STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175185	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smoky Hill Rehabilitation Center	1007 Johnstown Avenue 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. The facility identified a census of 67 residents. The sample included five residents reviewed for activities of daily living (ADL) and dignity. Based on observation, record review, and interview, the facility failed to promote R1's dignity by the failure to recognize R1's colostomy (surgical creation of an artificial opening on the stomach wall to excrete feces from the body) bag leaked through his shirt for approximately 45 minutes as he sat in the hallway unassisted. Findings included:- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following a cerebral infarct (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 right dominant side, major depressive disorder (major mood disorder which causes persistent feelings of sadness), and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). The Quarterly Minimum Data Set (MDS) dated 11/06/25 documented R1 had a Brief Interview for Mental Status score of eight, which indicated moderate cognitive impairment. The MDS documented R1 required moderate staff assistance with bed mobility, transfer, and personal hygiene. The MDS documented R1 required maximum staff assistance with toileting, bathing, and dressing. The Functional Abilities Care Area Assessment (CAA) located in the EMR and dated 08/07/25 documented R1's functional abilities were impaired related to weakness and comorbidities. R1's Care Plan documented R1 had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag) and a colostomy. The care plan directed staff to provide care to R1's catheter and colostomy site every shift and as needed and to monitor R1 for signs and symptoms of infection (08/25/25). The care plan documented R1 suffered from hemiplegia and hemiparesis. The care plan documented R1 would be cleaned, well-groomed, and appropriately dressed. The care plan directed staff to use short sentences while showering to encourage R1 to do as much as he could during a shower to promote independence (08/31/25). During an observation on 12/09/25 at 09:20 AM, R1 sat in the hallway in his wheelchair. R1's t-shirt was soiled with what appeared to be food stains. The bottom of R1's t-shirt revealed R1's colostomy bag, which had leaked a brown liquid substance that presented as bowel movement and soaked the shirt. R1's sweatpants were also stained with the appearance of brown food stains and liquid bowel movement. There was a foul odor to R1, which was notable just walking past. R1 sat in the hallway, unable to move himself to his room, while multiple staff members walked by him for over 45 minutes at this observational time. R1 was unable to communicate how he felt about staff not bathing/showering him on a timely basis. On 12/09/25 at 10:10 AM, Certified Nurse's Aide (CNA) M stated she felt bad about residents not getting their baths. CNA M stated R1 was not on the list to lay down first after breakfast, so she and the other CNA working with R1 left the resident sitting in the hall to remind them to get him into bed after breakfast. On 12/09/25 at 11:30 AM, Administrative Nurse D stated she would have expected staff not to (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	leave R1 in the hallway in the condition he was in and to take care of R1's needs and cares in a dignified manner. The facility's Quality of Life Policy, revised August 2009, documented residents would be provided a safe, clean, comfortable environment and receive treatments and supports for dignified daily living. Staff would provide person-centered care that emphasized the residents' comfort, independence, and personal needs while ensuring receipt of care and services.

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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. The facility identified a census of 67 residents. The sample included five residents reviewed for activities of daily living (ADL). Based on observation, record review, and interview, the facility failed to ensure staff provided bathing care per each resident's care plan/preference for Resident (R)1, R2, R3, and R4.Findings included:- During an observation on 12/09/25 at 09:05 AM, R4 laid in bed and watched television. R4's room had a distinct, bad odor in the room that was nauseating. The odor originated from R4 and R4's hair looked greasy and matted. During the observation, R4 stated he could not remember the last time he had a bath. R4 stated he was dependent on staff to assist him to bathe, and he did not feel like his hall had enough staff to take care of him. Review of bathing documentation from 11/01/25 through 12/09/25 (39 days) revealed the staff did not provide a bath for R4 during the 39 days. During an observation on 12/09/25 at 09:15 AM, R2 sat in the lobby area visiting with other residents. R2's hair looked greasy and matted. R2 had a distinct odor of urine about her. R2 stated she had received only two baths since she admitted to the facility, over a month ago. R2 stated bathing did not seem to be a priority in her care. R2 stated she felt gross and dirty, but what could she do, she was at the facility's mercy. Review of bathing documentation from 11/06/25 (date of admission) through 12/09/25 (34 days) revealed R2 received two baths in 34 days. During an observation on 12/09/25 at 09:20 AM, R1 sat in the hallway in his wheelchair. R1's t-shirt was soiled with what appeared to be food stains. The bottom of R1's t-shirt revealed R1's colostomy bag which had leaked a brown liquid substance that presented as bowel movement and soaked the shirt. R1's sweatpants were also stained with the appearance of brown food stains and liquid bowel movement. There was a foul odor to R1, which was notable just walking past. R1 sat in the hallway, unable to move himself to his room, while multiple staff members walked by him for over 45 minutes, at this observational time. R1 was unable to communicate how he felt about staff not bathing/showering him on a timely basis. During an observation on 12/09/25 at 09:30 AM, staff assisted R1 into the shower. Review of bathing documentation from 11/01/25 through 12/09/25 (39 days) revealed R1 received three baths in 39 days. During an observation on 12/09/25 at 09:20 AM, observation revealed R3 lay in bed and watched television. R3's hair looked matted and greasy. There was a distinct body odor to R3. R3 stated she rarely got baths at the facility and felt dirty and unclean most of the time. R3 stated she felt like she smelled. Review of bathing documentation from 11/01/25 through 12/09/25 (39 days) revealed R3 received two baths in 39 days. During an interview on 12/09/25 at 10:10 AM, Certified Nurse's Aide (CNA) M stated it was hard for staff to get all of the baths done the way the baths were scheduled to be done, and then the evening shift had their baths, and all of the baths that didn't get done on the day shift. CNA M stated she felt bad about residents not getting their baths. During an interview on 12/09/25 11:30 AM, Administrative Nurse D stated the facility was having problems with getting the bathing done on the evening shift because the evening shift was all agency staff, and agency staff felt like they were too good to give baths and would not perform bathing cares. During an interview on 12/09/25 at 11:45 AM, Administrative Staff A stated the facility was working on improving bathing on all shifts. The facility's Shower/Tub Bath Policy revised October 2010, documented the facility would provide bathing to residents to promote cleanliness, provide comfort, and observe the condition of the residents' skin.