STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175328	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Ellis	1101 Spruce Street Ellis, KS 67637

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. The facility identified a census of 37 residents, with three residents reviewed for accidents and hazards. Based on record review, observation, and interview, the facility failed to prevent a hot liquid burn to Resident (R) 1. The facility failed to evaluate the temperature of the liquid from the hot water/coffee machine, relying on a temperature regulator that had failed, and allowed the hot water dispensed from the machine to be too hot.Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), gastroparesis (a chronic digestive disorder where the stomach muscles weaken, slowing or stopping food from moving into the small intestine), epilepsy (brain disorder characterized by repeated seizures), and convulsions (involuntary series of contractions of a group of muscles).The Significant Change Minimum Data Set (MDS) dated 11/13/25 documented R1 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. The MDS documented R1 had impairment of his bilateral upper and lower extremities. The MDS documented R1 required set-up or clean-up assistance with eating. The MDS documented R1 was dependent on staff for all other activities of daily living (ADL).The Functional Abilities Care Area Assessment (CAA) dated 11/13/25 documented R1, a paraplegia, required total assistance with ADL self-care. The CAA documented R1 was not safe to use his electric wheelchair anymore and was now dependent on a manual wheelchair and dependent on staff for locomotion.R1's Care Plan, initiated 12/05/13, documented R1 had impaired ability to manage hot beverages and soups related to paraplegia (03/10/22). The care plan directed staff to offer R1 foods that were at a liquid state at room temperature (06/15/21). The care plan documented R1 would be free from injury and would safely manage hot beverages, serve soup in a mug, provide cup with lid, and remind R1 about being cautious with hot beverages and soups (03/10/22). The care plan documented R1 was on a full liquid diet (06/15/21). The care plan documented R1 was dependent on two staff and a full lift for transfers (04/09/24).The Communication with Resident/Family Note dated 12/18/25 documented R1's responsible party was notified of the burn incident and wound care performed.The Communication /Visit with Physician Note dated 12/18/25 documented R1's primary care provider (PCP) was faxed regarding spilled chicken broth.The Weekly Skin Observation Assessment dated 12/18/25 documented R1 had a reddened area to his left elbow, which measured 22 centimeters (cm) by 7 cm, and a red area to his left lateral abdomen, which measured 9 cm by 5 cm and 4 cm by 1 cm. Staff applied sterile dressing to cover per facility policy and notified R1's PCP for additional orders.The Urgent Fax dated 12/18/25 documented R1 spilled hot tea on his left elbow and left abdomen. Reddened areas on the lateral abdomen measured 4 cm by 1 cm and 9 cm by 5.5 cm. Reddened area on the elbow measured 22 cm by 7 cm. The areas were flushed with cold water and applied a sterile dressing. Please advise on any additional treatment orders. R1's PCP responded to continue the current treatment for seven days.The Communication with Resident/Family Note dated 12/19/25 documented staff talked with R1 about accidentally dropping his hot beverage on his arm. R1 stated, Yep, I just did (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 0689 Level of Harm - Actual harm Residents Affected - Few	that to myself, fell out of my hand. Staff asked R1 if he was okay, and R1 stated he was okay and he was not in any pain. R1 voiced that he did not feel trauma or feel this was a traumatic experience.The Physician Order Fax dated 12/22/25 documented the facility informed R1's PCP the blisters were open. Staff requested an order for burn cream to apply before dressing change, as the dressing change caused R1 pain. PCP responded with an order to apply Silvadene (a topical antibiotic used in partial thickness and full thickness wounds to prevent infection) cream twice a day to the affected areas until healed.The Communication/Visit with Physician Note dated 12/23/25 documented a new order had been received for Silvadene cream to the affected area twice a day and cover with a sterile dressing until healed.The Facility Incident Report, dated 12/23/25, documented on 12/18/25 at 11:55 AM Licensed Nurse (LN) G poured chicken broth for R1 in the dining room and placed it in a cup with a lid. At 11:57 AM, LN G entered R1's room, placed the cup on the resident's bedside table, and exited the room. R1 sat up in his bed with his head elevated. At 12:04 AM, Housekeeping Staff heard R1 yelling for help and entered his room. R1 had spilled chicken broth on himself. The lid was still on the cup; the liquid had spilled out through the straw opening. Housekeeping staff immediately notified Administrative Nurse D, who was coming down the hallway. Administrative Nurse D immediately assessed R1, removed his clothing, and followed the facility's burn policy. The burned areas were treated and dressed per protocol. R1's family and PCP were notified. R1 was able to explain to Administrative Nurse D and Administrative Staff A how the incident occurred. At the time of the incident, R1's care plan indicated R1 was to be served hot liquids in a mug with a lid and reminded to use caution with hot beverages and soups. Following the incident, Administrative Nurse D and Administrative Staff A manually checked the temperature of the hot water from the dispenser. The water temperature measured 159 degrees Fahrenheit (F) immediately after dispensing and decreased to 154 degrees F within a couple of minutes. The initial skin assessment of R1 revealed two red areas on his left lateral abdomen, which measured 9 cm by 5.5 cm and 4 cm by 1 cm, and one red area on the left elbow, which measured 2 cm by 7 cm. A follow-up skin assessment was completed on 12/22/25. At that time, R1 had a small blister on the left elbow that had begun to scab, with no remaining skin concerns noted on the left lateral abdomen.The Health Status Note dated 12/31/25 documented R1 had a healing blister on his left arm.The Communication/Visit with Physician Note dated 01/01/26 documented the request for the discontinuation of wound treatment as the wound had healed.On 01/06/26 at 10:30 AM, observation revealed R1 sitting up in bed at a 45-degree angle with his bedside table over the bed. R1 had a protein drink with a straw in the top on the bedside table. R1 ate a snack. R1's left outer elbow was dark pink in color, where his burn had been, in deep contrast to the rest of his pale skin. R1 stated the day the burn occurred, he had not gotten out of bed for lunch. R1 stated LN G brought the chicken broth in and set it down there (indicating the middle edge of the bedside table closest to his body). R1 stated he reached over the chicken broth to reach for something in the middle of his table and knocked the chicken broth off to the left side. R1 stated he could not grab the cup, and it was leaking hot chicken broth. R1 stated he tried to sop up the liquid with a napkin but could not get it all. R1 stated it was his own fault for not reaching high enough over the chicken broth. R1 stated the burns hurt quite a bit at the time, but now there was nothing on his stomach, and then pointed to the dark pink area on his left elbow and stated, That's all that is left on that one.On 01/06/26 at 11:00 AM, Administrative Nurse D stated the facility did not regularly check the temperatures from the water/coffee pot because it had a temperature regulator on it that was to keep the temperature below 150 degrees. Administrative Nurse D stated they did not realize the temperature regulator was not working until the accident happened with R1, and they measured how hot the liquid was. Administrative (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Nurse D stated the water/coffee pot was placed out of commission, and the company was sending a new temperature regulator to be put on. Until that time, the kitchen staff was brewing all coffee and hot liquids in the kitchen and tempering them to the appropriate temperature for serving. Administrative Nurse D stated all employees were re-educated regarding the hot liquid policy and resident-specific care plans.The facility's Hot Liquids Policy, revised 04/28/25, documented hot liquids are prepared or brewed at high temperatures to maximize flavor and quality. Temperature affects palatability, which varies from person to person. When self-service of hot liquids is available in the dining room, consider serving liquids at temperatures at or below 150 degrees F, supervise the area, do not overfill the carafes or service containers, and pre-pour liquids whenever possible into drinking cups with lids or per care plan. When serving hot liquids to residents: do not overfill the drinking cup, place liquid away from the edge of the table and near the resident's dominant hand, explain to the resident that a hot liquid is being served, and place the hot liquid in the resident's field of vision. When serving hot liquids to residents with behavior or medical conditions that put them at risk for spills: evaluate the ability of the resident to manage hot liquids independently and provide assistance when needed, allow hot liquids to cool before serving it to reduce the risk or severity of burns, add ice to the hot liquids before serving, if resident agrees, and ensure interventions are added to the care plan from the Hot Liquid Safety focus.The facility completed corrective actions by 12/22/25, which included the coffee/hot water machine placed out of service on 12/18/25. All hot liquids are currently prepared by dietary staff, temperature checked prior to service, and placed in carafes before serving to residents. A hot temperature regulator has been ordered for the coffee/hot water machine and will be installed once received. Staff education was immediately initiated regarding the facility's hot liquid policy and resident-specific care plan requirements and completed on 12/22/25. All residents were audited with all hot liquid interventions listed in their care plan to ensure accuracy and compliance. The dietary staff or the designated representative audits and logs temperatures of all hot liquids prior to service. This was completed prior to the onsite survey; therefore, the deficient practice was deemed past noncompliance and remained at the scope and severity of a G to represent the actual, but isolated harm to R1.