STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175263	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Olathe	20705 W 151st Street Olathe, KS 66061

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 120 residents. The sample included three residents. Based on observation, record review, and interviews, the facility failed to notify Resident (R) 1's representative of care plan changes and/or results. This deficient practice had the risk of miscommunication between R1, their representative, and the facility. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of heart failure (HF-a condition with low heart output and the body becomes congested with fluid), hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (cerebrovascular accident [CVA]/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, and seizures. The Significant Change Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status was not conducted due to R1 rarely or never understood. R1 had coughing or choking during meals or when swallowing medications. R1 had weight loss. The Cognitive Loss/Dementia (progressive mental disorder characterized by failing memory, confusion) Care Area Assessment (CAA) dated 11/11/24, documented R1 experienced strokes and seizures and other medical and physical complications including dysphasia (a condition that affects your ability to produce and understand spoken language). The Nutrition CAA dated 11/12/24, documented R1 had impaired nutrition related to weight loss and poor appetite. R1 needed set-up assistance and cueing and staff placed items in reach of R1's left hand. R1's Care Plan dated 03/22/19, documented R1 had impaired cognitive function related to CVA and directed the facility to communicate with R1 and her representative regarding R1's capabilities and needs. R1's EMR revealed the following: (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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Communication/Visit with Physician note on 09/06/24 at 05:04 PM, documented that staff notified R1's provider of her seizure activity. The provider gave a new order to restart Lacosamide (medication used to treat seizures) 250 milligrams (mg) daily. R1's clinical record lacked evidence the facility notified R1's representative of her seizure activity and new medication order. A Health Status note on 09/07/24 at 01:08 PM, documented R1 had two short seizures that shift. R1 came out of the seizures quickly and seemed to return to her normal self shortly after. R1's clinical record lacked evidence the facility notified R1's representative of her seizure activity. A Provider/Practitioner note on 10/21/24 at 06:49 PM, documented R1 had diffuse (throughout) wheezing (breathing with a whistling or rattling sound in the chest) in all lung fields. R1 had a chest x-ray completed and the results were pending at the time of the visit. The provider ordered levofloxacin 500 mg daily if the chest x-ray showed pneumonia (inflammation of the lungs). R1's clinical record lacked evidence that the facility notified R1's representative of the order for a chest x-ray or the plan of care in case of pneumonia. A Health Status note on 10/22/24 at 09:13 AM, documented R1's provider ordered a chest x-ray on 10/21/24 due to respiratory symptoms. The x-ray results showed R1's lungs were free of infiltrates (substances that are not normally present in the lungs, but instead build up in the lung tissue) with no pleural effusion (abnormal accumulation of fluid in the lungs) or pneumothorax (accumulation of air and blood in the area around the lungs). R1's clinical record lacked evidence the facility notified R1's representative of the chest x-ray results. A Communication/Visit with Physician note on 10/23/24 at 09:27 AM, documented R1 had an open area to her sacrum (large triangular bone/area between the two hip bones) from shearing/pressure. R1 had weight loss and the facility placed R1 in a different wheelchair with a new cushion. The facility notified the registered dietitian and R1's provider. R1's clinical record lacked evidence the facility notified R1's representative of the open area to her sacrum, weight loss, and the new wheelchair. A Health Status note on 10/26/24 at 10:34 AM, documented R1 had a mild seizure episode and staff noted R1 stared for a couple of seconds then responded to her name. R1's clinical record lacked evidence the facility notified R1's representative of R1's seizure activity. A Provider/Practitioner note on 11/01/24 at 11:53 PM, documented the provider discussed R1's weight loss and sacral wound with her representative. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 12:07 PM, R1 sat in a Broda (specialized wheelchair with the ability to tilt and recline) at a dining room table and ate spaghetti. On 11/19/24 at 10:52 AM, R1's representative stated the facility did not notify her about changes. She stated she found out in a provider visit a few weeks ago that the facility treated R1 for pneumonia. R1's representative stated the facility did not notify her about the Broda chair. On 11/19/24 at 01:42 PM, Administrative Nurse E stated as a nursing intervention, the facility changed R1 to a new wheelchair for her weight loss and open sacral area. She stated R1's provider talked to her representative about the new wheelchair and documented it in a provider note. On 11/19/24 at 01:46 PM, Licensed Nurse (LN) G stated she notified families and representatives of medication changes, physical changes such as sickness, or any new orders for testing such as x-rays then again with the results. LN G stated most of R1's seizures lasted less than a minute, but the facility sent her out for significant seizures. She stated she did not notify R1's representative after each seizure but she might if R1 had more than one per day. LN G stated she notified representative notifications in the progress notes including attempts to call the representative. She stated the facility notified resident representatives if a resident changed to a Broda chair. On 11/19/24 at 02:09 PM, LN G stated she notified a resident's representative before the end of her shift except for emergencies then she notified their representative right away. On 11/19/24 at 02:26 PM, Administrative Nurse D stated the facility notified the resident's representative for weight loss and medication changes. She stated she expected staff to notify the resident's representative of any changes, as soon as possible that day. Administrative Nurse D stated staff documented notifications in the progress notes, and she expected staff to document attempts at notifying representatives. She stated staff should have notified R1's representative about the Broda chair. She stated R1's representative responded better when talking to the provider and R1's provider notified R1's representative about the Broda chair. Administrative Nurse D stated she expected staff to notify the resident's representative and provider after seizures and document the notification in the progress notes. The facility's Notification of Changes policy, last revised 12/04/23, directed the facility to immediately inform the resident, their physician, and their representative of a significant change in the resident's physical, mental, or psychosocial status and a need to alter treatment significantly. The facility failed to notify R1's representative of the plan of care changes and/or results. This deficient practice had the risk of miscommunication between R1, their representative, and the facility.