STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175231	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Ellsworth Village	1156 Highway 14 Ellsworth, KS 67439

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify causative factors and implement effective interventions to prevent falls for Residents (R) 17, R25, and R30. Findings included: -R17's Electronic Medical Record (EMR) documented diagnoses of chronic kidney disease, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), neurocognitive disorder with Lewy bodies (a type of progressive brain disorder that leads to a decline in thinking, reasoning, and independent function), visual hallucinations (sensing things while awake that appear to be real, but the mind created), generalized weakness, and unsteadiness on feet. R17's Quarterly Minimum Data Set (MDS), dated [DATE], documented R17 had severe cognitive impairment, disorganized thinking fluctuations, hallucinations, delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and physical behavior symptoms directed toward others, which occurred one to three days of the look-back period. R17 had no functional range of motion impairments, required substantial/ maximal assistance with sitting to lying, lying to sitting on the side of the bed, and was dependent on sitting on the side of the bed, chair/bed-to-chair transfers, toileting transfers, and walking ten to 50 feet. R17 had two or more noninjury falls. The Fall Care Area Assessment (CAA), dated 07/21/25, documented R17 had Parkinson's disease with decreased cognition and safety awareness, had tremors that made ambulation unsafe without assistance, and staff were instructed to assist with ambulation when he was restless. R17's Care Plan had a revision date of 03/24/25 documented that R17 had an actual fall with minor injury related to a history of falling. R17's Event Report documented the following findings: On 05/29/25 at 10:30 AM, R17 was found on the floor and was unwitnessed. R17 stood up, his feet caught on the wheelchair pedal, and he lost balance. The care plan lacked new interventions to prevent further falls. The Event Report lacked a root cause analysis. On 07/23/25 at 11:30 AM, R17 was found on the floor. R17 reported he was trying to reach his walker. The intervention, dated 07/23/25, directed staff to monitor R17 for significant changes in gait, mobility, positioning devices, standing/sitting balance, and lower extremity joint function, and that no (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changes were determined at this time. The Event Report lacked a root cause analysis. On 07/28/25 at 01:24 PM, a non-nursing staff member observed R 17 standing in his room and reported to the nursing staff. The nurse went to R17's room, where R17 was found on the floor. The wheelchair had one brake locked, and the walker was approximately two feet in front of R17. R17 had reported he had an appointment and was unclear about where he was going at the time of the fall. The intervention, dated 07/28/25, directed staff to try leaving the walker out of sight of R17 to reduce attempts to get up to walk on his own. The Event Report, completed on 08/01/25, lacked a root cause analysis. On 08/07/25 at 04:20 PM, R17 was found on the floor of his room, on the fall mat next to the bed. The call light had not been activated, and he had not been incontinent. R18 reported he was trying to help a baby. Staff reported R17 had been agitated earlier and leaning over in the wheelchair to pick up stuff on the floor. The intervention, dated 08/07/25, was to bring R17 to the commons area or the nurses' station if staff could not stay in the room with him. The Event Report lacked a root cause analysis. On 09/01/25 at 01:15 PM, R17 was found in his room, on the floor in front of his wheelchair, with a bedside table had lunch on it, and R17 had silverware in his hand. The intervention, dated 09/01/25, documented R17's Care Plan was reviewed, and no new interventions were added. The Event Report lacked a root cause analysis. On 09/10/25 at 07:20 PM, R17 was found on the floor, having slid out or rolled out of bed. At 07:15 PM, staff reported R17 was found standing in front of his wheelchair trying to go to bed, so staff put him to bed. The intervention, dated 09/10/25, was to bring R17 to the lobby area for monitoring. The Event Report lacked a root cause analysis. On 09/30/25 at 02:45 PM, R17 was found on the floor in his room. R17 pants were wet and wheelchair brakes were not locked. R17 laughing and joking with staff. The immediate intervention was to educate staff if R17 had not wanted assistance from the staff to get another staff member to care for him. The intervention, dated 09/30/26, directed staff that if R17 did not allow the aide to work with him, to get other staff who he will allow to care for him. The Event Report lacked a root cause analysis. On 10/10/25 at 07:35 PM, R17 was found on the floor in the lobby area and attempted to stand out of the wheelchair. R17 attempted to stand, but the pedals were on and out front, and he tripped and lost balance. The wheelchair was not to be locked. R17 reported he saw someone around the corner, but could not get around the corner in his wheelchair. The staff assisted R17 back into his wheelchair and sat with R17 until bedtime medications were given and then assisted him to bed. The intervention, dated 10/10/25, directed staff to ensure wheelchair pedals are removed/out of the way when R17 was left in the lobby for self-propelling. The intervention, dated 10/30/25, directed staff to review R17's medications or combination of medications that could predispose to falls or increase the risk of injury. The Event Report lacked a root cause analysis. On 11/18/25 at 11:50 AM, R17 was found on the floor of his room. R17's wheelchair was near his feet, and the brakes were unlocked. The care plan lacked a new intervention to prevent further falls. The Event Report lacked a root cause analysis. On 01/03/26 at 12:25 PM, R17 was found on the floor of his room, with his lower body underneath the wheelchair. R17 reported he was looking for a place to eat. The immediate intervention for the staff (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was to inform R17 when dinner was and to take him to the dining room. The care plan lacked a new intervention to prevent further falls. The Event Report lacked a root cause analysis. On 01/17/26 at 03:34 PM, R17 was found on the floor in his doorway to the hall. R17 reported trying not to fall, but someone had pushed him. R17 was taken to the lobby, where staff could assist him with eating. The care plan lacked a new intervention to prevent further falls. The Event Report lacked a root cause analysis. On 01/17/26 at 02:00 PM, R17 was found on the floor of his room, and the wheelchair brakes were not locked. R17 was unable to say what had happened. R17 was assisted to bed using a mechanical lift. The care plan lacked a new intervention to prevent further falls. The Event Report lacked a root cause analysis. On 02/08/26 at 03:50 PM, R17 was found on the floor of his room. R17 was assisted to his wheelchair and brought to the living room area for snacks and to watch football on the television. The care plan intervention, dated 02/08/26, directed staff to review the status of medical conditions that predispose to falls or that could increase the risk from falls, such as Parkinson's disease, and medication review from the physician. The Event Report lacked a root cause analysis. On 03/23/26 at 12:15 PM, R17 found on the floor in his room, approximately two feet from his wheelchair. R17 reported he was trying to make seven points. Staff education was to reposition the chair. The intervention, dated 03/24/26, documented that the staff was re-educated not to leave R17 in the bathroom by himself and to stay in the room to assist him when finished. The Event Report lacked a root cause analysis. On 04/05/26 at 08:30 AM, R17 was found on the floor of his room, with his lower body lying on the wheelchair pedals. R17 was mumbling and yelling. The care plan, dated 04/05/26, documented an antipsychotic medication change on 03/ 27/26, and R17 had a neurology appointment on 04/18/26. The Event Report lacked a root cause analysis. On 04/26/25 at 01:05 PM, R17 was found on the floor of his room, with his wheelchair at his feet. The Care Plan revision, dated 04/26/26, directed staff to monitor the room floor to ensure the room is free of items and spills. The intervention also directed staff to increase side supports in the wheelchair for better positioning, use pillows if R17 is leaning down in the chair, encourage him to go to bed with positioning devices, and therapy to adjust the wheelchair for improved positioning. The intervention, dated 04/26/26, documented R17's bedtime was 08:00 PM. Staff were to check R17 at 05:45 AM to see if R17 needs toileting, and to encourage R17 to lie down at 01:00 PM. The Event Report lacked a root cause analysis. On 05/20/26 at 02:05 PM, R17 is sitting in his room in a wheelchair, with his feet resting on the foot pedals, leaning to the left without side support. R17's fall mat was under his bed, and he had the television on. On 05/20/26 at 03:33 PM, Certified Nurse Aide (CNA) O, reported staff position R17 with support pillows while he is in bed to keep him from rolling out, had a floor mat next to the bed, checked on him frequently, kept the call light within reach, turn the television on to the channel he liked. CNA O also reported that the staff try to toilet him or make sure he is not incontinent and needs to be changed, to assist him with his meals, and do at least hourly checks on him. (continued on next page)

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	175231	A. Building B. Wing	05/21/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/21/26 at 01:00 PM, Administrative Nurse D verified R17 fell often and R17's Care Plan lacked new interventions with each fall. Administrative Nurse D reported the facility had not implemented a root cause analysis for resident falls. The facility's Fall Prevention and Management policy, revised on 04/08/2026, documented if a resident had a fall, the facility would complete the fall tool and identify fall risk factors. The care plan would have appropriate interventions for fall risks, and these interventions would be communicated to staff. - The Electronic Medical Record (EMR) for R25 documented diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness) and dementia with mood disturbance (a progressive mental disorder characterized by failing memory and confusion). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R25 had severely impaired cognition and required toileting supervision. R25 required partial staff assistance with transfers and was independent with mobility and ambulation. R25 had no functional impairment, was frequently incontinent of urine, had no toileting program, and had one non-injury fall since the prior assessment. The Quarterly MDS, dated 05/01/2026, documented R25 had severely impaired cognition and rejected care one to three days. R25 was dependent on staff for toileting, required partial staff assistance with transfers, and was independent in mobility. R25 had no functional impairment, was frequently incontinent with the bladder and bowel, had no toileting program, and had two or more non-injury falls since the prior assessment. The Fall Risk Assessments, dated 01/09/2026, 01/23/2026, 02/01/2026, 02/09/2026, 02/17/2026, 05/02/2026 and 05/10/2026, documented R25 was a high risk for falls. R25's 05/07/2026 Care Plan included the following interventions for R25: 01/23/2026- One staff provided substantial assistance with toileting and required an insert in his incontinence brief for protection. Staff assist with incontinence care and changing their brief. 08/14/2024- Remind R25 not to bend over to pick up dropped items. Encourage R25 to come out of his room for meals. 04/15/2025- Do not leave folding chairs in his room. 11/03/2025- Observe for injury and check range of motion at the time of the fall. [NAME] his bed frame on the wall, the top of the mattress, or the top of his headboard to ensure the correct bed height. 01/12/2026- Monitor/document/report as needed for 72 hours to the health care provider for pain, bruises, and change in mental status. 01/09/2026- Ensure R25 wore newer shoes, and height placement visible was indicated on the wall so staff can ensure proper bed height. 02/01/2026- Place a board behind his recliner to keep it from sliding backwards. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/09/2026- Ensure R25 wears appropriate footwear and gripper socks when in bed. 02/17/2026- Place Dycem (non-slip mat used for stabilization and gripping to prevent slipping). 02/13/2026- Monitor him every hour and assist with toileting. 05/02/2026- Monitor R25 every hour at night. 05/09/2026- Electric cord removed from the electric recliner. The Fall Investigation, dated 01/12/2026 at 05:45 AM, documented R25 was on the floor in his room, his pants were down, and he was incontinent of bowel. R25 was alert and confused. R25 had sustained a skin tear and a bruise on his left elbow. The Fall Investigation, dated 02/01/2026 at 03:45 PM, documented R25 was on the floor in his room. He was alert and confused. R25 was incontinent and attempted to ambulate to the bathroom. R25 did not sustain any injury. The Fall Investigation, dated 02/05/2026 at 08:40 PM, documented R25 was on the floor in his room. R25 was alert and confused. R25 was incontinent and attempted to ambulate to the bathroom. R25 did not sustain any injury. The Fall Investigation, dated 02/09/2026 at 02:25 AM, documented R25 was on the floor in the bathroom. He had attempted to sit on the toilet and fell. R25 wore socks, and he slipped. R25 did not sustain any injury. The Fall Investigation, dated 02/17/2026 at 09:10 AM, documented R25 was on the floor in front of his recliner. He was alert and confused. R25 was incontinent with bowel and bladder. His recliner was slightly raised as he tried to stand up and slid out of the recliner with the bed pad underneath him. R25 did not sustain any injury. The Fall Investigation, dated 05/02/2026 at 01:45 AM, documented R25 was on the floor in his room by the bed. He was alert and confused. He was incontinent with urine, he was disoriented, attempted to self-transfer, and fell. R25 did not sustain any injury. The Fall Investigation, dated 05/09/2025 at 01:00 AM, documented R25 was on the floor in his room. He was alert and confused. R25 had used his remote to raise the recliner, lifted it way up, and slid out onto the floor. R25 did not sustain any injury. The Fall Investigation, dated 05/15/2025 at 01:11 AM, documented R25 was on the floor in his room behind his recliner. He was alert and confused. R25 was incontinent of urine and sustained no injury. The EMR lacked documentation of a toileting plan, toileting diary, or toileting assessments after his falls. On 05/20/2026 at 07:40 AM, R25 sat in his recliner. Certified Nurse Aide (CNA) N used the remote to lift the seat of the recliner to assist R25 to stand. CNA N took R25's hands and walked with him into the bathroom. CNA N pulled down his pants, but not his incontinence brief, and he sat down on the toilet. CNA N put on a new incontinence brief, assisted him to stand, removed the soiled brief, and put (continued on next page)

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	175231	A. Building B. Wing	05/21/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the clean brief. CNA N stated he had a lot of falls and that they had to put Dycem in his chair so he would not slip out. CNA N stated R25 did not have a toileting routine, staff just observed him hourly, but if he was asleep, they did not wake him up. On 05/21/2026 at 12:15 PM, Licensed Nurse (LN) H stated staff monitors R25 hourly to prevent falls. She stated he was not on a toileting plan and had discussed taking his blood sugar in the morning due to increased output, but it had not been implemented yet. On 05/21/2026 at 01:30 PM, Administrative Nurse D stated she knew there were issues with resident falls and had started to work on root cause analysis to get a better system in place. Administrative Nurse D stated they would start obtaining R25's blood sugar in the mornings to see if there was a medical reason for his increased output, and staff should assist him with toileting. The facility's Fall Prevention and Management policy, revised on 04/08/2026, documented if a resident had a fall, the facility would complete the fall tool and identify fall risk factors. The care plan would have appropriate interventions for fall risks, and these interventions would be communicated to staff. - The Electronic Medical Record (EMR) for R30 documented diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), dementia without behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion), and hypertension (high blood pressure). The Significant Change Minimum Data Set (MDS), dated [DATE], documented R30 had severely impaired cognition, disorganized thinking, and inattention that fluctuated. R30 required substantial staff assistance with transfers, ambulation, and mobility, and partial staff assistance with toileting. R30 had no functional impairment, and one non-injury fall since the prior assessment. The Quarterly MDS, dated 04/30/26, documented R30 had severely impaired cognition and wandered one to three days. R30 was dependent upon staff for toileting, mobility, and substantial staff assistance for transfers. R30 had no functional impairment and had two or more falls since the prior assessment. The Fall Risk Assessment, dated 08/18/2025, 10/13/2025, 01/13/2026, 02/12/2026, and 04/27/2026 a high risk for falls. The 04/40/2026 Care Plan included the following interventions for R30's falls: 12/10/2024- Review her medical record for medications or combinations of medications that could predispose her to falls or increase the risk of injury from falls 03/04/2025- Leave her room door open during the night for visual checks. 07/19/2025- Ask for other staff to get the items required instead of leaving her unattended when doing cares. 08/16/2025- Instruct staff that she is on 30-minute checks and to make sure they are monitoring her. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	08/28/2025- If she is awake during checks, get her up until she is ready to go back to sleep. 01/13/2026-Reviewed the care plan, and no interventions are needed for this fall. 02/12/2026- Use a high back wheelchair for mobility with anti-roll back brakes and not the Broda chair (specialized wheelchair with the ability to tilt and recline). 04/27/2026- Monitor resident every 30 minutes when in bed. The Fall Investigation, dated 08/09/2025 at 10:45 PM, documented R30 was on the floor in her room. R30 had gripper socks, was incontinent of urine, and the door to her room was closed. The care plan lacked documentation a new intervention was put into place. The Fall Investigation, dated 08/16/2025 at 09:50 PM, documented R30 was on the floor in her room. She was alert and confused. R30 sustained a laceration (cut) which measured 0.5 (centimeters) cm to her right ear, a skin tear which measured 1.5 cm x 1.5 cm to her right upper arm, and a bruise to her right ear. The Fall Investigation, dated 08/18/2025 at 10:10 PM, documented R30 was on the floor in her room. She was alert and confused and had attempted to self-transfer. R30 did not sustain any injury. The care plan lacked documentation a new intervention was put into place. The Fall Investigation, dated 08/29/2025 at 11:40 PM, documented R30 was on the floor in her room. She was alert, confused, and attempted to self-transfer. R30 sustained a skin tear to her left great toe. The care plan lacked documentation a new intervention was put into place. The Fall Investigation, dated 10/13/2025 at 01:40 PM, documented R30 was on the floor in the front lobby. R30 was alert, confused, and did not sustain any injury. The care plan lacked documentation a new intervention was put into place. The Fall Investigation, dated 01/13/2026 at 11:15 AM, documented R30 was on the floor in the front lobby. R30 attempted to lean forward in her wheelchair to reach out to the vacuum, and another resident attempted to pull back on her wheelchair, which caused her to slide down to the floor. R30 did not sustain any injury. The Fall investigation, dated 02/12/2026 at 6:40 PM, documented R30 was on the floor in the front lobby. She was alert, confused, and did not sustain any injury. The Fall Investigation, dated 04/27/26 at 04:45 AM, documented staff was unable to open the door to her room. The Licensed Nurse (LN) on duty was able to push her head through the door and saw that R30 was on the floor, wrapped in her blankets from her bed. Staff were able to push the door open, and R30's wheelchair, which had been beside the bed, was now in the center of the room. Staff were able to push open the door and assist R30 off the floor. R30 was alert, confused, and did not sustain any injury. On 05/20/2026 at 08:46 AM, R30 was out in the front lobby in her wheelchair. R30 attempted to stand up several times, and a visitor would tell her to sit back down. On 05/20/2026 at 09:00 AM, Licensed Nurse G stated they try to keep R30 out in the lobby area where (continued on next page)

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