STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175334	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Liberal	2160 Zinnia Lane Liberal, KS 67901

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Resident (R) 1 remained free of accident hazards on 01/17/26 at approximately 07:30 AM, when R1 fell from a mechanical lift and struck his head. R1 sustained two hematomas (a collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) on the back of his head. Findings included:- R1's Electronic Health Record (EHR) included diagnoses of diabetes mellitus type 2 (DM2 - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), cerebral infarction (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) hemiparesis (muscular weakness of one half of the body) and hemiplegia (paralysis of one side of the body) following cerebrovascular disease affecting right dominant side, and malignant (cancer) neoplasm (tumor) of the brain. R1's 01/08/26 Quarterly Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 99, which indicated the interview could not be completed. Staff assessed R1 to have a memory problem with moderately impaired cognition. The assessment documented R1 utilized a wheelchair for locomotion and was dependent on staff assistance for all care and transfers. The assessment documented no falls since the previous assessment. R1's Care Plan documented on 10/16/13 R1 was at risk for falls related to a history of stroke with hemiparesis and required assistance for transfers. Interventions dated 10/16/13 directed staff to assist with all transfers and utilize his wheelchair for the primary mode of locomotion. R1's Care Plan dated 04/08/20 documented R1 had an activity of daily living (ADL) self-care performance deficit related to a history of a stroke. Interventions dated 12/27/24 directed staff to utilize a total lift with the assistance of two staff with a large sling. Staff would ensure proper positioning in the sling before bearing weight in the sling. R1's EHR, under the Progress Notes on 01/17/26 at 07:30 AM, Licensed Nurse (LN) G documented a SAFE Event - Incident Report - SPN which revealed staff were transferring R1 from the bed to a wheelchair using a full mechanical lift. During the transfer, R1 fell from the lift and struck the back of his head on the legs of the lift. LN G documented she assessed R1 and identified two hematomas on the back of R1's head. LN G documented R1's mentation was at his baseline, and the resident's physician was notified immediately of the incident. On the Fall Scene Huddle Worksheet, LN G documented R1 fell on [DATE] at 07:30 AM in his room. The fall was witnessed by staff during an assisted transfer. The document did not contain an investigation or determination of the root cause of the fall. A Communication/Visit with Physician on 01/20/26 at 05:12 PM, LN I documented R1 was having neurological checks performed every eight hours due to a fall on 01/17/26. LN I documented during the most recent neurological checks, R1 had labored and shallow respirations, and his level of consciousness had declined from baseline. LN I documented R1's physician was notified. A Communication/Visit with Physician on 01/21/26 at 05:48 AM, documented a late entry for 01/20/26 at 06:46 PM, LN J documented R1's physician was notified and advised staff to encourage fluids. A Communication - Other on 01/21/26 at 05:43 PM, LN I documented R1's level of consciousness had returned to his baseline. Observation of the facility's equipment on 04/21/26 at 02:00 PM with (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	Administrative Staff A revealed the facility had five full-body mechanical lifts, with three lifts currently in service on the clinical floor. Each lift had a rounded metal knob fixed in place at the end of the arm of the lift. Each lift had a pouch that contained two metal arms with two hooks each that could be placed onto or removed from the [NAME] on the arm of the lift, which resulted in four hooks to connect to the sling. Administrative Staff A identified that none of the four available hooks on any of the lifts contained a mechanism to prevent the sling loops from unintentionally coming loose during the transfer. On 04/21/26 at 04:15 PM, CNA M stated that on 01/17/26 at approximately 07:30 AM, she and CMA R had finished performing morning cares for R1 and were preparing to transfer R1 from the bed to his wheelchair to go to the dining area for breakfast. CNA M reported she was standing close to R1 during the lift, and CMA R was manipulating the controls of the lift. CMA M said when R1 was lifted off the bed, the lift was pulled out from the bed to make room for the wheelchair. CMA M reported she turned around to get R1's wheelchair, and she heard CMA R scream. When CNA M turned back around, she saw R1 partially hanging from the lift with his feet in the air and his head on the ground. CNA M said that only two loops of the sling remained connected to the lift. CNA M said she was unsure who utilized the two-way radio to call for help, but LN G came with LN H, then she and CMA R stepped to the hallway to let LN G and LN H care for R1. CNA M was unable to recall what size or color of sling was utilized to transfer R1. On 04/21/26 at 04:55 PM, CMA R stated that on 01/17/26 at approximately 07:30 AM, she was performing morning cares for R1 with CNA M and prepared to transfer R1 from the bed to the wheelchair. CMA R stated she was operating the lift controls, and CNA M was holding onto R1. Once R1 was in the sling and lifted into the air, the lift was pulled back from the bed to allow CNA M to place R1's wheelchair in position. When CNA M let go of R1 and turned around to get R1's wheelchair, R1 suddenly rolled to his side in the sling, and the sling became partially undone, and R1 fell to the ground. CMA R stated she screamed when the fall was occurring because she was unable to go around the lift to keep R1 from falling. CMA R said that R1 appeared to hit his head on one of the legs of the lift, and only three of the four loops of the sling remained connected to the lift. CMA R was unable to recall what size or color of sling was utilized to transfer R1. On 04/21/26 at 02:49 PM, LN G stated that on 01/17/26 at approximately 07:30 AM, she was called to R1's room via the two-way radio system because R1 had fallen. Upon LN G's arrival at R1's room, Certified Nurse Aide (CNA) M and Certified Medication Aide (CMA) R were with R1, who was found on the ground between the legs of the lift. LN G stated R1 appeared to have slipped out of the sling during the transfer with the lift. R1 was assessed for injuries, and two hematomas were discovered on the back of his head. R1's physician was notified, and the physician instructed LN G to monitor R1 and report any changes. LN G stated that neurological checks were initiated, and a Fall Scene Huddle Worksheet was completed and submitted to Administrative Nurse D. LN G said that the lift and sling that were involved with R1's fall were immediately removed from the clinical floor for maintenance to inspect for any defects or malfunctions. LN G was unable to recall how many loops of the sling remained connected to the lift when she arrived at R1's room. On 04/21/26 at 02:00 PM, Administrative Staff A confirmed the fall report provided by the facility contained only two pages and said the report was all the available documents related to R1's fall on 01/17/26. Additionally, Administrative Staff A stated the fall report did not contain evidence that an investigation was performed or that a root cause of the fall was identified. Administrative Staff A reported that fall investigations were the responsibility of Administrative Nurse D. Administrative Staff A stated during a full body lift transfer, staff were expected to pause for approximately 30 seconds after the resident had been lifted free of the bed or wheelchair to double check the loops on the sling had not unintentionally come undone from the hooks on the lift, then proceed with the transfer if safe to continue. On 04/21/26 and 04/22/26, Administrative Nurse D was unavailable for interview. The facility's SRHP- Safe Resident Handling Program Overview R/S, LTC policy, dated 12/12/25, documented the facility's goal was to maintain a safe living and working environment for residents and employees. The policy documented that caregivers would perform a TIME OUT safety stop while (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the resident was in a sling and still over the surface of the bed or chair when the straps were taut, but before the resident left a surface to ensure the straps were secure prior to moving away from the surface.