STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N085005	A. BUILDING: _____ B. WING _____	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALINA PRESBYTERIAN MANOR	2601 E CRAWFORD STREET SALINA, KS 67401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaints (#191316 and #183537) at the above named facility conducted on 01/13/25.	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101 (f) (1) (B) The facility reported a census of 30 residents. The sample included 1 resident reviewed for elopement/wandering risk. Based on record review, observation, and interview for Resident (R) 2, Administrator A failed to ensure no resident was subjected to neglect when Administrator A failed to provide or coordinate services reasonably necessary to ensure R2's safety and well-being and to avoid harm when the resident was a known wander risk, did not have his "Roam Alert" bracelet on with staff knowledge, eloped from the secured memory care unit, left the building walking unsupervised and was found at a local fire department station.	S3026		

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

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S3026	Continued From page 1 This failure placed the resident in immediate jeopardy for harm, injury, or death. Findings included: - Review of R2's medical record revealed he admitted to the facility on 09/17/24 with diagnosis of dementia. The "Functional Capacity Screen" (FCS) dated 09/23/24 recorded the resident was independent with toileting, transfer, walking/ mobility, eating, and management of treatments, required supervision with bathing and dressing and was unable to perform management of medications. The FCS recorded the resident had short term memory impairment, memory/recall impairment, and impaired decision making. The FCS further recorded the resident was at risk for falls/unsteadiness and was at risk for wandering. The "Negotiated Service Agreement (NSA)/ Health Care Service Plan" recorded the resident was independent with bathing, dressing, toileting, eating, mobility, and transfer and used a walker for ambulation. The NSA recorded the resident had mild to moderate disorientation or difficulty recalling/retaining information, deficiency in judgement, anxious/paranoid or suspicious behavior. The NSA further recorded resident wore a monitoring device "Roam Alert" bracelet as ordered by his health care provider and displayed exit seeking behavior. R2 was at a high risk for falls, wore glasses for impaired vision, staff were to "monitor" for wandering, and "monitor as needed" for socially inappropriate disruptive behaviors and impaired decision making. The NSA failed to identify specific	S3026		

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S3026	Continued From page 2	S3026		

interventions or direction to staff to address the resident's impaired cognition and wandering behaviors.

The resident's "Elopement Risk Screening" dated 09/17/24 recorded a score of 16, which indicated the resident was at risk for elopement. The Elopement Risk Screening recorded the resident was fully ambulatory, disoriented, content with placement, no elopement attempts, no behaviors noted, two or more antipsychotic/ mood altering medications, and noted the resident had two or more dementia or mental health diagnoses.

Review of R2's "Progress Notes" revealed:

On 10/05/24 at 01:49 PM the writer recorded R2 stated he wanted to leave and walk home.

On 10/13/24 at 04:30 PM the writer recorded R2 was walking up and down the hallway demanding the doors be opened for him to get out.

On 10/14/24 at 04:36 PM the writer recorded R2 noted to be exit seeking throughout the day.

On 10/15/24 at 11:49 PM the writer recorded R2 was extremely agitated and demanded to go home.

On 10/17/24 at 06:19 PM the writer recorded R2 was agitated, restless, and was demanding to get out of the unit.

On 10/19/24, the writer recorded that R2 stated he could be out and back before lunch but no pacing or exit seeking was noted. At 11:20 AM , staff informed the writer they could not locate R2,

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S3026	Continued From page 3	S3026		

and a search began to locate the resident. Dietary staff reported observing a male that matched description of the resident boarding the city bus at approximately 10:45 AM. City bus services were contacted with no answer. R2 was located at the fire department station by a fireman, who contacted the facility. R2's daughter picked him up and returned him to the facility with no injuries noted upon assessment. The "Roam Alert" bracelet was placed on R2's right wrist upon return to the facility and hospice services were notified.

Record review of the October 2024 "Treatment Administration Record" (TAR) revealed facility staff were to check the "Roam Alert" to R2's left wrist three times a day. The October 2024 TAR revealed the "Roam Alert" bracelet was checked on 10/18/24 and in place. On 10/19/24 during the dayshift check, the October 2024 TAR recorded resident refused the Roam Alert bracelet and bracelet was not on.

Interview on 01/13/25 at 03:52 PM with Licensed Nurse (LN) B stated R2 would remove his "Roam Alert" bracelet with scissors that facility staff were not aware he had.

The facility failed to have a system in place when R2 refused or removed his "Roam Alert" bracelet.

Observation on 01/13/25 at 03:58 PM revealed R2 walking around the living room in the memory care unit in the facility and asked staff the reason for the "Roam Alert" bracelet to his right wrist.

Observation on 01/13/25 at 10:46 AM of the memory care unit revealed four entry/exit doors

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in the unit. Two doors led to the long-term care facility, one door led outside, and one door led to the stairwell.

On 01/13/25 , LN B confirmed all four exit doors in the memory care unit had "Roam Alert" alarms on them.

Per interview with Administrator A and LN B on 01/13/25 at 02:35 PM and facility reported investigation, on 10/19/24, Dietary Staff E opened the memory care unit door to the long-term care unit and let R2 out the door. Facility surveillance footage revealed R2 exited the facility's main entrance door on 10/19/24 at 10:37 AM. Administrator A and LN B stated Dietary Staff E was not aware R2 was a memory care unit resident .

Review of the facility obtained "Witness Statement" signed by Dietary Staff E dated 10/19/24 recorded, "I brought food over to memory care. When I opened the door, I was met with a man walking up right asking if that was the correct way out ...because he was walking fine, looked similar in age to the person I saw leaving, and was already headed towards the door, I didn't think anything of it. I watched him leave so the door shut and to make sure the alarm didn't go off. The door shut and the alarm didn't sound. When both coming in and leaving the unit, there was no one at the nurse's station."

"Weather Underground History" reported the following temperatures, events, and conditions for 10/29/24 at 10:53 AM; the temperature was 68 degrees F (Fahrenheit), 13 mile per hour wind from the south, no precipitation, mostly sunny.

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S3026	Continued From page 5 Observation and review of the area revealed the resident traversed approximately 3.2 miles from the facility. The terrain from the facility to the fire department station included sidewalks on city streets, a railroad track, 4 crosswalks, a four-lane street with speeds up to 40 miles per hour and 1 bridge over a river. The facility was unaware of how far the resident went on the bus as it stopped at various parts of the city. Facility's "Elopements and Wandering Residents" policy dated 10/26/17 recorded, "This community ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk." The facility failed to ensure no resident was subjected to neglect when Administrator A failed to provide or coordinate services reasonably necessary to ensure R2's safety and well-being and to avoid harm when the resident was a known wander risk, did not have his physician ordered "Roam Alert" bracelet in place with staff knowledge, eloped from the secured memory care unit, and walked unsupervised and was found at a fire department station. This failure placed the resident in immediate jeopardy for harm, injury or death. The Immediate Jeopardy was removed on 10/19/24 at 12:17 PM when the facility was notified by the fire department that R2 was located and safe and interventions were	S3026		

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S3026	Continued From page 6 immediately put in place to prevent further risk of elopement by R2. The following abatement plan was accepted by the State Agency: Roam Alert was placed on right ankle and later placed on right wrist per resident request, Dietary Staff E immediately educated regarding security need of residents, Staff instructed to perform 15-minute visual checks on R2, Education completed with all assisted living and dietary staff regarding unwitnessed exit risks, Roam Alert Door locks and alarms were checked for functionality, Leadership team met on 10/21/24 and teachable moments were distributed to all department managers for all staff to review and demonstrate competency.	S3026		
S3280 SS=E	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a	S3280		

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S3280	Continued From page 7 secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104 (d) (3) The census equaled 30 residents including 16 assisted living and 14 memory care residents.. The sample included 3 residents. Based on record review and interview, Administrator A failed to ensure disaster and emergency preparedness by ensuring the performance of quarterly review of the facility's entire "Emergency Management Plan" with residents. Findings included: - Review of the facility "Emergency Management Plan" revealed the plan contained procedures to manage potential emergencies and disasters including fire, flood, severe weather, tornado, explosion, natural gas leak and lack of electrical or water service, and missing residents. Review on 01/13/25 of the facility's quarterly reviews of the emergency management plan with residents revealed the following reviews with residents: On 11/27/23, the facility reviewed tornado and severe weather, On 02/19/24, the facility reviewed loss of water and natural gas leak, On 04/09/24, the facility reviewed tornado and loss of electrical services,	S3280		

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S3280	Continued From page 8 On 06/17/24, the facility reviewed explosion, On 08/19/24, the facility reviewed severe weather and flood, On 10/21/24, the facility reviewed loss of water, On 12/16/24, the facility reviewed natural gas leak Facility's "Assisted Living EPP Egress and Training Requirements" policy dated 10/20 recorded, "quarterly review of the facility's emergency management plan with employees and residents." The facility failed to review the procedures to manage potential emergencies including fire, flood, loss of electrical and water services, natural gas leak, explosion and missing resident for the fourth quarter of 2023 with residents. The facility failed to review the procedures to manage potential emergencies including fire, flood, tornado, severe weather and missing resident for the first quarter of 2024. The facility failed to review the procedures to manage potential emergencies including fire, flood, severe weather, natural gas leak and missing resident for the second quarter of 2024. The facility failed to review the procedures to manage potential emergencies including fire, tornado, loss of electrical or water services, natural gas leak, explosion and missing resident for the third quarter of 2024. The facility failed to review the procedures to manage potential emergencies including fire, flood, tornado, severe weather, explosion and	S3280		

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S3280	Continued From page 9 missing resident for the fourth quarter of 2024. Interview on 01/13/25 at 12:44 PM with Licensed Nurse B confirmed the facility's records lacked documentation all eight emergency topics were reviewed each quarter with residents. Administrator A failed to ensure disaster and emergency preparedness by the failure to ensure the performance of quarterly reviews of the facility's entire "Emergency Management Plan" with all residents.	S3280		
S3298 SS=E	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by:	S3298		

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S3298	Continued From page 10 KAR 26-41-206 (d) The census equaled 30 residents. Based on record review and interview for all residents living in the facility and receiving meal services, Administrator A failed to ensure the facility staff served food at the proper temperature. Findings included: - During the initial tour of the memory care unit on 01/13/25, facility food temperature monitoring logs were requested in the kitchen where meals were served to memory care unit residents. "Holding Temperature Log" were obtained for December 2024 and January 2025 from Licensed Nurse (LN) B. Record lacked breakfast food temperatures for the following dates: 12/08/24, 12/26/24, 01/05/25 Record lacked lunch food temperatures for the following dates: 12/05/24, 12/30/24, 01/02/25, 01/05/25 Record lacked supper food temperatures for the following dates: 12/01/24, 12/25/24, 12/28/24 Interview on 01/13/25 with LN B confirmed the above missing food temperatures. Kansas Department of Agriculture Food Safety guidelines records hot food must be maintained at a temperature of 135 degrees Fahrenheit or above, cold foods at 41 degrees Fahrenheit or below.	S3298		

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S3298	Continued From page 11 Facility's "Monitoring and Recording: Food" policy (no date) recorded, "Team members must monitor and record food temperatures to prevent foodborne illness." For all residents of the facility, Administrator A failed to ensure facility staff served food at the proper temperature.	S3298		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: K.A.R 26-41-207 (c) The census totaled 30 residents. The sample included 3 residents and review of 5 newly hired employees. Based on record review and interview for 1 of 5 sampled staff (Certified	S3310		

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S3310	Continued From page 12 Medication Aide (CMA) D), the facility failed to ensure compliance with the State Agency's tuberculosis (TB) guidelines. Findings included: - Review of CMA D's employee record revealed they hired onto the facility on 08/27/24. CMA D's first step of TB testing and TB questionnaire was completed on 09/16/24, approximately 3 weeks after being hired by the facility. Interview on 01/13/25 with Administrator A confirmed CMA D's first step of TB testing and TB questionnaires was not completed upon hire. Facility's "Immunization- Tuberculosis (TB) Testing for Employee Volunteer and Resident" policy dated 09/19/24 recorded, "Two-step TB skin test for new employees: a. Testing should be performed within seven days of employment/ admission and read 48-72 hours after PPD injected." The facility failed to ensure compliance with the State Agency's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105, which had the potential to affect all residents.	S3310		