STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175322	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Hays	2700 Canal Blvd Hays, KS 67601

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 44 residents. The sample included 12 residents, with two reviewed for urinary catheter or Urinary Tract Infection (UTI - Infection of any part of the urinary system). Based on observation, record review, and interview, the facility failed to provide appropriate care when staff failed to provide completed incontinent and catheter care for Resident (R) 3 after a bowel movement, before a dressing change, and who had a history of urinary tract infections. This deficient practice placed the resident at increased risk for UTI. Findings included: - R3's Electronic Medical Record (EMR) documented R3 had diagnoses of neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying) and urine retention (lack of ability to urinate and empty the bladder). R3's Quarterly Minimum Data Set (MDS), dated [DATE], documented R3 had a Brief Interview of Mental Status (BIMS) of 14, which indicated intact cognition. The MDS documented R3 had a urinary catheter and no UTI during the observation period. R3's Significant Change MDS; dated 12/05/25, documented R3 had a BIMS of 14, which indicated intact cognition. The MDS documented R3 had a urinary catheter and no UTI during the observation period. R3's Urinary Incontinence Care Area Assessment (CAA), dated 12/05/25, documented R3 had a chronic indwelling urinary catheter retaining to a neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), multiple sclerosis (MS - progressive disease of the nerve fibers of the brain and spinal cord), and limited mobility. R3 saw a urologist (a doctor who specializes in the study or treatment of the function and disorders of the urinary system. to manage chronic conditions retaining to her urinary system). R3's Care Plan, revised 02/06/25, documented R3 had a urinary catheter. The plan instructed staff to monitor, record, and report to the health care provider any signs and symptoms of UTI. The plan instructed staff to provide R3 catheter care every shift and as needed (PRN). A review of R3's EMR revealed R3 had a positive UTI on 11/06/24. (continued on next page)

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/20/25 at 10:41 AM, R3 laid in bed on her back. Administrative Nurse C donned a gown applied gloves, entered R3's room, asked the resident if she could change her dressing, and the resident replied yes. Administrative Nurse C removed R3's slacks, assisted R3 in turning on the right side, and unfastened R3's incontinent brief to reveal a moderate amount of soft brown bowel movement (bm) on her buttocks, butt crease, and up to the insertion site of the catheter. The BM touched the catheter tubing coming from the insertion site. Administrative Nurse C provided perineal care to R3's buttocks and butt crease, then removed R3's dressing but failed to provide incontinent care to R3's front perineal area or catheter care. Administrative Nurse C continued with the dressing change on R3's left gluteal fold, placed a new incontinent brief on R3, pulled up her slacks, and covered R3 up. On 02/20/25 at 11:12 AM, when Administrative Nurse C was asked if she should have provided catheter care and front urinary incontinent care after R3 had a BM, Administrative Nurse C stated yes, she should have. On 02/24/25 at 01:08 PM, Administrative Nurse D stated if a resident had a BM and a catheter, he would expect staff to provide full incontinent care. The facility's Catheter Care, Insertion and Removal, Drainage Bags, Irrigation, Specimen Policy, revised 07/30/24, documented catheter care would be completed with morning and bedtime care and as needed. The facility failed to ensure staff provided complete incontinence and catheter care after R3 had a BM. This deficient practice placed R3 at risk for UTI.

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 43 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported Resident (R) 34's blood pressure medication was administered outside the physician-ordered parameters and the parameters were transcribed incorrectly. This placed the resident at risk for physical decline, related complications, and at risk for unnecessary drugs. Findings included: - The Electronic Medical Record (EMR) for R34 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), hypertension (high blood pressure), atrial fibrillation (rapid, irregular heartbeat), and depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Admission Minimum Data Set (MDS), dated [DATE], documented R34 had moderately impaired cognition. R34 required supervision from staff for personal hygiene, mobility, and ambulation. The MDS documented R34 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), an antidepressant (a class of medications used to treat mood disorders), and an antiplatelet (medication that prevents blood clots from forming by stopping platelets from sticking together) medication. The Annual MDS, dated [DATE], documented R34 had moderately impaired cognition. R34 required partial assistance from staff for upper body dressing, mobility, toileting, and ambulation. The MDS documented R34 received an antipsychotic, an antidepressant, and an antiplatelet medication. R34's Care Plan dated 01/23/25, initiated on 01/24/24, directed staff to monitor, document, and report to the physician any signs or symptoms of malignant hypertension, which would cause headaches, visual problems, confusion (unclear in one's mind about something), and lethargy (a lack of energy and weakness). The Physician's Order, dated 01/18/24, directed staff to notify him when the systolic blood pressure (SBP - the number, the force your heart exert on the walls of your arteries each time it beats) was less than 90 millimeters of mercury (mmHg) or greater than 150 mmHg, the diastolic (BP - minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) was less than 60 mmHg or greater than 90 mmHg. The Physician's Order, dated 01/29/24, directed staff to administer amlodipine (high blood pressure medication), 10 milligrams (mg), by mouth, daily for hypertension. The order directed staff to hold the medication if the SBP was > (greater than) 90 mmHg or < (less than) 150 Hg, and DBP was >60 mmHg or < 90 mmHg. (continued on next page)

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician's Order, dated 01/29/24, directed staff to administer lisinopril (high blood pressure medication, 10 mg, by mouth, [NAME] for hypertension. The order directed staff to hold the medication if the SBP was > 90 mmHg or <150 Hg, and DBP was > 60 mmHg or < 90 mmHg. A review of the EMR revealed staff administer hypertension medications outside the physician-ordered parameters as follows: February 2024: 11 of the 29 administrations March 2024: 12 out of the 31 administrations April 2024: 11 out of the 30 administrations May 2024: six out of the 30 administrations June 2024: 17 out of the 30 administrations July 2024: 17 out of the 31 administrations August 2024: 13 out of the 31 administrations September 2024: 16 out of the 30 administrations October 2024: 21 out of the 31 administrations November 2024: 25 out of the 30 administrations December 2024: 15 out of the 31 administrations January 2025: 19 out of the 31 administrations February 2025: 14 out of 20 administrations A review of the Medications Regimen Reviews (MRR) by the CP from March 2024 through January 2025 lacked evidence the CP identified and reported the amlodipine and lisinopril given outside of the physician-ordered parameters or that the parameters were transcribed incorrectly. On 02/20/25 at 08:24 AM, Licensed Nurse (LN) G administered R34's medications within the ordered parameters and without incident. On 02/20/25 at 3:45 PM, Administrative Nurse D verified the parameters on the MAR had been transcribed incorrectly and that the parameters were backward. Administrative Nurse D stated that the admission orders had directed staff to also notify the physician when the medications were out of the directed parameters. Administrative Nurse stated that the order had not been placed on the MAR. Administrative Nurse D verified the CP had not identified and reported order discrepencies. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/20/25 at 04:00 PM, LN G verified the greater than and less than symbols were backward on the parameters but when she had read the orders, she knew what the resident's blood pressure parameters were. The facility's Drug Regimen Review policy, dated 12/02/24, documented the licensed pharmacist assessed the medication list and chart to identify potential clinically significant medication issues. The monthly drug regimen review was used to review medications to ensure that doses and duration were appropriate to each resident's clinical condition, age, and comorbidities. The CP would complete a written report noting any drug irregularities or issues of concern for each resident reviewed. The reports would be given to the director of nursing services. Upon completion of the report, it was shared with the attending physician, and medical director, and acted upon immediately. The facility failed to ensure the CP identified and reported R34's blood pressure medication was administered outside the physician-ordered parameters and the parameters were transcribed incorrectly. This placed the resident at risk for physical decline, related complications, and at risk for unnecessary drugs.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 43 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to hold and notify the physician of blood pressure medications per the physician-ordered parameters for one resident, Resident (R) 34. The facility also failed to transcribe physician-ordered parameters correctly. This deficient practice placed the resident at risk for physical decline, other related complications, and at risk for unnecessary drugs. Findings included: - The Electronic Medical Record (EMR) for R34 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), hypertension (high blood pressure), atrial fibrillation (rapid, irregular heartbeat), and depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Admission Minimum Data Set (MDS), dated [DATE], documented R34 had moderately impaired cognition. R34 required supervision from staff for personal hygiene, mobility, and ambulation. The MDS documented R34 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), an antidepressant (a class of medications used to treat mood disorders), and an antiplatelet (medication that prevents blood clots from forming by stopping platelets from sticking together) medication. The Annual MDS, dated [DATE], documented R34 had moderately impaired cognition. R34 required partial assistance from staff for upper body dressing, mobility, toileting, and ambulation. The MDS documented R34 received an antipsychotic, an antidepressant, and an antiplatelet medication. R34's Care Plan dated 01/23/25, initiated on 01/24/24, directed staff to monitor, document, and report to the physician any signs or symptoms of malignant hypertension, which would cause headaches, visual problems, confusion (unclear in one's mind about something), and lethargy (a lack of energy and weakness). The Physician's Order, dated 01/18/24, directed staff to notify him when the systolic blood pressure (SBP - the number, the force your heart exert on the walls of your arteries each time it beats) was less than 90 millimeters of mercury (mmHg) or greater than 150 mmHg, the diastolic (BP - minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) was less than 60 mmHg or greater than 90 mmHg. The Physician's Order, dated 01/29/24, directed staff to administer amlodipine (high blood pressure medication), 10 milligrams (mg), by mouth, daily for hypertension. The order directed staff to hold the medication if the SBP was > (greater than) 90 mmHg or < (less than) 150 Hg, and DBP was >60 mmHg or < 90 mmHg. The Physician's Order, dated 01/29/24, directed staff to administer lisinopril (high blood pressure medication, 10 mg, by mouth, [NAME] for hypertension. The order directed staff to hold the medication if the SBP was > 90 mmHg or <150 Hg, and DBP was > 60 mmHg or < 90 mmHg. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the EMR revealed staff administer hypertension medications outside the physician-ordered parameters as follows: February 2024: 11 of the 29 administrations March 2024: 12 out of the 31 administrations April 2024: 11 out of the 30 administrations May 2024: six out of the 30 administrations June 2024: 17 out of the 30 administrations July 2024: 17 out of the 31 administrations August 2024: 13 out of the 31 administrations September 2024: 16 out of the 30 administrations October 2024: 21 out of the 31 administrations November 2024: 25 out of the 30 administrations December 2024: 15 out of the 31 administrations January 2025: 19 out of the 31 administrations February 2025: 14 out of 20 administrations On 02/20/25 at 08:24 AM, Licensed Nurse (LN) G administered R34's medications within the ordered parameters and without incident. On 02/20/25 at 3:45 PM, Administrative Nurse D verified the parameters on the MAR had been transcribed incorrectly and that the parameters were backward. Administrative Nurse D stated that the admission orders had directed staff to also notify the physician when the medications were out of the directed parameters. Administrative Nurse stated that the order had not been placed on the MAR. On 02/20/25 at 04:00 PM, LN G verified the greater than and less than symbols were backward on the parameters but when she had read the orders, she knew what the resident's blood pressure parameters were. The facility's Medication Administration policy dated 06/21/24 documented that the orders from the provider were required for any medication administered and must include a diagnosis, name of the medication, dose, route, and frequency. If the order was not legible or did not include the items listed, the provider was notified for clarification before administration. Medications were to be administered correctly and timely to minimize opportunities for adverse medication events and errors. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to hold and notify the physician when R34's blood pressure medications were out of physician-ordered parameters and failed to transcribe the parameters correctly upon admission. This placed the resident at risk for physical decline, other related complications, and at risk for unnecessary drugs.

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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** 32358 The facility had a census of 44 residents. The sample included 12 residents, with two reviewed for hospice services. Based on observation, record review, and interview, the facility failed to include a hospice plan of care with a description of the services provided which included contact information, visit frequency, medications, and medical equipment for Resident (R) 8. This deficient practice placed the resident at risk of not receiving needed care. Findings included: - R8's Electronic Health Record (EHR) revealed diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and atherosclerotic heart disease of the native coronary artery (the buildup of plaque (fatty deposits) within the coronary arteries, which supply blood to the heart muscle). R8's Quarterly Minimum Data Set (MDS), dated [DATE], documented R8 had short and long-term memory problems and severe cognitive impairment. The MDS document R8 was dependent on staff with oral and toileting hygiene, showering, lower body dressing, putting on and taking off footwear, personal hygiene, bed mobility, and transfers. The MDS documented R8 required substantial to maximal staff assistance with upper body dressing, and partial to moderate assistance with eating. The MDS documented R8 received hospice services. R8 's Care Plan, revised 01/30/25, documented R8 was dependent on staff with most activities of daily living (ADL). The care plan lacked a section regarding hospice services with information regarding a description of the services provided which included contact information, visit frequency, medications, and medical equipment. A review of R8s' clinical record revealed the resident was admitted to hospice care on 10/27/24. The Hospice and Nursing Facility Services Agreement, revised 01/01/25, documented the designated member of the interdisciplinary team would be responsible for providing overall coordination of the hospice care for the hospice patient with facility representatives. On 02/20/25 at 08:24 AM, R8 rested quietly in bed with eyes closed and no signs or symptoms of pain. On 02/24/25 at 01:08 PM, Administrative Nurse D verified that R8's clinical record lacked a hospice care plan, and it should have one. On 02/24/25 at 12:02 PM, Administrative Staff B stated she was responsible for updating care plans. Administrative Staff B stated R8 had a recertification for hospice services, and somehow was resolved and taken off the care plan. The facility's Hospice-Provided Services Policy, revised 11/01/24, documented a coordinated comprehensive plan of care would be jointly developed by the location and hospice. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to coordinate care between the facility and the hospice provider for R8, who received hospice services. This deficient practice placed him at risk for inadequate end-of-life care.