| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175328 | A. Building<br>B. Wing | 12/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Good Samaritan Society - Ellis | 1101 Spruce Street<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 34 residents. The sample included 12 residents, with four residents reviewed for accidents. Based on observation, record review, and interview, the facility failed to provide a safe environment when the facility failed to assess Resident (R) 26 for safe use of an electric recliner. Findings included:- R26's Electronic Medical Record (EMR) recorded dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), wedge compression fracture thoracic spine levels 11-12, and muscle weakness. R26's Quarterly Minimum Data Set (MDS) dated [DATE] recorded R26 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS recorded R26 was independent with activities of daily living and had one fall, no injury. R26's Fall Care Area Assessment (CAA) dated 05/05/25 documented R26 was at risk for falls due to use of antidepressant (a class of medications used to treat mood disorders), antianxiety (a class of medications that calm and relax people) medications, and had chronic pain and discomfort due to low back pain. R26's Fall Care Plan dated 12/06/25 documented the resident had a fall on 10/27/25 due to missing the chair in activities. The care plan documented on 12/06/25 R26 slid out of the recliner. The care plan documented staff would educate/instruct the resident on the safe use of assistive devices, as well as looking back to ensure the chair was where she could sit before attempting to sit down. The care plan instructed staff to monitor the resident every hour to ensure safety and encourage her to keep her door open when she is feeling weak/tired from her current respiratory infection. R26's EMR lacked evidence the facility assessed R26 for the safe use of an electric lift recliner since admitting to the facility on [DATE]. The Nurses Note dated 12/06/25 at 06:43 AM recorded R26 had an unwitnessed fall from her electric lift recliner and was observed in the middle of the room on the floor on her right side. R26 stated she slid out of her chair and shimmied across the floor to try to get closer to the door to yell for help. The notes documented R26's oxygen saturation was low, and staff applied oxygen at two liters and increased her saturation from 85% to 90 % (normal is 95-100%). Staff instructed R26 to call for help when getting up to avoid further falls with injury. On 12/10/25 at 07:35 AM, observation revealed R26 sat in her electric lift recliner with feet elevated, and Licensed Nurse (LN) H obtained the resident's vitals. Observation revealed R26's call light was on the right arm of the recliner. On 12/10/25 at 03:00 PM, Administrative Nurse D verified the resident had an electric lift recliner since admission to the facility, and an electric lift chair safety assessment was not completed on R26 for safe use of the chair. Administrative Nurse D verified electric lift recliner assessments should be completed on admission, with a change in condition, and quarterly. The facility's Falls Management policy, dated 10/14/25, documented the facility would promote resident well-being by developing and implementing a fall prevention and management program. The facility would identify risk factors and implement interventions before a fall occurs and would give prompt treatment after a fall occurs. The policy documented if the fall involved a medical device, secure the device and any part of the accessories for follow-up investigation and report to the facility risk department. |

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 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 34 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility's Consultant Pharmacist failed to identify staff were not obtaining Resident (R) 7's blood pressure before the administration of losartan, as ordered. Findings Included:<br><br>- The Electronic Medical Record (EMR) for R7 documented diagnoses of hypertension (elevated blood pressure), congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), and atrial fibrillation (rapid, irregular heartbeat).<br><br>The Five-Day Medicare Minimum Data Set (MDS) dated [DATE] documented R7 had intact cognition. The MDS further documented R7 received diuretic (a medication to promote the formation and excretion of urine) medication.<br><br>The Quarterly MDS dated 10/23/25 documented R7 had intact cognition. The MDS documented R7 received diuretic medication.<br><br>R7's 10/17/25 Care Plan included the following interventions:<br><br>06/15/16 - Directed staff to administer medication as ordered, consult with the pharmacy, and healthcare provider to consider dosage reduction when clinically appropriate.<br><br>07/16/24 – Directed staff to monitor, document, and report to the healthcare provider changes in edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and weight changes.<br><br>The Physician's Order dated 11/15/21 directed staff to obtain weekly blood pressure on Mondays and notify the physician if the systolic blood pressure (SBP- top number, the force your heart exerts on the wall of your arteries each time it beats) was less than 90 millimeters of mercury (mmHg) or more than 180 mmHg. Notify the physician if the diastolic blood pressure (DBP- minimum level of blood pressure measured between contractions of the heart; the bottom number of the blood pressure reading) was less than 50 mmHg or more than 110 mmHg and notify the physician if her pulse was less than 50 beats per minute (bpm) or more than 112 bpm.<br><br>The EMR lacked documentation staff obtained weekly blood pressures for R7.<br><br>The Physician's Order for R7 dated 07/16/24 directed staff to administer losartan (hypertension medication), 50 milligrams (mg) by mouth at bedtime for CHF, and only if the blood pressure was more than 130/80 mmHg.<br><br>The EMR lacked documentation staff obtained R7's blood pressure prior to the administration of losartan.<br><br>A review of the Medications Regimen Reviews (MRR) by the Consultant Pharmacist (CP) from December 2024 through December 2025 lacked evidence the CP identified and reported the losartan order had been transcribed incorrectly or that her blood pressure was not obtained as ordered.<br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/10/25 at 10:15 AM, R7 sat in her recliner with her feet elevated and talked on the telephone.<br><br>On 12/10/25 at 10:20 AM, Licensed Nurse (LN) G verified staff did not obtain R7's blood pressure every Monday as ordered and verified that staff administered her losartan medication without knowing if R7's blood pressure was out of parameters.<br><br>On 12/10/25 at 12:40 PM, Administrative Nurse D stated back in July of 2024 R7 was in the hospital, and when she returned, they received an order to hold the medication and resume it if her blood pressure was more than 130/80 mmHg. The medication was held until 10/24/24, and the order was to administer the losartan medication without blood pressure parameters. Administrative Nurse D further stated the order did not get corrected at that time, but verified staff should have followed the physician's orders as written in the EMR. Administrative Nurse D stated staff should have been obtaining R7's blood pressure weekly as ordered and stated the order did not get populated into the EMR system correctly. Administrative Nurse D stated the Consultant Pharmacist had not made her aware of the irregularities of the losartan order or that R7's blood pressure was not obtained as ordered.<br><br>The facility's Medication Drug Regimen Review policy, dated 12/02/24, documented a drug regimen review was performed for each resident at least once a month by a licensed pharmacist. This review must include a review of the resident's medical chart. The drug regimen review would identify if the doses and duration were appropriate to each resident's clinical condition, age and comorbidities, and monitoring of medications for efficacy and adverse consequences of the potential medication irregularities, and response to these irregularities. The pharmacist would complete a written report noting any drug irregularities or issues of concern of each resident review, the Quality Assurance and Performance Improvement (QAPI) team would review the medication regimen review at the monthly meetings, and the irregularities would be reported to the medical director and attending physician by the director of nursing or designee. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 34 residents. The sample included 12 residents, with seven reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to administer medications as ordered by the physician for one resident. The facility failed to obtain weekly blood pressures as ordered for Resident (R) 7, who received hypertension (high blood pressure) medication.Findings included:- The Electronic Medical Record (EMR) for R7 documented diagnoses of hypertension, congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), and atrial fibrillation (rapid, irregular heartbeat).The Five-Day Medicare Minimum Data Set (MDS) dated [DATE] documented R7 had intact cognition. R7 was dependent upon staff for toileting hygiene, dressing, and transfers. The MDS documented R7 required set-up staff assistance for oral hygiene, showers, and personal hygiene. The MDS further documented R7 received diuretic (a medication to promote the formation and excretion of urine) medication.The Quarterly MDS dated 10/23/25 documented R7 had intact cognition. R7 required substantial staff assistance for upper body dressing, personal hygiene, mobility, and was dependent upon staff for transfers. The MDS documented R7 received diuretic medication.R7's 10/17/25 Care Plan included the following interventions:06/15/16 - Directed staff to administer medication as ordered, consult with the pharmacy, and healthcare provider to consider dosage reduction when clinically appropriate.07/16/24 - Directed staff to monitor, document, and report to the healthcare provider changes in edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and weight changes.The Physician's Order dated 11/15/21 directed staff to obtain weekly blood pressure on Mondays and notify the physician if the systolic blood pressure (SBP- top number, the force your heart exerts on the wall of your arteries each time it beats) was less than 90 millimeters of mercury (mmHg) or more than 180 mmHg. Notify the physician if the diastolic blood pressure (DBP- minimum level of blood pressure measured between contractions of the heart; the bottom number of the blood pressure reading) was less than 50 mmHg or more than 110 mmHg. And notify the physician if her pulse is less than 50 beats per minute (bpm) or more than 112 bpm.The EMR lacked documentation that staff obtained weekly blood pressures.The Physician's Order dated 07/16/24 directed staff to administer losartan (hypertension medication), 50 milligrams (mg) by mouth at bedtime for CHF. Take only if the blood pressure is more than 130/80 mmHg.The EMR lacked documentation R7's blood pressure was taken before administering the bedtime dose of the losartan in October 2025, November 2025, and December 2025.On 12/10/25 at 10:15 AM, R7 sat in her recliner with her feet elevated and talked on the telephone.On 12/10/15 at 10:20 AM, Licensed Nurse (LN) G verified that staff did not obtain R7's blood pressure every Monday as ordered and verified that her losartan medication was administered without knowing if the blood pressure was out of parameters.On 12/10/25 at 12:40 PM, Administrative Nurse D stated back in July of 2024 R7 was in the hospital, and when she returned, they received the order to hold the medication and resume it if her blood pressure was more than 130/80 mmHg. The medication was held until 10/24/24, and the order was to administer the losartan medication without blood pressure parameters. Administrative Nurse D further stated the order did not get corrected at that time but did verify that staff should have followed the physician's orders as written in the EMR. Administrative Nurse D stated that staff should have obtained her blood pressure weekly as ordered and stated the order did not get populated into the EMR system correctly.The facility's Medication Administration Including Scheduling and Medication Aides policy, dated 04/08/25, documented that the medication was to be administered correctly and in a timely manner. A provider's order for any medication was required and must include the diagnosis, name of medication, route, frequency, and stop order if indicated. |