STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N085010	A. BUILDING: _____ B. WING _____	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SALINA FAIRDALE	2251 E CRAWFORD 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 attached complaints (#189692 and #186458) at the above named facility conducted on 04/08/25.	S 000		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (a) (1) The facility reported a census of 25 residents. The sample included 3 residents. Based on record review, observation and interview for 2 sampled residents (R)1 and R3, Administrative Staff A failed to ensure the Negotiated Service	S3085		

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
	N085010	A. BUILDING: _____ B. WING _____	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SALINA FAIRDALE	2251 E CRAWFORD 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
S3085	Continued From page 1 Agreement (NSA) was fully developed based on the resident's Functional Capacity Screen (FCS), service needs, and preferences. Findings included: - Record review for R1 revealed an admission date of 07/13/22 with diagnoses of dementia, bradycardia, hyperlipidemia, mood disturbance and anxiety, major depressive disorder and edema. The "Resident Functional Capacity Screen" (FCS) dated 01/24/25 recorded the resident was unable to perform transfer and walk/ mobility. The FCS further recorded R1 used a lift and wheelchair for ambulation. Review of R1's current "Personal Service Plan" (combined NSA/ Health Care Service Plan) dated 01/24/25 recorded R1 required standby assistance for evacuation, utilized a wheelchair for mobility, was independent within apartment with use of mobility device, staff supervised with use of walker for longer distances, resident ambulated at times without staff assistance and sit to stand lift used for all transfers with resident active participation. Observation on 04/08/25 at approximately 01:00 PM in R1's room revealed two certified staff members use sit to stand lift to transfer resident from wheelchair to commode. Interview on 04/08/25 at 03:06 PM with Certified Medication Aide (CMA) B stated R1 was a total assist of two staff members using a sit to stand lift for all transfers and R1 was unable to	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N085010	A. BUILDING: _____ B. WING _____	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SALINA FAIRDALE	2251 E CRAWFORD 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
S3085	Continued From page 2 ambulate. Electronic interview on 04/09/25 at 03:30 PM with Regional Nurse C acknowledged R1's "Personal Service Plan" dated 01/24/25 did not accurately state the cares staff members provided. The "Personal Service Plan" failed to accurately reflect R1's status for transfer and walk/ mobility. - Record review for R3 revealed an admission date of 02/23/17 with diagnoses of hypokalemia, major depressive disorder, dementia and anxiety disorder. The "Resident Functional Capacity Screen" (FCS) dated 11/07/24 recorded the resident required physical assistance with transfers and walk/ mobility. The FCS further recorded R3 used a wheelchair for ambulation. Review of R3's current "Personal Service Plan" (combined NSA/ Health Care Service Plan) dated 11/07/24 recorded R3 required possible physical assistance with evacuation, was able to transfer self without cuing, oversight, or physical assistance, would require staff assistance at times with transfers, escort and mobility, was able to transfer with one person assist if cooperative, needed a second person to assist with transfers due to reluctance or increased behaviors. Interview on 04/08/25 at 03:06 PM with CMA B stated R3 was a two person assist with a walker or wheelchair.	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N085010	A. BUILDING: _____ B. WING _____	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SALINA FAIRDALE	2251 E CRAWFORD 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
S3085	Continued From page 3 Electronic interview on 04/09/25 at 03:30 PM with Regional Nurse C acknowledged R3's "Personal Service Plan" dated 01/24/25 did not accurately state the cares staff members provided. The "Personal Service Plan" failed to accurately reflect R3's status for transfer and walk/ mobility. Administrative Staff A failed to ensure the Negotiated Service Agreement (NSA) was fully developed based on the resident's Functional Capacity Screen (FCS), service needs, and preferences.	S3085		