anxiety, restlessness, and agitation. This is to be discontinued on 07/14/25.The EMR lacked documentation R5's family received a risk versus benefit or any other treatment alternatives.The Nurse's Note, dated 03/19/25, documented R5 sat on the side of her bed, speaking and pointing to the room across the hall, asking if there was a problem in that room. R5 began to speak faster Spanish, then leaned forward and went down onto the mat on her knees. R5 stated she was looking for something. The note documented staff called R5's family and was advised to administer Ativan to R5.The Nurse's Note, dated 04/20/25, documented R5 had multiple behaviors today, attempted to stand up from her wheelchair, and then walk. The note further documented R5 also bothered her daughter in her room.The Nurse's Note, dated 06/22/25, documented R5 was very agitated, restless, yelled, and cried that she wanted to go home. Staff asked R5 if she wanted to go to her room to be near her daughter, and she stated yes. The note documented staff were able to medicate R5 for her agitation.The Hospice Note, dated 06/30/25, documented, during a routine visit, facility staff attempted to keep R5 in her wheelchair as R5 was agitated and attempted to stand up. R5 spoke very rapidly in Spanish and allowed a Spanish-speaking employee to wheel her into her room. The note further documented R5 hit, screamed, and bit at staff during the day, and an order to increase R5's Seroquel was obtained.On 07/08/25 at 01:08 PM, R5 hollered out in Spanish, cried, and Licensed Nurse (LN) G told her she needed to speak in English. R5 stated 'I don't want to speak English. R5 continued to cry, and LN G asked her if she could take her to her room to be close to her daughter. LN G pushed R5 to her daughters room.On 07/08/25 at 09:40 AM, Certified Nurse Aide (CNA) M stated that R5 liked to be close to her daughter as they are in the same

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 45 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to notify the physician of blood sugars (a system which measures blood glucose in the body) outside of ordered parameters for one resident, Resident (R) 20. This placed the residents at risk for adverse effects related to medication.Findings included:- The Electronic Medical Record (EMR) for R20 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), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and dementia (a progressive mental disorder characterized by failing memory and confusion).The Quarterly Minimum Data Set (MDS), dated [DATE], documented R20 had moderately impaired cognition. R20 required substantial assistance from staff for upper body dressing, personal hygiene, and transfers. R20 received seven days of insulin (a hormone that lowers the level of glucose in the blood), antidepressant (a class of medications used to treat mood disorders), and antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medications during the lookback period. R20's Care Plan, dated 05/08/25, initiated on 11/17/23, directed staff to administer insulin as prescribed by the physician and to notify him if her blood sugar was greater than 70 or less than 300. The care plan further directed staff to monitor her blood glucose (blood glucose monitoring test) as ordered by the physician and as needed.The Physician's Order, dated 11/18/23, directed staff to monitor blood glucose before meals and at bedtime and notify the physician if R20's blood glucose was greater than 300 milligrams (mg) per deciliter (dL) or if below 70 mg/dl.R20's Medication Administration Record, dated May 2025, documented the following days R20's blood sugar was out of parameters, and the physician was not notified.05/22/25 - 325 mg/dl05/29/25 - 302 mg/dlR20's Medication Administration Record, dated June 2025, documented the following days R20's blood sugar was out of parameters, and the physician was not notified.06/04/25 - 313 mg/dl06/06/25 - 303 mg/dl06/08/25 - 321 mg/dl06/25/25 - 69 mg/dlOn 07/08/25 at 08:13 AM, R20 sat in her recliner watching television.On 07/08/25 at 10:45 AM, Licensed Nurse (LN) G stated that if R20's blood sugar was out of parameters, she would retake her blood sugar. LN G further stated that it would be written in a progress note if the physician was notified by phone or by fax.On 07/08/25 at 03:00 PM, Administrative Nurse D stated she was unable to find that the physician was notified of the out-of-parameter blood sugars and would reeducate staff on the procedure. On 07/09/25 at 10:30 AM, Consultant GG verified that the care plan for blood sugar monitoring parameters was backwards and would correct the care plan.The facility's Notification of Changes policy, dated 04/27/18, documented that the facility would inform the resident, the resident's physician, and the resident's representative of any changes in the resident's status. The facility would immediately consult the physician if a need to alter treatment significantly.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. The facility had a census of 45 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to correctly prepare a pureed (a texture-modified diet where all foods are blended or mashed into a smooth, pudding-like consistency) diet for Resident (R) 8. This placed the residents at risk for inadequate nutrition.Findings included:- On 07/08/25 at 11:30 AM, observation revealed Dietary Staff (DS) BB prepared one pureed diet. DS BB placed one serving, approximately three ounces of baked barbecued rib patty in a food processor/blender. DS BB blended the barbecued rib patty, added an unmeasured amount of meat juice, blended to the correct pureed texture, and emptied the barbecued meat into a stainless-steel food storage container, then placed the steel food container in the oven. Continued observation revealed DS BB placed approximately four ounces of cauliflower and broccoli in a food processor/blender. DS BB blended the vegetables to the correct pureed texture and emptied the vegetables into a stainless-steel food storage container, then placed the steel food container on the steam table. Continued observation revealed DS BB placed four ounces of O'Brien potatoes in a food processor/blended. DS BB blended the potatoes to the correct pureed texture and emptied the potatoes into a stainless-steel food storage container, then placed the steel food container on the steam table. Observation revealed there was no recipe for DS BB to look at with food preparation. On 07/08/25 at 11:40 AM, observation revealed DS CC prepared one pureed dessert. DS CC placed one approximately two-inch by two-inch piece of lemon bar in the kitchen aide blender. DS CC blended the lemon bar, added an unmeasured amount of milk, blended to the correct puree texture, and emptied the pureed lemon bar in a stainless-steel food container and placed it beside the steam table covered with foil. Observation revealed there was no recipe for DS CC to look at with food preparationOn 07/08/25 at 12:35 PM, Certified Dietary Manager (CDM) DD verified that the dietary staff are expected to use a pureed recipe when preparing a pureed diet, and the facility had the recipes available. CDM DD verified she would instruct the staff on the use of the facility-provided recipes. The facility's Mechanically Altered Food Preparation policy, dated 04/06/20, documented mechanically altered foods would be prepared using standardized recipes. Standardized recipes would be used to prepare all mechanically altered foods. The recipes would be adjusted according to the number of diets needed and would indicate seasoning and technique to ensure the highest quality, to ensure quality flavor, and maximum nutritive value. The diet spreadsheets would be used for all mechanically altered diets to include mechanical soft and puree diets. Recipes would not use water on thin pureed foods; only milk, broth, juice, gravy, margarine, or other appropriate condiments that preserve the flavor shall be used. Pureed foods shall have the consistency of pudding or mashed potatoes, and a food processor is preferred, but a blender may be used. The flavor of pureed foods would be assessed, and they should have the same desirable flavor as the meu item. The staff shall be in-serviced on proper preparation of mechanically altered foods.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility had a census of 45 residents. Based on observation, interview, and record review, the facility failed to prepare and serve food in a sanitary manner when dietary staff did not complete hair coverage with the hairnet and beard cover. This deficient practice placed the residents of the facility who received meals from the facility at risk for foodborne illness.Findings included:- On 07/08/25 at 11:40 AM, observation revealed Dietary Staff (DS) BB in the facility kitchen preparing Resident (R) 8's pureed lemon bar dessert. DS BB wore a beard net but did not cover his entire beard or mustache, and had a hair net that did not cover the back of his hair. On 07/09/25 at 11:45 AM, observation revealed DS EE in the facility kitchen preparing to serve the residents' lunch food trays to the tables. DS EE wore a beard net but did not cover his entire beard or mustache, and had a hair net that did not cover the back of his hair.On 07/09/25 at 12:00 PM, observation revealed the stove hood with brownish gray fuzz substance covered and hanging from the front panel of the stove top hood. Continued observation revealed two commercial convection ovens behind the stove with a fan and motor assembly covered with brownish grease/sticky substance and gray fuzz covering the area located directly behind the stove cooking top. On 07/08/25 at 12:30 PM, observation in the facility kitchen revealed DS FF walked from the dining room door through the kitchen to a closet without a hair net on. DS FF then obtained a hair net and placed it on her head, then washed her hands to start working in the kitchen. On 05/14/25 at 10:00 AM, Certified Dietary Manager BB stated staff were to wear hairnets, cover beards, and have thorough hair coverage, including mustaches with a beard net. Certified Dietary Manager BB verified the maintenance staff, and Dietary staff were responsible for cleaning the kitchen and appliances. Dietary Manager BB verified the stove hood had gray fuzz on the front panel and verified the convection oven had brownish grease/sticky substance on the fan and motor assembly. The facility's Hair Restraint policy, dated 04/27/20, documented hair restraints and/or beard guards shall be worn by all staff in food production, dish washing areas, or when serving food from the steam table. Hair restraints and/or beard guards shall be used to prevent hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use items. Hair restraints shall be worn by all staff in food production, kitchen, dish washing, and serving from the steam table, and all hair must be contained within the approved hair restraint. Facial hair must be covered by a beard guard regardless of how closely trimmed. The facility's Cleaning Rotation policy, dated 04/27/20, documented the Dining Services staff would uphold sanitation of the dining and food service areas, equipment, and utensils according to a thorough, written schedule and following manufacturers' guidelines. The Director of Dining Services would record the necessary cleaning and sanitation tasks for the department. Tasks would be designated to specific departmental positions. All cleaning schedules would be posted for all cleaning tasks, and staff would initial the tasks as they were completed.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 45 residents. The sample included 12 residents, with two reviewed for Hospice (specialized care that mainly aims to provide comfort and dignity to the patients by providing physical comfort and emotional, social, and spiritual support for people nearing the end of life) services. Based on observation, record review, and interview, the facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice, was developed and available for Resident (R) 5 and R2. This placed the residents at risk for inappropriate and/or unmet end-of-life care.Findings included:- The Electronic Medical Record (EMR) for R5 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) without behavioral disturbances, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made or the boy cannot respond to the insulin). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R5 had severely impaired cognition. The MDS documented R5 required substantial staff assistance for toileting, upper body dressing, personal hygiene, mobility, transfer, and did not ambulate. The MDS further documented R5 received hospice services. R5's Care Plan, dated 06/12/25, initiated on 02/24/25, directed staff to coordinate care with the hospice staff to assure all her needs were being met, and to make sure she was able to spend quality time with family. The care plan documented R5 wanted to be involved in her healthcare and life decisions for as long as she was able. If R5 reached a point where she was no longer able to do so, please honor and respect her advanced directives and other verbalized wishes. The care plan further directed staff to let her family know what her condition was and if she needed or wanted to see them. The staff were directed to provide R5 with medications and other measures to maintain her comfort. The care plan lacked when hospice staff would be in the building and what care and supplies they would provide. The Physician's Order, dated 02/24/25, directed staff to admit R5 to hospice services. On 07/08/25 at 08:15 AM, R5 sat at the dining room table and ate her breakfast. On 07/08/25 at 12:36 PM, Administrative Nurse D stated she would ensure the care plan reflected the collaboration between the facility and hospice. The facility's Hospice policy, dated 11/28/17, documented a significant change in status assessment would be initiated, and the plan of care would be updated to reflect coordination of care and services with hospice. - R2's Electronic Medical Record (EMR) included diagnoses of chronic kidney disease, diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), overactive bladder, chronic lymphocytic leukemia (a type of cancer of the blood and bone marrow) of B-cell type, polyarthritis (arthritis in five or more joints), Crohn's disease (chronic inflammation of the bowel), and chronic pain syndrome. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Significant Change Minimum Data Set, dated [DATE], documented R2 had severe cognitive impairment, and inattention behavior which fluctuated. R2 required partial/moderate assistance with oral hygiene, personal hygiene, lower body dressing, and sit-to-stand. R2 required substantial/moderate assistance with toileting hygiene. R2 was independent with bed rolling, sit to lying, lying to sitting, and toilet transfers. The MDS further documented R2 had occasional urinary incontinence, received a scheduled pain medication regimen, had moderate, frequent pain, which occasionally interfered with day-to-day activities. R2 had a condition or chronic disease that may result in a life expectancy of less than six months. R2's Care Plan dated 06/26/25, instructed staff to coordinate care with the hospice staff to assure all her needs were met, and she had chosen a hospice provider to assist with comfort and care. R2's Care Plan lacked specific discipline visits, medication, and supplies that the hospice provider would provide. The Physician Order dated 05/16/25 instructed staff to admit R2 to a specific hospice provider with the diagnosis of chronic lymphocytic leukemia. The Progress Note dated 05/12/25 at 02:06 PM, documented R2 had returned from a physician appointment with orders for hospice to evaluate and treat R2. On 07/08/25 at 01:20 PM, R2 ambulated with her walker into her bathroom independently, from where she sat in her recliner. On 07/09/25 at 09:07 AM, Certified Nurse Aide (CNA) P reported that the hospice provider supplied R2 with wipes and incontinent supplies. CNA P reported she thought the hospice aide came weekly and was unsure how often a nurse visited the resident. On 07/09/25 at 09:30 AM, Licensed Nurse (LN) I stated that the supplies provided by the hospice provider were on the back of the supply room door. This included gloves, wipes, bed pads, and creams for care. LN I stated that a hospice nurse came one to two times a week, unless the resident was actively dying, and then a nurse would come daily. LN I reported that a hospice aide usually came twice a week and provided bathing for residents. On 07/09/25 at 10:17 AM, Nurse Consultant GG stated that she had not included the hospice staff visits or supplies for care on the facility's plan of care. The facility's Hospice/End of Life policy, dated 11/28/17, documented hospice/end of life services will be provided according to the resident's needs and preferences. Upon the decision to elect hospice services, the physician will be contacted to obtain orders. A significant change in status will be initiated, and the plan of care will be updated to reflect coordination of care and services with hospice.

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. The facility had a census of 45 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to ensure that its Quality Assessment and Assurance Committee adequately identified deficient areas of practice and to develop and implement appropriate plans of action to correct the deficient practices for the 45 residents residing in the facility.Findings included:- Based on observation, record review, and interview, the facility failed to identify, document the clinical rationale for administering R5, an antipsychotic medication, when staff failed to understand the resident's wants and needs due to a language barrier. Refer to F605.Based on observation, record review, and interview, the facility failed to notify the Ombudsman and provide a bed hold policy when R32 was transferred to the hospital. Refer to F628. Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan for R5 regarding communication, dementia care, and antipsychotic use for behaviorsRefer to 656.Based on observation, record review, and interview, the facility failed to provide R5 communication devices for a Spanish-speaking resident to communicate her wants and needs to the staff. Refer to 676.Based on observation, record review, and interview, the facility failed to provide dependent residents, R6 and R8, with bathing as care planned.Refer to 677.Based on observation, record review, and interview, the facility failed to provide a safe smoking environment for R32, who was assessed as unsafe and kept his smoking materials in his room. The facility further failed to use a gait belt for safe transfers, which resulted in a fall. Refer to 689.Based on observation, record review, and interview, the facility failed to post daily nursing staffing.Refer to 732.Based on observation, record review, and interview, the facility failed to provide non-pharmacological interventions for R5, who received antipsychotic medication for dementia. Refer to 744. Based on observation, record review, and interview, the facility failed to notify the physician when R20 had blood sugars out of the physician's parameters.Refer to 757.Based on observation, record review, and interview, the facility failed to follow a pureed diet recipe for R8.Refer to 804.Based on observation, record review, and interview, the facility failed to store, prepare, and serve in the kitchen when male dietary staff did not cover their mustache with net covers and failed to maintain clean equipment in the kitchen and failed to discard expired supplements, and lacked a label with the date on food in the nutrition center.Refer to 812.Based on observation, record review, and interview, the facility failed to collaborate the facility care plan with the hospice care plan and documented what services would be provided by hospice. Refer to 849.Based on observation, record review, and interview, the facility failed to offer or provide residents with the Prevnar 20 vaccination.Refer to 883.Based on observation, record review, and interview, the facility failed to maintain the walk-in freezer door in the kitchen.Refer to 908.On 07/09/25 at 01:10 PM, Administrative Staff A stated that the QAA meetings were held monthly and included the medical director. The undated facility's Quality Assurance and Performance Improvement (QAPI) policy documented that the facility would develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life.

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	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 45 residents. The sample includes 13 residents, with five residents reviewed for immunizations: Resident (R) 6, R8, R25, R26, and R33, to include pneumococcal (a disease that refers to a range of illnesses that affect various parts of the body and are caused by infection) vaccinations. Based on record review and interviews, the facility failed to offer, obtain an informed declination or a physician documented contraindication for the pneumococcal PCV20 vaccination per the latest guidance from the Centers for Disease Control and Prevention (CDC). This placed the residents at risk for pneumococcal infection and related complications.Findings included:- Review of R6, R8, R25, R23, and R33 clinical medical records lacked evidence that the facility or the resident representative received or signed a consent to receive or informed declination for the pneumococcal vaccine PCV20.Review of R6's electronic health record revealed the resident was admitted to the facility on [DATE]. R6 had not been offered or received a pneumococcal PCV20 vaccine since admission.Review of R8's electronic health record revealed the resident was admitted to the facility on [DATE]. R8 had not been offered or received a pneumococcal PCV20 vaccine since admission.Review of R25's electronic health record revealed the resident was admitted to the facility on [DATE]. R25 had not been offered or received a pneumococcal PVC20 vaccine since admission.Review of R26's electronic health record revealed the resident was admitted to the facility on [DATE]. R26 had not been offered or received a pneumococcal PCV20 vaccine since admission. Review of R33's electronic health record revealed the resident was admitted to the facility on [DATE]. R33 had not been offered or received a pneumococcal PCV20 vaccine since admission.On 07/09/25 at 08:30 AM, Nurse Consultant G stated residents are offered the pneumonia vaccines on admission and as indicated. Nurse Consultant GG said the resident would sign a consent or declination for receiving the vaccine. Nurse Consultant GG verified that every resident in the building had not been reviewed to determine if they were eligible to receive the PCV20 vaccine or if they were they did not have written documentation the facility offered the PCV20 vaccination. Nurse Consultant GG verified they did not have a definitive system in place to determine who was eligible, or if they were eligible, if they had been offered or declined the vaccinations.The facility's Pneumococcal Vaccine policy dated 11/28/17, documented pneumococcal vaccinations would be offered to all residents per the Centers for Disease Control (CDC). At the time of admission, the resident, the resident representative, or attending physician would be contacted to obtain a history of previous pneumococcal vaccinations. The resident and the resident's representative would sign a consent form to receive or to refuse the vaccination. Both the Pneumococcal Conjugate (PCV13) and Pneumococcal Polysaccharide (PPSV23) vaccines would be available. At that time, the facility would provide a copy of the CDC vaccination summary (VIS) to provide them with the vaccination's risks

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 45 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to ensure and maintain the kitchen walk-in freezer was in a safe operating condition, as the freezer door would build up with ice and would not completely shut. This placed the 45 residents who resided in the facility and received their meals from the facility's kitchen at risk for foodborne illness.Findings included:- On 07/07/25 08:20 AM, observation in the kitchen revealed the walk-in freezer door had ice buildup on the frame of the door and was hard to keep closed.On 07/07/25 at 12:14 PM, Maintenance Staff (MS) U stated he was aware of the problems with the walk-in freezer door building up with ice and not shutting. MS U stated he had talked to six or seven refrigeration vendors, and they could only do part of what needed to be fixed in the walk-in freezer. MS U stated about a year ago that the food in the freezer had to be thrown away due to the out-of-range temperature in the freezer. MS U stated staff have to routinely clean the ice off the freezer door.On 07/07/25 at 08:20 AM, Dietary Staff (DS) DD verified the walk-in freezer door had ice buildup on it for a long time. DS DD stated staff have to break the ice off the freezer door all the time to get it to close tightly. DS DD stated the door needs to be replaced.On 07/09/25 at 10:35 AM, Consultant HH stated he was aware of the issue with the walk-in freezer and had been working on getting it repaired for approximately two months. The facility had several local contractors come out, and they could not fix it. Consultant HH stated the problem was that the two boxes available to use were not the right size, and one could not place the sprinkler in them. The facility had the roof repaired due to it was leaking water into the freezer. The door had come off at one time, and that was repaired and sealed. Consultant HH verified there was an issue approximately a year ago when they had to throw food away due to the temperature of the freezer being too warm. [NAME] stated several local companies had been out to look at repairing the issues, but turned down the job. Consultant HH stated he had recently contacted a contractor out of town who is going to come and look at it, but so far, they have not been here. Consultant HH stated that the problem with repairing it is the company would have to build a hallway to a new one due to its location. When asked if he had documentation regarding details of companies coming out, he stated he had no documentation.Upon request, the facility failed to provide a preventative maintenance policy.