STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175260	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Hutchinson Village	810 E 30th Avenue Hutchinson, KS 67502

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. The facility identified a census of 51 residents. The sample included 14 residents. Based on record review and interview, the facility failed to ensure the required annual performance reviews were completed at least once every 12 months for one Certified Medication Aide (CMA) and three Certified Nurse Aides (CNA).Findings included:- Review of the requested facility performance reviews noted the following staff lacked an annual review:CMA T's, hired on 01/11/08, last performance evaluation was completed on 05/31/24. The facility lacked evidence that a performance review was completed in the last 12 calendar months upon request. CNA NN's, hired on 12/19/14, last performance evaluation was completed on 05/31/24. The facility lacked evidence that a performance review was completed for CNA NN.CNA O was hired on 07/26/24. The facility lacked evidence that a performance review was completed for CNA O.CNA MM was hired on 11/19/24. The facility lacked evidence that a performance evaluation was completed for CNA MM.On 12/02/25 at 12:35 PM, CNA O stated she had not had a performance evaluation yet, and her anniversary date was in July.On 12/03/25 at 11:57 AM, Administrative Nurse D stated that the facility has had quite a bit of turnover in staff recently, and she had gotten behind in getting the performance evaluations completed. Administrative Nurse D stated that she and Administrative Nurse E had been working on getting the performance evaluations completed and caught up on staff.The facility's Performance Management policy dated 07/08/25 documented the performance management process was designed to encourage ongoing, meaningful conversations between employees and leaders. These connections should take place throughout the calendar year and be personalized to each employee's role and responsibilities. Performance management conversations should clarify role expectations, reinforce contributions, and provide ongoing feedback related to performance, behaviors, and development. Performance management conversations may also inform decisions related to career growth, development opportunities, recognition, as well as other decisions (i.e., merit, promotion, employee relations decisions, etc.). Eligible employees will receive a notification from One Source when their self-evaluation were available. Once submitted, leaders will receive a notification to complete their step of the evaluation process in One Source, which includes providing performance feedback and ratings for their employees based on role expectations, quality of work, behaviors, and contributions. Leaders should schedule one-on-one meetings with employees to share feedback, discuss performance and development opportunities, and review the performance rating.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 51 residents. Based on observation, interview, and record review, the facility failed to provide sanitary food preparation and storage. This placed the 51 residents at risk for food-borne illness. Findings included: - On 12/01/25 at 08:20 AM, the walk-in refrigerator and freezer did not have thermometers inside.The November 2025 Temperature Log directions directed staff to obtain temperatures in the morning and afternoon. The log lacked recorded temperatures for both the morning and the afternoon on 11/01/25, 11/02/25, 11/03/25, 11/04/25, 11/05/25, 11/09/25, 11/13/25, 11/14/25, 11/22/25, and 11/27/25. The log documented the one temperature on 11/20/25 in the afternoon temperature, but lacked a morning temperature. On 12/02/25 at 11:40 AM, observation used dish rags sat next to clean pitchers in the dishwasher room. The magnetic knife holder above the make table had dried food on it. The toaster had a copious amount of dried bread particles on it and on the controls. On 12/01/25 at 08:20 AM, Dietary Staff BB verified the lack of thermometers in the walk-in cold storage. On 12/02/25 at 11:40 AM, Consultant GG verified the findings and stated staff were to ensure food equipment and shelves were kept clean. The facility's Food Supply Storage, Food and Nutrition Services policy, dated 03/07/25, stated internal temperatures of all refrigerators and freezers were to be recorded two times daily on the temperature log. The facility's General Sanitation, Food, and Nutrition policy, dated 06/27/25, stated the location stored, prepared, and distributed food under sanitary conditions at all times. All food contact surfaces would be washed, rinsed, and sanitized after each use and when working with one kind of food to another. Fixed or immobile equipment was cleaned with detergent and hot water.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. The facility had a census of 51 residents. Based on observation, interview, and record review, the facility failed to remove or dispose of expired medication in the facility's north medication room. Findings included: - On 12/01/25 at 03:07 PM, inspection of the facility's north medication room revealed:Three unopened bottles of magnesium chloride pills, with an expiration date of 10/2025. A box of 100 bisacodyl suppositories, with an expiration date of 09/2025. On 12/01/25 at 03:07 PM, Administrative Nurse E verified the expiration dates and stated staff were to remove expired medications from service. The facility's Medication Acquisition, Receiving, Dispensing and Storage policy, dated 03/04/25, stated nursing staff would routinely check for expired medications, and necessary disposal would be done in accordance with state/pharmacy regulations.

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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 identified a census of 51 residents. The sample included 14 residents with Resident (R) 6 reviewed for hospice services. Based on observation, record review, and interview, the facility failed to ensure a collaboration of care between R6's hospice provider and the facility, which included the information on what hospice services would be provided to the residents, as well as how often hospice staff would visit the facility.Findings included:- R6's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), hypertension (HTN- elevated blood pressure), and chronic kidney disease (CKD- a long-term condition where the kidneys become damaged and cannot filter blood well, causing waste buildup).R6's Significant Change Minimum Data Set (MDS) dated [DATE] documented she had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. R6 required partial to moderate assistance from staff for her functional abilities and activities of daily living (ADL). R6 was on a hospice care program.R6's Care Plan revised on 09/10/25, directed staff to monitor, document, and report to the provider as needed any signs and symptoms of cardiac issues, chest pain, etc. The plan of care directed staff to assess for shortness of breath and cyanosis.R6's Care Plan lacked a care area specific to her hospice care and collaboration with the hospice provider that directed staff on what medications, durable medical equipment (DME), supplies provided by hospice, and how often hospice would visit the facility/resident.R6's Orders tab documented a physician's order dated 08/02/25 to admit to hospice.R6's EMR contained a scanned document IDG Report dated 08/02/25 that contained the hospice provider's information, plan of care, medication orders, the list of hospice staff that would visit R6 and how often, supplies and equipment provided.On 12/02/25 at 02:00 PM, R6 attended an activity in the activity room with other residents.On 12/02/25 at 09:30 AM, Certified Medication Aide (CMA) R stated a resident's chart should state whether they were on hospice or not. CMA R stated the nurses would typically tell staff when a resident was placed on hospice care, and hospice usually supplied briefs and other supplies. CMA R stated the care plan should contain information about hospice.On 12/03/25 at 08:15 AM, Administrative Nurse D stated that staff, including herself, had dropped the ball on ensuring that R6's care plan was updated to include her being admitted to hospice care. Administrative Nurse D stated the facility was going through a turnover in staffing, and not all tasks had been completed as they should have been. Administrative Nurse D stated that the hospice care area would be added to R6's care plan.The facility's Hospice-Provided Services policy dated 11/01/24 documented a coordinated comprehensive plan of care shall be jointly developed by the location and hospice. Hospice participation in the care plan conference and input from the hospice representative were required. The plan of care must include directives for managing pain and other symptoms associated with hospice care and must be revised and updated as necessary to reflect the resident's current clinical, psychosocial, and spiritual condition. Location employees would address the discipline-specific resident needs in the care plan. The hospice team and location employees must communicate with each other when any changes are made to the resident's plan of care. Location employees would assist nursing and the hospice in monitoring the resident's pain and reporting the resident's needs. for example, issues of pain may exacerbate mood and behavior, and all employees should help in monitoring and communicating resident condition changes so appropriate interventions can be implemented. The hospice information/documentation should be integrated into the electronic medical record (EMR). Hospice documentation received from the hospice agency will be scanned and retrieved in OnBase in a timely manner. Progress notes related to hospice services for nursing or social work may be completed in PointClickCare (PCC)/EMR using the PN - Hospice. CNA documentation related to the direct care of the hospice resident will be completed in PCC - POC/EMR only when car is provided by Society (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	employees. When hospice employees provide activities of daily living (ADL) care, it will be documented on hospice forms and scanned into OnBase or copied.