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	06/24/2026

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

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify and implement measures consistent with and in accordance with professional standards of practice to prevent the development of and promote the healing of pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) for Resident (R) 9, who developed a facility acquired, unstageable, deep tissue injury to her right heel. The staff failed to monitor skin checks weekly, failed to ensure R9's heels were offloaded, and failed to ensure R9 received the required interventions including a low air loss mattress to prevent pressure ulcer development. Additionally, the facility failed to monitor R1's wound for two weeks. Findings included:- R9's Electronic Medical Record (EMR) revealed diagnoses of leukemia (malignant disease affecting bone marrow) and arthritis (inflammation of a joint characterized by pain, swelling, redness, and limitation of movement). R9's 02/07/2026 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 11,which indicated moderately impaired cognition. R9's MDS documented no behaviors or refusals of cares. She was independent with activities of daily living (ADL) including bed mobility to roll left and right, and she required supervision for transfers. R9 was at risk of developing pressure ulcers/injuries, had no skin issues, did not use a pressure reducing mattress and/or cushion, and did not require repositioning. R9's 02/13/2026 Pressure Ulcer/Injury Care Area Assessment (CAA) documented R9 had potential for pressure ulcer development related to immobility, and staff would immediately notify the nurse of any new areas of skin breakdown noted during daily care. R9's 05/08/2026 Quarterly MDS documented a BIMS of five, indicating severely impaired cognition. R9 required supervision/touch assistance for bed mobility. She was at risk of developing pressure ulcers/injuries, had no skin issues, no pressure-reducing mattress, and was on a repositioning program. R9's Care Plan, dated 02/03/2026, revealed staff were instructed that R9 required one staff assistance with bed mobility, as she was not always able to turn side to side. R9's Care Plan, dated 02/13/2026, revealed staff were instructed to notify the nurse immediately of any new areas of skin breakdown, which included: redness, blister, bruises, discoloration, etc. noted during bath or daily care. R9's Care Plan lacked any preventative interventions related to the resident's skin, until 06/17/2026 when staff noted a deep tissue injury (DTI- purple or maroon localized area of discolored intact skin or blood^filled blister due to damage of underlying soft tissue from pressure and/or shear) on right heel. (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 0686 Level of Harm - Actual harm Residents Affected - Few	R9's Braden Scale (scale used to predict pressure ulcer risk), dated 02/02/2026, revealed a score of 13, which indicated moderate risk. R9's 06/17/2026 Physician's Orders documented the resident's heels were to be floated when in bed. Heel protectors would be placed on the resident when out of bed every shift for a DTI of the right heel. The staff would apply Skin-prep (liquid skin protectant) to the DTI of the right heel, once a day. R9's Weekly Skin Check in the EMR lacked evidence of skin checks completed on the resident since admission on [DATE] through 06/17/2026. R9's Weekly Skin Check, dated 06/17/2026 at 04:41 PM, documented a skin issue that had not been evaluated. The location of the skin issue was the right heel and identified as a pressure ulcer/injury, unstageable, and presenting as deep tissue injury. The wound was acquired in-house (in the facility). The Weekly Skin Issue, dated 06/17/2026 at 05:07 PM, documented a new wound to R9's right heel. The injury was noted to be an unstageable, deep tissue injury. The wound measured 1.59 centimeters (cm) in length, 1.31 cm in width, and had no depth documented. R9's Weekly Skin Check, dated 06/17/2026 at 10:22 AM, revealed a slight increase in the wound measurement and noted there was no open area; slight redness to the wound margins blanched with immediate return. R9 reported slight pain in the area but stated the pain was not increasing. R9's Weekly Skin Issue, dated 06/24/2026 at 10:46 AM, documented a right heel stable previously deteriorating wound characteristics plateaued. Right heel unstageable pressure injury presenting as deep tissue injury. Wound was acquired in-house on 06/17/2026. The right heel DTI measured a length of 1.54 cm and a width of 2.73 cm; surrounding tissue noted erythema (redness or inflammation of the skin). R9's EMR lacked evidence of a turning and repositioning program. R9's Hospice Binder lacked any progress notes for care or information regarding the resident's wound. R9's EMR lacked nutritional notes related to her wounds. On 06/23/2026 at 07:28 AM, observation revealed R9 was in a low bed, her eyes were closed, and her heels were flat on the bed. On 06/23/2026 at 08:49 AM, Certified Nurse Aide (CNA) M assisted R9 to her bedside commode, R9 wore shoes. On 06/23/2026 at 11:15 AM, R9 lay in bed with no pillow or bootie noted under her heels. Licensed Nurse (LN) H folded a blanket and lifted the resident's right heel off the mattress. On 06/23/2026 at 12:30 PM, R9 was in the dining room having lunch; she had no heel booties on. On 06/24/2026 at 07:50 AM, R9 was in dining room waiting for breakfast; she had no heel booties on. On 06/24/2026 at 09:07 AM, R9 sat in her recliner, she had yellow nonskid socks on with no heel booties noted, she said she was comfortable. R9 reported that the facility or hospice company had not (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	offered her an air mattress for her bed. On 06/24/2026 at 09:45 AM, Administrative Nurse E removed R9's sock and noted a foam dressing on her right heel. Administrative Nurse E reported that R9 was supposed to have just skin prep and did not know who applied the foam dressing. R9 reported that the hospice nurse put it on her heel today. Administrative Nurse E measured and took a picture of the right heel noting the length was 1.54 cm and the width was 2.73 cm with no depth and slight redness that blanched when Administrative Nurse E applied pressure. R9 reported that her heel did have more pain when touched today. On 06/23/2026 at 10:33 AM, LN H reported that a weekly skin assessment was completed and documented in the EMR in the assessments tab. On 06/23/2026 at 11:12 AM, LN H reported that she could not locate any weekly skin check notes in R9's EMR completed prior to 06/17/2026. LN H reported R9 entered as a hospice resident and the weekly skin check must not have been ordered. On 06/23/2026 at 01:00 PM, CNA M reported if a resident had a new skin issue or a bruise, she would report that to the nurse. CNA M reported that R9 did not have heel booties, and she would use a folded blanket under R9's heels when she was in bed. CNA M was unsure whether R9 required turning and repositioning. On 06/23/2026 at 04:30 PM, Administrative Nurse D and Consultant Staff II (Regional Improvement Advisor) were in Administrative Nurse D's office. Administrative Nurse D reported she expected the weekly skin checks to be completed weekly on all residents, including hospice residents. Consultant Staff II reported she also expected weekly skin checks to be completed to avoid skin issues. On 06/24/26 at 08:00 AM, Consultant Staff HH (LN from hospice) reported they did not notice R9 had an issue with her right heel until the second week of June 2026. The facility's policy Wound and Pressure Ulcer Management, dated 07/07/25, documented the purpose was to provide current and consistent standards of practice in wound care management. Wound care management may include the management and treatment of surgical wounds, pressure ulcers, diabetic ulcers, and skin conditions, as well as arterial and venous ulcers. These are the most common types of wounds that occur. Good Samaritan wound care programs, pressure ulcer guidelines and protocols have been developed and implemented to provide quality services to our residents. A comprehensive management program to prevent development of pressure ulcers or other skin conditions (Braden, following interventions identified on care plan, nutritional intervention, specialty surfaces, etc.). - R1's admission Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R1 had no behaviors noted. R1 required a formal assessment for pressure ulcer risk and R1 was identified as at risk for pressure ulcer development. R1 admitted to the facility with a stage three pressure ulcer. R1's Care Plan, dated 05/07/2026, indicated staff were to avoid repositing the resident on their back/sacral area, monitor wound healing daily, and report improvements to the healthcare provider. Staff would clean the resident's sacral wound and left buttock and cover the area with a foam dressing daily, and as needed. Staff would notify the nurse immediately of any new areas of skin breakage, bruises, or discoloration. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Skin Assessment, dated 04/29/2026, indicated a stage three pressure ulcer to the lateral coccyx, which was present at the time of admission with purulent drainage noted. The surrounding skin was pink and blanchable with a length of 2.5 centimeters and 1.5 cm in width with no tunneling noted. Staff were to cleanse the area with normal saline, pat the area dry, and apply foam dressing daily and as needed. The Skin Assessment, dated 05/01/2026, revealed redness around wound bed, no granulation noted, 60 percent slough (a yellowish or white soft stringy or moist material made of dead cells); the area measured 2.5 cm in length and 1.5 cm in width. The Skin Assessment dated 05/03/2026 revealed the no changes to the resident's wound. The Skin Assessment dated 05/06/2026 revealed the wound measured 1/7th cm in length by 1/8th cm in width. The Skin Assessment dated 05/27/2026 revealed the wound measured 1/14 cm in length by 0.74 cm in width. The Skin Assessment dated 06/03/2026 lacked any measurement of the pressure injury. The Skin Assessment dated 06/11/2026 revealed the wound measured 1.33 cm in length and 0.94 cm in width. The Skin Assessment dated 06/18/2026 lacked any measurement of the pressure injury. An observation on 06/24/2026 at 02:30 PM revealed Administrative Staff E cleansed, measured, photographed, and dressed the residents' wounds. On 06/24/2026 at 11:20 AM, an interview with Administrative Nurse E revealed if the measurements were not documented they were not done. On 06/24/2026 at 01:57 PM, an interview with Administrative Staff D revealed wound measurements should be documented and if the wound nurse was unable to complete her duties the nurses were supposed to measure and document the residents' wounds. The facility's policy Wound and Pressure Ulcer Management, dated 07/07/2025, revealed staff were to implement a current and consistent standard of practice in wound care management. Wound care management may include the management and treatment of surgical wounds, pressure ulcers, diabetic ulcers, and skin conditions.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to prepare and serve food under sanitary conditions to prevent the outbreak of foodborne bacteria.Findings included:- During an observation of meal preparation on 06/23/2026 at 04:15 PM, Dietary Staff CC donned gloves then used the gloved hands to open the refrigerator door, touched a soft round flatbread, added ground chicken, and rolled the contents of the flatbread into a burrito-like structure making a chicken wrap. Dietary Staff CC failed to change gloves and/or wash hands and proceeded to place three of the chicken wraps in a blender.During an interview on 06/24/2026 at 03:40 PM, Dietary Manager BB stated the dietary staff were very nervous during the observation and mistakes were made regarding the use of gloves. Dietary Manager BB stated staff did not utilize gloves or wash their hands properly during the observation.The facility's policy Hand washing and Glove Use Food Nutrition Services, dated 06/24/2026, was intended to provide guidelines regarding hand hygiene and glove use to reduce the risk of cross-contamination when serving highly susceptible populations.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to inform Resident (R) 6 and/or their representatives regarding the risks related to psychotropic (alters mood or thoughts) medications. Findings included:- R6's Electronic Medical Record (EMR) recorded diagnoses of hemiplegia affecting the left side and dementia (a progressive mental disorder characterized by failing memory and confusion).R6's 05/28/2026 Annual MDS documented a BIMS score of six, indicating severely impaired cognition. R6 had no rejection of care during the observation period. R6 received antianxiety (a class of medications that calm and relax people) medications in the look back period. R6's 06/11/2026 Psychotropic Drug Use Care Area Assessment (CAA) documented antianxiety medication for anxiety related to dialysis (a procedure where impurities or wastes are removed from the blood).R6's 06/11/2026 Care Plan documented staff were instructed to monitor R6's condition based on guideline or clinical standard of practice related to use of Ativan (anti-anxiety medication). R6's 06/11/2026 Care Plan documented staff were instructed to monitor target behaviors related to anxiety: agitation, anxiety, tearfulness, and or resistance to care including resistance to going to dialysis. R6's 03/23/2026 Physician Order documented Ativan 0.5 milligrams (mg), give 1 tablet by mouth, one time a day every Monday, Wednesday, and Friday for anxiety, give before leaving for dialysis.R6's EMR lacked a documented progress note or consent for the education regarding risk vs. benefits for the Ativan. On 06/22/2026 at 08:56 AM R6 was seated in her wheelchair with chipped nail polish on all her nails, R6 reported she liked them polished and hoped to get the staff to do them.On 06/24/2026 at 11:00 AM R6 reported no one told her the facility was doing manicures and painting resident nails. R6 got very upset.On 06/24/2026 at 04:00 PM Licensed Nurse (LN) H reported that the nurse would not complete the psychoactive medication consents, she reported that Administrative Nurse D would complete the consent. On 06/24/2026 at 04:10 PM Administrative Nurse D reported that she just completed a psychoactive consent for R6's Ativan on 06/24/2026 and reported that it was a medication that dialysis requested, and she expected the charge nurse to complete a consent when a new psychoactive medication was ordered.The facility's policy Psychotropic Medications, dated 12/09/2025, documented A consent form must be signed for the use of psychotropic medications. The permission for use of psychotropic medications will be used to obtain consent.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interviews, the facility failed to provide form CMS-10055 Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage Form 10055 (SNF-ABN: used to notify Medicare A participants discharging from services of potential charges) and Notification of Medicare Non-Coverage Form 10123 (NOMNC- the form used to notify Medicare A participants of their rights to appeal and the last covered date of service) to the resident or their representative for Resident (R) 18.Findings included:- R18's Electronic Medical Record (EMR) documented a Medicare Part A episode beginning 02/17/2026 and ending on 03/09/2026.On 06/22/2026 at 04:30 PM Administrative Staff B reported R18 was unable to sign for the SNF-ABN and the NOMNC as R18 was very confused. Administrative Staff B reported R18 did not have a durable power of attorney (DPOA- a legal document that names a person to make healthcare decisions when the resident is no longer able to). Administrative Staff B reported that R18's brother signed all his admission paperwork. During an interview on 06/23/2026 at 3:00 PM with Administrative Staff A revealed the paperwork needs to be signed for NOMNC and SNF.The facility's policy SNF Medicare Part A Advance Beneficiary Notice of Non-Coverage (SNABN), documents Medicare's limitation on liability requires a provider to notify a Medicare beneficiary in advance of furnishing an item or service that is believed to likely be denied by Medicare in order to shift financial liability to the beneficiary. The Skilled Nursing Advance Beneficiary Notice of Non-Coverage (SNFABN) informs the beneficiary of potential non-coverage and shift of financial liability for those Part A items or services if Medicare denies the claim.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on observation, interview, and record review the facility failed to provide a written bed hold policy at the time for transfer for Resident (R) 5.Findings included:- R5's 05/20/2026 Quarterly Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition.The Nurse's Progress note dated 06/18/2026 at 08:49 AM, revealed R5 reported dizziness and inability to bear weight during a transfer to the wheelchair. The note documented that R5 appeared pale in color, blood pressure was 94/54 millimeters of mercury (mmHg), pulse was 255 beats per minute, and oxygen saturation was 67 percent on room air. R5 was placed on five liters of oxygen per nasal cannula, and the staff notified the physician who gave orders to transfer the resident to the emergency room.The Nurse's Progress note dated 06/18/2026 at 01:33 PM, revealed the hospital informed the facility that R5 had been admitted to the Intensive Care Unit for septic shock (system infection).R5's EMR lacked evidence of a written bed hold policy provided at the time of the 06/18/2026 transfer to the hospital.During an interview on 06/24/2026 at 08:25 AM, Administrative Staff B revealed it was the nurse's responsibility to send the bed hold policy with any resident who transferred from the facility to the hospital. Administrative Staff B stated the business office then followed up to make sure the bed hold was sent and said R5's bed hold policy was missed.During an interview on 06/24/2026 at 08:40 AM, Administrative Staff D stated Social Service staff took care of the bed hold. Administrative Staff D said the bed hold policy was not sent every time a resident went to the emergency room because it was not known if the resident would be staying.The facility policy Bed Hold, dated 12/23/2025, would ensure the resident/resident representative is made aware of the facility's bed hold and reserve bed payment policy before and upon transfer to a hospital or when taking a therapeutic leave of absence from the facility, and determine if the resident/resident representative wants to hold the bed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview, observation, and record review, the facility failed to provide services to meet professional standards of care when staff failed to ensure Resident (R) 11's Electronic Medication Administration Record (EMAR) was signed off with initials after medications were administered. Additionally, the staff failed to ensure R11 received her medications at the ordered time. Findings included:- R11 's Electronic Medical Record (EMR) revealed diagnoses of spastic hemiplegia affecting left side (paralysis of one side of the body) and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).R11's 01/07/2026 admission Minimum Data Set (MDS), documented a Brief Interview for Mental Status (BIMS) of 11, which indicated moderately impaired cognition. R1 had no rejection of care during the observation period and received an anticoagulant (a class of medications used to prevent the blood from clotting), a diuretic (a medication to promote the formation and excretion of urine), and a hypoglycemic (a medication to manage high blood sugar levels). R11's 01/11/2026 Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) revealed R11 had left-sided weakness/hemiplegia and required one staff assistance with activities of daily living (ADLs). R11's Care Plan, dated 01/14/2026, instructed staff to refer to boxed warnings in the orders or EMAR, or medication reference of choice.R11's 01/01/2026 Physician's Orders documented Furosemide (diuretic) 40 milligrams (mg), givetablet by mouth, one time a day for hypertension (HTN-elevated blood pressure).R11's 01/15/2026 Physician's Orders documented Apixaban (anticoagulant) 5mg, give one table by mouth, two times a day for by mouth two times a day for atrial fibrillation (rapid, irregular heartbeat).R11's 01/15/2026 Physician's Orders documented Losartan Potassium 50 mg, give one tablet by mouth one time a day for hypertension.R11's 01/15/2026 Physician's Orders documented Diltiazem 90 mg, give one tablet by mouth one time a day related to hypertension.R11's 05/20/2026 Physician's Orders documented Sitagliptin 50 mg, give one tablet by mouth one time a day for diabetes.R11's 05/20/2026 Physician's Orders documented metformin 1000 mg, give one tablet by mouth two times a day for diabetes.Review of facility's handout Schedule of Medication Administration Times from the entrance conference on 06/22/2026 documented AM medication pass was 08:15 AM - 09:00 AM. On 06/24/2026 at 07:45 AM, R11 ambulated to the dining room with a gait belt and walker with assistance from Certified Nurse Aide (CNA) N.On 06/24/2026 at 07:50 AM, Licensed Nurse (LN) H reported that Certified Medication Aide (CMA) R had left the facility to take care of a personal matter and would be back soon to administer the morning medications to the residents. On 06/24/2026 at 08:15 AM, CMA R reported that she had administered R11's morning medications and verified that none of R11's medications had been signed off on the EMAR as administered at this time. CMA R reported that she was unsure what time she administered R11's medications and reported she was unable to sign them out when she prepared and administered the medications, as it was not highlighted on the EMAR at that time. CMA R reported she left the facility this morning and had just clocked back in. CMA R reported that she would start the morning medication pass right after she arrived at the facility at 06:00 AM and would sign off the 08:00 AM medications when the EMAR highlighted them in yellow. CMA R reported that the nurses know what she does and probably would not administer the medications again if they assisted with the morning medication pass if she was unable to return to work. LN H and LN G were located at the other medications carts next to CMA R's medication cart, and they both reported that when they administer the resident AM medications right after they arrive at the facility to work, they must go back on the EMAR once the medications are highlighted in yellow to sign the medications off then. LN H reported there was no open medication pass at the facility and reported that the medications should really be given at the scheduled time or one hour before or after and signed off once administered. On 06/24/2026 8:30 AM, Administrative Nurse D reported there was not an open medication administration. Administrative Nurse D reported she expected the LNs and CMAs to administer (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication one hour before or after the scheduled time and be signed off once administered.The facility did not provide a policy on Medication Administration.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents received assistance with activities of daily living (ADL), including facial hair removal for Resident (R) 18 and assistance with nail care for R18, R6, and R11. Findings included:1. R11's Electronic Medical Record (EMR) revealed diagnoses of spastic hemiplegia affecting left side (paralysis of one side of the body) and assistance with personal care.R11's 01/07/2026 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 11, which indicated moderately impaired cognition. R1 had no rejection of care during the observation period and required moderate assistance with personal hygiene.R11's 01/11/2026 Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) revealed R11 had left-sided weakness/hemiplegia and required one staff assistance with activities of daily living (ADLs).R11's Care Plan, dated 01/14/2026, instructed staff to provide one staff assistance with grooming due to affected left side.On 06/22/2026 at 08:50 AM, R11 was seated in her room in a recliner, she wore a dirty pink t-shirt with dried food on it. R11 had long fingernails with chipped nail polish, and she reported that she liked long nails, but noted they needed new polish. R11 had two jagged, broken nails on her left hand.On 06/23/2026 at 07:42 AM, R11 was seated in her wheelchair with new clothes on. Her two nails remained jagged on left hand and the nail polish remained chipped.On 06/24/2026 at 07:45 AM, R11 ambulated to the dining room with a gait belt and walker with assistance from Certified Nurse Aide (CNA) N. R11's [NAME] fingernails remained jagged and with chipped nail polish. 2. R6's EMR recorded diagnoses of hemiplegia affecting the left side and assistance with personal care.R6's 05/28/2026 Annual MDS documented a BIMS score of six, which indicated severely impaired cognition. R6 had no rejection of care during the observation period. R6 required set-up assistance with personal hygiene.R6's 06/11/2026 Functional Abilities (Self-Care and Mobility) CAA documented R6 had impaired mobility related to cognitive status.R6's Care Plan, dated 10/31/2024, documented staff were instructed to provide one staff assistance with personal hygiene.On 06/22/2026 at 08:56 AM, R6 was seated in her wheelchair with chipped nail polish on all her nails; R6 reported she liked them polished and hoped to get the staff to do them.On 06/23/2026 at 07:35 AM, R6 sat in the dining room in her wheelchair with chipped nail polish on all her nails. On 06/24/2026 at 07:51 AM, R6 sat in her wheelchair in the dining room with chipped worn-off nail polish.On 06/24/2026 at 11:00 AM, R6 reported no one told her the facility was doing manicures and painting resident nails; R6 became upset.3. R18's EMR recorded diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness) and assistance with personal care.R18's 02/23/2026 admission MDS documented a BIMS of zero, which indicated severely impaired cognition. R18's MDS documented that he had no rejection of care during the observation period and required total assistance with personal hygiene.R18's 03/03/2026 Cognitive Loss/Dementia CAA documented R18 had impaired cognitive function and/or impaired thought processes, evidenced by impaired decision making and long-term memory loss. Goals included for R18 to be able to communicate basic needs through the review date.R18's 05/26/2026 Quarterly MDS documented a BIMS of 99, indicating severely impaired cognition. R18's MDS documented no behaviors and no rejection of care during the observation period. R18's MDS documented he required maximal assistance with personal hygiene. R18's Care Plan, dated 02/18/2026, documented staff were instructed to provide one to two staff assistance with personal hygiene as he was dependent on the staff. On 06/22/2026 at 09:45 AM, R18 was seated in his room in his wheelchair. Observed very long nails on all his fingers and stubbly facial hair. On 06/22/2026 at 01:01 PM, a phone interview with a family member revealed R18 should have his nails trimmed and his facial hair removed as R18 liked to be well-groomed. On 06/23/2026 at 07:24 AM, R18 was seated in his wheelchair, the long nails remained, and the stubbly facial hair remained.On 06/24/2026 at 09:00 AM, R18 was seated in (continued on next page)

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	175334	A. Building B. Wing	06/24/2026

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his wheelchair propelling self. R18's fingernails remained long, and his stubbly facial hair remained.On 06/23/2026 at 08:23 AM, Certified Nurse Aide (CNA) S reported showers and baths were documented in EMR under the tasks. CNA S reported if the resident refused care the charge nurse would be notified and the nurse would check with the resident and document that. CNA S reported that in the EMR under the activities, there was a beauty shop/barber task where staff document for the fingernail care and shaves and note if they were completed or refused. CNA S reported there was no paper form for bathing sheet to be filled out by staff. CNA S reported that she would complete nail care on non-diabetic residents and facial hair removal. She reported that activities generally completed the nail polish with manicures. On 06/24/2026 at 11:50 AM, Licensed Nurse (LN) G reported she expected the CNAs to complete nail care on non-diabetic residents on bath days or as needed. LN G reported the nurse would cut the diabetic residents' nails. LN G expected the resident's facial hair to be removed on bath days or when needed or requested. LN G reported activities should complete the nail polish as needed. She reported the CNAs should let the nurse know when a diabetic resident required their nails to be trimmed.On 06/24/2026 at 01:49 PM, Administrative Nurse D reported there was no place in the EMR/tasks tab for staff to document nail care or facial hair removal. She reported she expected the residents to have their nails polished, cleaned, and trimmed, per their preference, and facial hair removed. She reported that if a resident refused their baths the charge nurse would document that in the progress notes. Administrative Nurse D revealed that the activity for manicures was not held in the normal area of the facility today and that is why R6 may have missed the manicure.The facility's policy Activities of Daily Living, dated 12/10/2025, documented any resident who is unable to carry out activities of daily living will receive necessary services to maintain good nutrition, grooming and personal and oral hygiene.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review the facility failed to monitor and respond to Resident (R) 25's lack of bowel movements for 13 consecutive days. Findings included:- R25's Electronic Medical Record (EMR) revealed diagnoses of constipation (difficulty passing stools) and dementia (a progressive mental disorder characterized by failing memory and confusion).R25's 11/27/2025 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 99, indicating severely impaired cognition. R25 required maximal assistance with toileting and was always incontinent with bowel movements. R25's 12/07/2025 Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) documented R25 was incontinent of bowel and bladder. R25 refuses to use the bathroom and would become extremely angry when offered the toilet, as she prefers to go in her brief. R25's Care Plan, dated 07/29/2014, revealed staff were to teach the resident/family the relationship of constipation to food, medicine, treatment regimen, disease process, and psychosocial factors, and teach the resident/family to identify and avoid causative factors.R25's Care Plan, dated 02/23/2021, revealed R18 wore briefs, and staff were to assist to toilet as requested, check brief, and change at least every two hours and when toileted. R25's Care Plan, dated 03/08/2024, revealed R18 refused to be toileted and was incontinent of bowel and bladder and wore a large wrap brief.R25's Physician Orders documented Milk of Magnesia (stool softener) suspension 1200 milligrams (mg)/15 milliliters (ml), administer 30 ml by mouth, as needed for constipation one time a day, ordered 03/04/2024. R25's Physician Orders documented Bisacodyl (laxative) rectal suppository 10 mg, insert 10 mg rectally every 24 hours as needed for constipation, ordered 08/12/2024. R25's Physician Orders documented Senna (laxative) tablet 8.6 mg, give one tablet by mouth, two times a day related to constipation, may hold for loose stools, ordered 10/30/2024. Review of R25's bowel movement frequency in the EMR dated 06/06/2026 through 06/18/2026 revealed the resident exceeded three days/72 hours without a bowel movement. From 06/06/2026 through 06/18/2026 (13 consecutive days) the record lacked documentation of bowel movements for R25. Review of R25's Electronic Medication Administration Record (EMAR) lacked documentation of the administration of as needed medications to R25 in the 13 consecutive days with no documented bowel movements.Review of R25's EMR revealed the progress notes lacked documentation of monitoring for bowel movements or the lack of bowel movements for 13 consecutive days (06/06/2026 through 06/18/2026). On 06/22/2026 at 09:13 AM, R25 laid in her low bed, declined the interview, and reported she did not feel well but did not state specifics. On 06/23/2026 at 04:30 PM, R25 sat in her wheelchair in the lobby eating a snack.On 06/24/2026 at 11:25 AM, Certified Medication Aide (CMA) R reported the CMAs would receive a list from the nurses on which residents have not had a bowel movement for three days, and the nurse would instruct the CMA to give Milk of Magnesia. On 06/24/2026 at 11:45 AM, Licensed Nurse (LN) G reported the night nurse printed off a ?no bowel movement in three days' list and the nurse would instruct the CMA to administer Milk of Magnesia, if no results then a suppository. LN G reviewed R25's EMAR and EMR for the month of June and verified that R18 had no bowel movements from 06/06/2026 through 06/18/2026 and nothing was documented. LN G reported she was not sure how that could have happened. On 06/24/2026 at 11:55 AM, Administrative Nurse D reported she expected the staff to follow the bowel protocol and revealed she did not know why R25 had no bowel movement documented, or why the staff had not assessed the resident. The facility's policy Bowel & Bladder: Evaluation, Assessment, Toileting Programs, dated 04/30/2026, lacked monitoring bowel movements and follow up if no bowel movement in 72-hours.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, record review, and interviews, the facility failed to ensure an environment free of chemical hazards for severely cognitively impaired Resident (R) 26 who had a bottle of 91 percent rubbing alcohol on his tray table. Findings included:- R26's Electronic Medical Record (EMR) revealed diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion).R26's 05/15/2026 Annual Minimum Data Set(MDS) documented a Brief Interview for Mental Status (BIMS) of zero, indicating severely impaired cognition. R26's MDS documented he required set-up assistance for wheelchair mobility. R26's 05/26/2026 Cognitive Loss/Dementia Care Area Assessment (CAA) documented R26 had impaired cognitive function or impaired thought processes, related to disease processes. R26 had forgetfulness, short term memory loss, resistance to care, and agitation. R26's Care Plan dated 05/29/2025 revealed staff were instructed to minimize the potential of resident behavior problems by modifying environmental factors and daily routine.R26's Progress Note on 05/15/2026 at 02:19 PM documented R26 was alert to self. R26 required one staff assistance with activities of daily living. R26 was able to self-propel in the wheelchair following set up assist from staff. R26 had a WanderGuard (a bracelet that helps monitor residents who are at risk of wandering) in place due to previous wandering. On 06/22/2026 at 10:19 AM, R26 was in his room lying in his bed. R26 had a bottle of 91 percent rubbing alcohol that was approximately 3/4 full on the tray table. R26 reported that he used rubbing alcohol for the syringes and shots he takes. On 06/23/2026 at 07:22 AM, R26 had a container full of disinfectant wipes open on his table near the television and the same bottle of rubbing alcohol in his room. R26 was in the dining room at this time for breakfast. An observation on 06/24/2026 at 09:17 AM noted the same bottle of rubbing alcohol in his room, R26 was in his wheelchair at the nurse station. On 06/24/2026 10:11 AM, Certified Medication Aide (CMA) R reported she was not sure why R26 had a three quarters full bottle of rubbing alcohol in his room and removed it. CMA R reported the facility did not have bottles of rubbing alcohol. On 06/24/2026 at 03:30 PM, Licensed Nurse (LN) G reported R26 should not have a bottle of rubbing alcohol or disinfectant wipes in his room and reported that the aides should have removed the bottle from his room and reported that to the nurse. On 06/24/2026 at 04:45 PM, Administrative Nurse D reported the residents were not allowed to have unsecured bottles of rubbing alcohol in their room and R26 had friends who liked to bring him in items that he should not have. She expected the staff to notice those items and let the nurse know so it could be removed. The facility did not provide a policy regarding safe storage of chemicals.

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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. Based on observation, interview, and record review, the facility failed to ensure adequate catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) related care for Resident (R) 18 when staff did not ensure each resident's catheter tubing was secure to prevent pulling or dislodgement. The facility additionally failed to ensure R18 had a diagnosis for the indwelling catheter. Findings included:- R18's Electronic Medical Record (EMR) recorded diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness) and assistance with personal care.R18's 02/23/2026 admission Minimum Data Set (MDS) documented a BIMS of zero, indicating severely impaired cognition. R18's MDS documented that he required total assistance with toileting hygiene.R18's 03/03/2026 Urinary Indwelling Catheter Care Area Assessment (CAA) documented: R18 was admitted without catheter and then on 02/16/26 catheter was initiated and added to plan of care. R18's Care Plan, dated 02/17/2026, instructed staff that R18 had a 16French/10 milliliter (ml) balloon foley catheter. Change catheter as needed if dislodged, occluded, and unable to clear with irrigation. Staff instructed to monitor for pain or discomfort due to catheter. R18's 04/20/2026 Physician Orders documented 16French/10 ml balloon foley catheter. Change catheter as needed if dislodged, occluded, and unable to clear with irrigation. No directions specified for order. R18's 02/16/2026 Electronic Medication Administration Record (EMAR) documented follow up with primary care provider to reassess continuation of catheter. Recommended to remain in place for one week until Flomax a medication that relaxes the muscles in the prostate and the neck of the bladder, making it easier to urinate) was at its peak. R18's 02/23/2026 EMAR documented initials on the record to reassess no progress note was written that catheter was removed. R18's Provider Notes lacked documentation regarding foley catheter. R18's Progress Note, dated 02/24/2026 at 01:46 AM, documented R18 has a 16French catheter in place.R18's Progress Note, dated 02/25/2026 at 10:51 AM, documented R18 a catheter in place, patent and draining yellow urine to gravity.R18's Progress Note, dated 02/26/2026 at 11:54 AM, documented R18 a catheter in place, patent and draining yellow urine to gravity.R18's Progress Note, dated 03/01/2026 at 11:49 AM, documented R18 a catheter in place, patent and draining yellow urine to gravity.R18's Progress Note, dated 04/20/2026 at 06:28 PM, documented order was requested for catheter to be changed monthly and as needed. Provider ordered it to be changed as needed.On 06/22/2026 at 09:45 AM, R18 was seated in his room in his wheelchair. R18 was unsure why he had a catheter. On 06/22/2026 at 01:01 PM, a phone interview with a family member revealed he was unsure why R18 had a catheter. On 06/23/2026 at 10:37 AM, Certified Nurse Aide (CNA)M and CNA O assisted R18 onto the mechanical lift. R18's catheter bag was leaking urine in the privacy bag. CNA M held the drainage bag higher than the urinary bladder. Licensed Nurse (LN) H knocked on R18's door and was updated by CNA M the bag was leaking as CNA M continued to hold the catheter bag above R18's urinary bladder. R18 was assisted into bed, CNA M checked R18's briefs no catheter anchor was noted holding catheter in place. CNA M reported that she performed catheter care this morning and R18 did not have an anchor then and CNA M reported R18 should have an anchor on, and she did not go to get one from storage this morning. LN H applied an anchor for the catheter to his inner right thigh. R18 reported it would save him a lot of pain from pulling like it was. On 06/23/2026 at 01:00 PM, CNA M reported the catheter bag should always be below the bladder.On 06/24/2026 at 09:45 AM, CNA N reported R18 always had a catheter and was not sure it had ever been removed.On 06/24/2026 at 03:30 PM, LN G reported when R18 was admitted he was to have the foley catheter re-evaluated in one week by the provider and it should be in the progress note why he still had the catheter. On 06/24/2026 at 03:45 PM, Administrative Nurse D reported that R18 should always have an anchor to support his catheter. Administrative Nurse D revealed she expected drainage bag always (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be maintained below the bladder and was uncertain why R18 had a foley catheter, she reported that they would need to inquire about bladder training and expected any resident who had a foley catheter to have a qualifying diagnosis. The facility's policy Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen, dated 03/02/2026, documented that a resident is not to be catheterized unless the clinical condition demonstrates that catheterization is medically necessary and is not used solely for nurse/physician convenience. Catheter tubing is secured to the resident's leg, coiled on bed with no kinks or obstructions and the rest of the tubing should be in a straight line into urinary drainage bag. Make sure drainage bag and tubing remain below level of catheter and bladder.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to ensure adequate infection control practices related to urinary catheter (tube inserted into the bladder to drain urine) care, hand hygiene, and glove use with intravenous (IV) medication.Findings included:- During an observation on 06/23/2026 at 09:00 AM, Licensed Nurse (LN) H entered Resident (R) 21's room to empty the urinal. After she emptied the urinal, LN H removed her soiled gloves and did not perform hand hygiene before she applied new gloves that were in her pocket. LN H then wore those gloves as she primed the tubing of the IV bag, wiped the IV port with an alcohol wipe, flushed the IV line with normal saline, attached the IV tubing to the end cap, and set the IV pump.During an observation on 06/23/2026 at 10:37 AM Certified Nurse Aide (CNA) M and CNA O applied personal protective equipment (PPE) before entering R18's room to transfer the resident with a mechanical lift. During the transfer R18's indwelling urinary catheter bag began to leak, when staff held the bag above the level of R18's bladder. The bathroom in R18's room did not have soap for hand hygiene and both CNA's left the room, wearing their PPE, to go wash their hands. CNA M returned to R18's room to empty the urinary catheter bag and the bag spout touched the inside of the graduated cylinder. CNA M then wiped the port with alcohol and attached the bag spout. LN H returned to the room to apply a new catheter bag without cleaning the connectors.During an interview on 06/23/2026 at 10:55 AM, LN H revealed she should have wiped the drainage bag and catheter opening before connecting them together and should have washed her hands after removing her gloves, before she hung the IV medication.The facility's undated policy Personal Protective Equipment (PPE) revealed all PPE must be removed prior to leaving the work area and placed in a designated area or container for storage, washing, decontamination or disposal, and staff should discharge all PPE upon completing a task.The facility did not provide a policy for the administration of IV fluids.