STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175356	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Decatur County	108 E Ash Street Oberlin, KS 67749

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. The facility identified a census of 14 residents, with five residents reviewed for resident rights, activities, staffing, and Activities of Daily Living (ADL). Based on record review, observation, and interview, the facility failed to provide Resident (R) 2, R3, R4, R5, R6, and R7 with the resident's right to a dignified existence by ensuring the residents were well groomed, clean, and dressed appropriately for the day. This deficient practice placed R2, R3, R4, R5, R6, and R7 at risk for impaired dignity and psychosocial impairment. Findings included: - R2's Electronic Medical Record (EMR) documented R2 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). R2's Quarterly Minimum Data Set (MDS), dated 03/01/25, documented R2 had a Brief Interview for Mental Status score of 99. The MDS documented R2 had short-term and long-term memory loss, and R2 was severely cognitively impaired. The MDS documented R2 was dependent on the staff for completing all of her activities of daily living (ADL). The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 08/29/24, documented R2 had a diagnosis of dementia, had memory loss, and required a proxy for health care decisions. The Behavioral Symptom CAA, dated 08/29/24, documented R2 had behaviors of physical aggression towards staff during cares, which placed R2 at risk for injury. R2's Care Plan directed staff to engage R2 in simple, structured activities that were not demanding (09/27/23). The care plan directed staff to ensure R2 wore a bra daily and to smooth her shirt so it was not wrinkled (03/18/25). The care plan directed staff to transfer R2 with a full lift with two staff assistance using the high-backed yellow sling (10/04/24). The care plan directed staff to provide weekly one-on-one visits and manicures, and R2's preferred activities were hymns and devotions (09/27/23). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175356	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Decatur County	108 E Ash Street Oberlin, KS 67749

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/28/25 at 09:30 AM, observation revealed R2 sat in the activity room after breakfast in her wheelchair with a yellow high-backed lift sling under her. R2's hair had not been combed and was mussed. R2 had dried yellow and brown food particles on the sides of her wheelchair that appeared to be days old. R2's blouse was wrinkled. There was no staff in the activity room, and there was no activity for R2 to enjoy. R2 sat and either looked around the room at the five other residents sitting with her or slept in her wheelchair. On 04/28/25 at 10:30 AM, R2 sat in the same position. Someone had placed hymnals to play on the iPad. No staff were in the room interacting with R2. R2 slept with her head tilted to her right shoulder. On 04/28/25 at 01:30 PM, observation revealed Certified Nurse's Aide (CNA) M rolled R2 back and forth in bed by herself to provide R2 incontinent care. R2 grabbed CNA M's hands and arms to try and stop her. After CNA M left the room, observation revealed R2 had a dark brown food ring around her mouth that had not been cleaned from lunch. On 04/28/25 at 09:35 AM, Certified Nurse's Aide (CNA) M stated there were not enough CNAs working on the floor for the day shift or evening shift to make sure all resident cares were completed. CNA M stated that over half of the residents were full lifts or sit-to-stand lifts that required two staff, and by the time the staff got all the residents up, there was not enough time to take care of morning personal hygiene before breakfast. On 04/28/25 at 10:00 AM, CNA N stated she was responsible for the restorative program. CNA N stated there was not enough staff to make sure the residents were cared for the way they were supposed to be. CNA N stated that when she first started at the facility, the facility was one of the best, and she recommended to her family to place family members who required care in the facility. CNA N stated that was not the case anymore, and her family was thinking about pulling her family members out of the facility. On 04/28/25 at 11:10 AM, CNA O stated there were not enough CNAs on shift to take care of the residents responsibly. CNA O stated that two CNAs on the floor to take care of all the residents did not leave any extra time to take care of personal hygiene for residents, and a lot of the time, when they finally got everyone out to breakfast food was cold. CNA O stated that just one extra CNA would make a world of difference. CNA O stated administrative staff never came out of their offices to assist with resident care. On 04/28/25 at 02:30 PM, Administrative Nurse D stated she had been fighting corporate on staffing for a while, and she would not drop her staffing numbers anymore. Administrative Nurse D stated she thought staffing was okay for staff to take care of the needs of the residents. Administrative Nurse D became emotionally upset when the resident's conditions and activity involvement were described to her. Administrative Nurse D stated she would expect the nursing staff to take care of all the residents' ADLs and personal hygiene needs and not leave them in the condition they were found in. Administrative Nurse D verified that over half of the fourteen residents required a full lift or sit-to-stand lift for transfers, which required two staff for the transfers. On 04/28/25 at 03:30 PM, Administrative Staff A stated she felt staffing was appropriate for the facility. Administrative Staff A stated she expected staff to make sure all the residents' needs were provided for to ensure the residents' dignity. (continued on next page)

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Good Samaritan Society - Decatur County	108 E Ash Street Oberlin, KS 67749

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Nursing Services Staff Policy, revised 10/29/24, documented the facility must have sufficient nursing staff with the appropriate competencies and skill set to provide nursing and related services to assure resident safety and maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and induvial plans of care and considering the number, acuity, and diagnoses of the facility's resident population. The facility must provide services with the sufficient number of staff to provide nursing care to all residents. - R3's EMR documented R3 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R3's Quarterly Minimum Data Set (MDS), dated 03/05/25, documented R3 was rarely/never understood. The MDS documented R3 had short-term and long-term memory loss and had severely impaired cognition. The MDS documented R3 was dependent on staff for all of her activities of daily living (ADL). The MDS documented R3 had physical and verbal behaviors directed towards others for four to six days during the look-back period. R3's Cognitive Loss/Dementia Care Area Assessment (CAA), dated 12/03/24, documented R3 had diagnoses of dementia and Alzheimer's disease and was severely cognitively impaired. The Psychosocial Well-Being CAA, dated 12/03/25, documented R3 was no longer able to tell of her favorite activity. The CAA documented that R3 received family visits one to two times a week and would attend morning devotions. R3's Care Plan directed staff to reminisce with R3 using photos of family and friends (06/15/22). R3's care plan directed staff R3 preferred to have makeup and perfume on every day (12/08/23). R3's care plan directed staff that R3 required two staff to transfer her with a sit-to-stand lift with the green bordered lift sling. R3's care plan directed staff to assist R3 out of bed at 04:00 PM every day and place R3 in front of the TV (07/14/23), provide weekly one on one visits (12/15/20), and offer weekly visits with the chaplain/attends Catholic mass (12/08/23), and invite and remind R3 of scheduled activities and assist as needed (12/15/20). On 04/28/25 at 09:30 AM, R3 sat in her wheelchair in the activity room with five other wheelchair bound residents. There was no activity for R3 to enjoy. There was no staff in the room. R3's hair had not been combed that morning and was sticking up on end. R3 did not have a bra on, and her left breast and nipple were showing through the blouse she had on. R3 did not have any makeup on. There were dark brown food particles on the sides of R3's wheelchair that appeared to be days old. On 04/28/25 at 10:30 AM, R3 sat in the same position. Someone had placed hymnals to play on the iPad. No staff were in the room interacting with R3. R3 slept with her chin on her chest. On 04/28/25 at 01:30 PM, observation revealed CNA N rolled R3 back and forth in bed by herself to provide R3 incontinent care. After CNA N left the room, observation revealed R3 had a dark brown food ring around her mouth that had not been cleaned from lunch. (continued on next page)

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Good Samaritan Society - Decatur County	108 E Ash Street Oberlin, KS 67749

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/28/25 at 09:35 AM, Certified Nurse's Aide (CNA) M stated there were not enough CNAs working on the floor for the day shift or evening shift to make sure all resident cares were completed. CNA M stated that over half of the residents were full lifts or sit-to-stand lifts that required two staff, and by the time the staff got all the residents up, there was not enough time to take care of morning personal hygiene before breakfast. On 04/28/25 at 10:00 AM, CNA N stated she was responsible for the restorative program. CNA N stated there was not enough staff to make sure the residents were cared for the way they were supposed to be. CNA N stated that when she first started at the facility, the facility was one of the best, and she recommended to her family to place family members who required care in the facility. CNA N stated that was not the case anymore, and her family was thinking about pulling her family members out of the facility. On 04/28/25 at 11:10 AM, CNA O stated there were not enough CNAs on shift to take care of the residents responsibly. CNA O stated that two CNAs on the floor to take care of all the residents did not leave any extra time to take care of personal hygiene for residents, and a lot of the time, when they finally got everyone out to breakfast food was cold. CNA O stated that just one extra CNA would make a world of difference. CNA O stated administrative staff never came out of their offices to assist with resident care. CNA O stated she did not know anything about activities. On 04/28/25 at 02:30 PM, Administrative Nurse D stated she had been fighting corporate on staffing for a while, and she would not drop her staffing numbers anymore. Administrative Nurse D stated she thought staffing was okay for staff to take care of the needs of the residents. Administrative Nurse D became emotionally upset when the resident's conditions and activity involvement were described to her. Administrative Nurse D stated she would expect the nursing staff to take care of all the residents' ADLs and personal hygiene needs and not leave them in the condition they were found in. Administrative Nurse D verified that over half of the fourteen residents required a full lift or sit-to-stand lift for transfers, which required two staff for the transfers. On 04/28/25 at 03:30 PM, Administrative Staff A stated she felt staffing was appropriate for the facility. Administrative Staff A stated she expected staff to make sure all the residents' needs were provided for to ensure the residents' dignity. The facility's Nursing Services Staff Policy, revised 10/29/24, documented the facility must have sufficient nursing staff with the appropriate competencies and skill set to provide nursing and related services to assure resident safety and maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and induvial plans of care and considering the number, acuity, and diagnoses of the facility's resident population. The facility must provide services with the sufficient number of staff to provide nursing care to all residents. - R4's EMR documented R4 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), non-traumatic brain dysfunction (damage to the brain that does not result from an external force, such as a fall or accident), need for assistance with personal care, edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and abnormalities of gait and mobility. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Quarterly Minimum Data Set (MDS), dated 01/07/25, documented R4 had a BIMS score of three, which indicated severely impaired cognition. The MDS documented R4 was dependent on staff for toileting, bathing, and transfer. The MDS documented R4 required maximum/substantial assistance from staff for ambulation, dressing, and bed mobility. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 07/07/24, documented R4 had dementia, memory problems, and required assistance with decision making. The Psychosocial Well Being CAA, dated 07/07/24, documented R4 had been a farmer his whole life and rarely socialized. R4's brother visited a few times a week, otherwise, there was no family involvement. R4's Care Plan directed staff R4 preferred to get up at 07:00 AM, eat breakfast, watch TV, and would like to attend morning activities (03/14/25). The care plan directed R4 required a sit-to-stand lift utilizing the yellow bordered sling with two staff assist for transfers and a wheelchair for mobility (02/27/25). On 04/28/25 at 08:45 AM, observation revealed R4 sat in his wheelchair at a table with breakfast in front of him. R4 sat with his head down, his chin on his chest. R4's pants were stained with food particles, his button-down shirt only had two buttons buttoned, and showed a large portion of his chest and stomach. R4's shirt had a large, old orange stain on the cuff. R4 had coughed up some yellow, bloody phlegm on his shirt. On 04/28/25 at 09:30 AM, R4 sat in his wheelchair in the activity room with five other wheelchair bound residents. There was no activity for R4 to enjoy. There was no staff in the room. R4's wheelchair had dark brown dried food particles on the sides of his wheelchair that appeared to have been there for days. On 04/28/25 at 10:30 AM, R4 sat in the same position. Someone had placed hymnals to play on the iPad. No staff were in the room interacting with R4. R4 wrung his hands and played with his fingers. On 04/28/25 at 01:40 PM, R4 sat in his wheelchair in his room. The TV was not on, and R4 looked around his room. R4 continued to be in stained, unclean clothing with the large yellow, bloody phlegm on the front of his shirt. On 04/28/25 at 09:35 AM, Certified Nurse's Aide (CNA) M stated there were not enough CNAs working on the floor for the day shift or evening shift to make sure all resident cares were completed. CNA M stated that over half of the residents were full lifts or sit-to-stand lifts that required two staff, and by the time the staff got all the residents up, there was not enough time to take care of morning personal hygiene before breakfast. She knew that after breakfast, the wheelchair bound residents were brought into the activity room, and usually, some kind of activity would occur. On 04/28/25 at 10:00 AM, CNA N stated she was responsible for the restorative program. CNA N stated there was not enough staff to make sure the residents were cared for the way they were supposed to be. CNA N stated that when she first started at the facility, the facility was one of the best, and she recommended to her family to place family members who required care in the facility. CNA N stated that was not the case anymore, and her family was thinking about pulling her family members out of the facility. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Decatur County	108 E Ash Street Oberlin, KS 67749

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/28/25 at 11:10 AM, CNA O stated there were not enough CNAs on shift to take care of the residents responsibly. CNA O stated that two CNAs on the floor to take care of all the residents did not leave any extra time to take care of personal hygiene for residents, and a lot of the time, when they finally got everyone out to breakfast food was cold. CNA O stated that just one extra CNA would make a world of difference. CNA O stated administrative staff never came out of their offices to assist with resident care. On 04/28/25 at 02:30 PM, Administrative Nurse D stated she had been fighting corporate on staffing for a while, and she would not drop her staffing numbers anymore. Administrative Nurse D stated she thought staffing was okay for staff to take care of the needs of the residents. Administrative Nurse D became emotionally upset when the resident's conditions and activity involvement were described to her. Administrative Nurse D stated she would expect the nursing staff to take care of all the residents' ADLs and personal hygiene needs and not leave them in the condition they were found in. Administrative Nurse D verified that over half of the fourteen residents required a full lift or sit-to-stand lift for transfers, which required two staff for the transfers. On 04/28/25 at 03:30 PM, Administrative Staff A stated she felt staffing was appropriate for the facility. Administrative Staff A stated she expected staff to make sure all the residents' needs were provided for to ensure the residents' dignity. The facility's Nursing Services Staff Policy, revised 10/29/24, documented the facility must have sufficient nursing staff with the appropriate competencies and skill set to provide nursing and related services to assure resident safety and maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and induvial plans of care and considering the number, acuity, and diagnoses of the facility's resident population. The facility must provide services with the sufficient number of staff to provide nursing care to all residents. - R5's EMR documented R5 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), atrial fibrillation (rapid, irregular heartbeat), and a history of falling. R5's Annual MDS, dated 02/14/25, documented R5 had a BIMS score of 99, R5 had short and long-term memory deficits, and R5 made poor decisions and required supervision. The MDS documented R5 was dependent on staff for all of her ADLs. The Cognitive Loss/Dementia CAA, dated 02/14/25, documented R5 had dementia, was unable to make decisions appropriately, and had short and long-term memory loss. The Psychosocial Well Being CAA, dated 02/14/25, documented R5 was unable to describe her favorite activity, and family visited often. R5's Care Plan documented R5's preferred activities were devotions, bible study, group exercises, social events, and current events. The care plan directed staff to reminisce with R5 using photos of family and friends. The care plan documented R5 transferred with a full lift using a red-bordered high back sling and two staff. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/28/25 at 09:30 AM, R5 sat in her wheelchair in the activity room with five other wheelchair bound residents. There was no activity for R5 to enjoy. There was no staff in the room. R5's hair had not been combed that morning and was sticking up on end. There were dried yellow egg particles on R5's shirt and pants, probably from breakfast. There were dark brown food particles on the sides of R5's wheelchair that appeared to be days old. On 04/28/25 at 10:30 AM, R5 sat in the same position. Someone had placed hymnals to play on the iPad. No staff were in the room interacting with R5. R5 played with the arm protectors on her arms. On 04/28/25 at 11:00 AM, someone brought a cart into the activity room with cookies, tea, and coffee on it. Someone had given R5 a cookie, and R5 broke up the cookie and threw it on the floor. R5 went from 09:30 AM to lunchtime without anything to drink while in the activity room. On 04/28/25 at 01:20 PM, R5 sat in her wheelchair in a living area off the activity room by herself. No staff were interacting with R5. R5 continued to have clothes covered with dried yellow egg particles from breakfast. On 04/28/25 at 09:35 AM, Certified Nurse's Aide (CNA) M stated there were not enough CNAs working on the floor for the day shift or evening shift to make sure all resident cares were completed. CNA M stated that over half of the residents were full lifts or sit-to-stand lifts that required two staff, and by the time the staff got all the residents up, there was not enough time to take care of morning personal hygiene before breakfast. She knew that after breakfast, the wheelchair bound residents were brought into the activity room, and usually, some kind of activity would occur. On 04/28/25 at 10:00 AM, CNA N stated she was responsible for the restorative program. CNA N stated there was not enough staff to make sure the residents were cared for the way they were supposed to be. CNA N stated that when she first started at the facility, the facility was one of the best, and she recommended to her family to place family members who required care in the facility. CNA N stated that was not the case anymore, and her family was thinking about pulling her family members out of the facility. On 04/28/25 at 11:10 AM, CNA O stated there were not enough CNAs on shift to take care of the residents responsibly. CNA O stated that two CNAs on the floor to take care of all the residents did not leave any extra time to take care of personal hygiene for residents, and a lot of the time, when they finally got everyone out to breakfast, the food was cold. CNA O stated that just one extra CNA would make a world of difference. CNA O stated that the administrative staff never came out of their offices to assist with resident care. On 04/28/25 at 02:30 PM, Administrative Nurse D stated she had been fighting corporate on staffing for a while, and she would not drop her staffing numbers anymore. Administrative Nurse D stated she thought staffing was okay for staff to take care of the needs of the residents. Administrative Nurse D became emotionally upset when the resident's conditions and activity involvement were described to her. Administrative Nurse D stated she would expect the nursing staff to take care of all the residents' ADLs and personal hygiene needs and not leave them in the condition they were found in. Administrative Nurse D verified that over half of the fourteen residents required a full lift or sit-to-stand lift for transfers, which required two staff for the transfers. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/28/25 at 03:30 PM, Administrative Staff A stated she felt staffing was appropriate for the facility. Administrative Staff A stated she expected staff to make sure all the residents' needs were provided for to ensure the residents' dignity. The facility's Nursing Services Staff Policy, revised 10/29/24, documented the facility must have sufficient nursing staff with the appropriate competencies and skill set to provide nursing and related services to assure resident safety and maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and induvial plans of care and considering the number, acuity, and diagnoses of the facility's resident population. The facility must provide services with the sufficient number of staff to provide nursing care to all residents. - R6's EMR documented R6 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), major depressive disorder (major mood disorder which causes persistent feelings pf sadness), mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time), and anxiety(mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). R6's Quarterly MDS, dated 01/01/25, documented R6 had a BIMS score of three, which indicated severely impaired cognition. The MDS documented R6 was dependent on staff for most of her ADLs. The Cognitive Loss/Dementia CAA, dated 07/01/24, documented a cognitive deficit, short-term and long-term memory loss, and required assistance with decision-making. R6's Care Plan documented R6 would express satisfaction with activities and would come and go during morning activities, manicures, and parties/programs. The care plan directed staff R6 required a full lift with two staff assistance for transfer and bed mobility using the yellow bordered sling. R6's care plan documented R6 used a wheelchair for mobility and could propel short distances. The care plan directed staff R6 enjoyed watching sports on TV, enjoyed bingo, and liked social hour and group exercises. On 04/28/25 at 09:30 AM, R6 sat in her wheelchair in the activity room with five other wheelchair bound residents. There was no activity for R6 to enjoy. There was no staff in the room. R6's hair had not been combed that morning and was sticking up on end. There were dried yellow egg particles on R6's shirt and pants, probably from breakfast. There were dark brown food particles on the sides of R6's wheelchair that appeared to be days old. On 04/28/25 at 10:30 AM, R6 sat in the same position. Someone had placed hymnals to play on the iPad. No staff were in the room interacting with R6. R6 slept with her chin on her chest. On 04/28/25 at 09:35 AM, Certified Nurse ' s Aide (CNA) M stated there were not enough CNAs working on the floor for the day shift or evening shift to make sure all resident cares were completed. CNA M stated that over half of the residents were full lifts or sit-to-stand lifts that required two staff, and by the time the staff got all the residents up, there was not enough time to take care of morning personal hygiene before breakfast. CNA M stated she did not know about the activities for that morning. She knew that after breakfast, the wheelchair bound residents were brought into the activity room, and usually, some kind of activity would occur. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/28/25 at 10:00 AM, CNA N stated she was responsible for the restorative program. CNA N stated there was not enough staff to make sure the residents were cared for the way they were supposed to be. CNA N stated that when she first started at the facility, the facility was one of the best, and she recommended to her family to place family members who required care in the facility. CNA N stated that was not the case anymore, and her family was thinking about pulling her family members out of the facility. On 04/28/25 at 11:10 AM, CNA O stated there were not enough CNAs on shift to take care of the residents responsibly. CNA O stated two CNAs on the floor to take care of all the residents did not leave any extra time to take care of personal hygiene for residents, and a lot of the time, when they finally got everyone out to breakfast food was cold. CNA O stated just one extra CNA would make a world of difference. CNA O stated administrative staff never came out of their offices to assist with resident care. On 04/28/25 at 02:30 PM, Administrative Nurse D stated she had been fighting corporate on staffing for a while, and she would not drop her staffing numbers anymore. Administrative Nurse D stated she thought staffing was okay for staff to take care of the needs of the residents. Administrative Nurse D became emotionally upset when the resident's conditions and activity involvement were described to her. Administrative Nurse D stated she would expect the nursing staff to take care of all the residents' ADLs and personal hygiene needs and not leave them in the condition they were found in. Administrative Nurse D verified that over half of the fourteen residents required a full lift or sit-to-stand lift for transfers, which required two staff for the transfers. On 04/28/25 at 03:30 PM, Administrative Staff A stated she felt staffing was appropriate for the facility. Administrative Staff A stated she expected staff to make sure all the residents' needs were provided for to ensure the residents' dignity. The facility's Nursing Services Staff Policy, revised 10/29/24, documented the facility must have sufficient nursing staff with the appropriate competencies and skill set to provide nursing and related services to assure resident safety and maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and induvial plans of care and considering the number, acuity, and diagnoses of the facility's resident population. The facility must provide services with the sufficient number of staff to provide nursing care to all residents. - R7's EMR documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), failure to thrive, muscle weakness, and dysphagia (swallowing difficulty). R7's Annual MDS, dated 01/29/25, documented R7 had a BIMS score of 99. The MDS documented R7 had short-term and long-term memory problems and moderately impaired cognitive skills for daily decision making. The MDS documented R7 was dependent on staff for toileting, bathing, donning and doffing footwear, and personal hygiene. The MDS documented R7 required substantial/maximum assistance for dressing, transfer, and bed mobility. The Cognitive Loss/Dementia CAA, dated 01/29/25, documented R7 had dementia and short and long-term memory loss. The CAA documented R7's communication was slow, and R7 would often not respond; R7 could sit in silence for long periods. (continued on next page)

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	175356	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Decatur County	108 E Ash Street Oberlin, KS 67749

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R7's Care Plan directed staff to engage R7 in simple, structured activities that avoided overly demanding tasks such as sorting or folding and directed staff to reminisce with R7 using photos of family and friends (04/29/22). The care plan documented R7 had a self-care performance deficit and required extensive staff assistance for ADLs (05/18/22). The care plan directed staff R7's preferred activities were devotions, bingo, watching TV, and visits (11/07/23). The care plan directed staff to turn on R7's TV in her room when R7 chose not to participate in organized activities 11/07/23). On 04/28/25 at 09:35 AM, observation revealed R7 sat in a recliner in her room with the lights off and the TV off. R7 leaned clear to the recliner's left and over the side. R7's water pitcher was too far away for her to reach to get a drink of water. R7's hair was standing up on end, and her clothes appeared to have been slept in. On 04/28/25 at 10:35 AM, observation revealed, R7 sat in the same position as previously. R7 did not have any activities going on in her room to enjoy. On 04/28/25 at 11:15 AM, R7 continued to sit in the same position; continued to lean clear to the left side of her chair, over the armrest, in an uncomfortable position. On 04/28/25 at 09:35 AM, Certified Nurse's Aide (CNA) M stated there were not enough CNAs working on the floor for the day shift or evening shift to make sure all resident cares were completed. CNA M stated that over half of the residents were full lifts or sit-to-stand lifts that required two staff, and by the time the staff got all the residents up, there was not enough time to take care of morning personal hygiene before breakfast. On [TRUNCATED]

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. The facility identified a census of 14 residents, with five residents reviewed for resident rights, activities, staffing, and Activities of Daily Living (ADL). Based on record review, observation, and interview, the facility failed to provide Resident (R) 2, R3, R4, R5, R6, and R7 with appropriate ADL care for each resident to maintain a dignified existence and quality of life to maintain the highest practicable physical, mental, and psychosocial wellbeing. This deficient practice placed R2, R3, R4, R5, R6, and R7 at risk for an undignified existence and a decline in their mental and psychosocial well-being. (Refer to F725) Findings included: - R2's Electronic Medical Record (EMR) documented R2 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). R2's Quarterly Minimum Data Set (MDS), dated 03/01/25, documented R2 had a Brief Interview for Mental Status score of 99. The MDS documented R2 had short and long-term memory loss, and R2 was severely cognitively impaired. The MDS documented R2 was dependent on the staff for completing all of her activities of daily living (ADL). The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 08/29/24, documented R2 had a diagnosis of dementia, had memory loss, and required a proxy for health care decisions. The Behavioral Symptom CAA, dated 08/29/24, documented R2 had behaviors of physical aggression towards staff during cares, which placed R2 at risk for injury. R2's Care Plan directed staff to engage R2 in simple, structured activities that were not demanding (09/27/23). The care plan directed staff to ensure R2 wore a bra daily and to smooth her shirt so it was not wrinkled (03/18/25). The care plan directed staff to transfer R2 with a full lift with two staff assistance using the high-backed yellow sling (10/04/24). The care plan directed staff to provide weekly one-on-one visits and manicures, and R2's preferred activities were hymns and devotions (09/27/23). On 04/28/25 at 09:30 AM, observation revealed R2 sat in the activity room after breakfast in her wheelchair with a yellow high-backed lift sling under her. R2's hair had not been combed and was mussed. R2 had dried yellow and brown food particles on the sides of her wheelchair that appeared days old. R2's blouse was wrinkled. There was no staff in the activity room, and there was no activity for R2 to enjoy. R2 sat and either looked around the room at the five other residents sitting with her or slept in her wheelchair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/28/25 at 10:30 AM, R2 sat in the same position. Someone had placed hymnals to play on the iPad. No staff were in the room interacting with R2. R2 slept with her head tilted to her right shoulder. On 04/28/25 at 11:00 AM, someone had brought a cart into the activity room that had cookies, tea, and coffee on it. No one had served R2 a drink or snack. R2 went from 09:30 AM to lunchtime without anything to drink while in the activity room. On 04/28/25 at 01:30 PM, observation revealed Certified Nurse's Aide (CNA) M rolled R2 back and forth in bed by herself to provide R2 incontinent care. R2 grabbed CNA M's hands and arms to try and stop her. After CNA M left the room, observation revealed R2 had a dark brown food ring around her mouth that had not been cleaned from lunch. On 04/28/25 at 09:35 AM, Certified Nurse's Aide (CNA) M stated there were not enough CNAs working on the floor for the day shift or evening shift to make sure all resident cares were completed. CNA M stated that over half of the residents were full lifts or sit-to-stand lifts that required two staff, and by the time the staff got all the residents up, there was not enough time to take care of morning personal hygiene before breakfast. CNA M stated she did not know about the activities for that morning. She knew that after breakfast, the wheelchair bound residents were brought into the activity room, and usually, some kind of activity would occur. On 04/28/25 at 10:00 AM, CNA N stated she was responsible for the restorative program. CNA N stated there was not enough staff to make sure the residents were cared for the way they were supposed to be. CNA N stated that when she first started at the facility, the facility was one of the best, and she recommended to her family to place family members who required care in the facility. CNA N stated that it was not the case anymore, and her family was thinking about pulling her family members out of the facility. CNA N stated that there were times when the activity staff was gone, she would cover for her, but she was not aware that there was no activity staff on duty for the day. CNA N stated that overall, the activities were subpar. On 04/28/25 at 11:10 AM, CNA O stated there were not enough CNAs on shift to take care of the residents responsibly. CNA O stated that two CNAs on the floor to take care of all the residents did not leave any extra time to take care of personal hygiene for residents, and a lot of the time, when they finally got everyone out to breakfast food was cold. CNA O stated that just one extra CNA would make a world of difference. CNA O stated administrative staff never came out of their offices to assist with resident care. CNA O stated she did not know anything about activities. On 04/28/25 at 01:30 PM, Activities Staff/Social Services Staff Z stated she was in charge of activities and social services and was allowed three and a half hours a day for each position. Activities Staff Z stated she was gone on Friday and today but had a replacement staff member covering for her activities. It was explained to Activities Staff Z that there was no observed staff who took her place that day. Activities Staff Z stated that a normal morning would be for devotions to be read to residents, hymnals played for residents, an exercise group, and a social hour group. Activities Staff Z stated a folding group was also on the schedule for residents who like to fold clothing protectors, but Activity Staff Z stated a lot of those residents had passed on. Activities Staff Z stated she did not make changes to the activity schedule often. Activity Staff Z stated a Catholic priest was scheduled to come into the facility to meet with Catholic residents, but would not come into the facility and had not since COVID. Activity Staff Z stated the Catholic priest was hard to talk to and admitted she had not tried to get anyone but the local pastor to come in for the spirituality of the residents, and admitted the Catholic residents would not want to meet with him. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/28/25 at 02:30 PM, Administrative Nurse D stated she had been fighting corporate on staffing for a while, and she would not drop her staffing numbers anymore. Administrative Nurse D stated she thought staffing was okay for staff to take care of the needs of the residents. Administrative Nurse D became emotionally upset when the resident's conditions and activity involvement were described to her. Administrative Nurse D stated she would expect the nursing staff to take care of all the residents' ADLs and personal hygiene needs and not leave them in the condition they were found in. Administrative Nurse D verified that over half of the fourteen residents required a full lift or sit-to-stand lift for transfers, which required two staff for the transfers. Administrative Nurse D stated she was not aware Activity Staff Z was going to be gone today. Administrative Nurse D admitted that the activities provided to the residents were old, redundant, and the activity calendar was rarely changed to meet residents' activity needs. On 04/28/25 at 03:30 PM, Administrative Staff A stated she felt staffing was appropriate for the facility. Administrative Staff A stated she expected staff to make sure all the residents' needs were provided for to ensure the residents' dignity. Administrative Staff A verified that not all the activities on the activity calendar met all of the residents' needs for activity. The facility's Nursing Services Staff Policy, revised 10/29/24, documented the facility must have sufficient nursing staff with the appropriate competencies and skill set to provide nursing and related services to assure resident safety and maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and induvial plans of care and considering the number, acuity, and diagnoses of the facility's resident population. The facility must provide services with the sufficient number of staff to provide nursing care to all residents. - R3's EMR documented R3 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R3's Quarterly Minimum Data Set (MDS), dated 03/05/25, documented R3 was rarely/never understood. The MDS documented R3 had short-term and long-term memory loss and had severely impaired cognition. The MDS documented R3 was dependent on staff for all of her activities of daily living (ADL). The MDS documented R3 had physical and verbal behaviors directed towards others for four to six days during the look-back period. R3's Cognitive Loss/Dementia Care Area Assessment (CAA), dated 12/03/24, documented R3 had diagnoses of dementia and Alzheimer's disease and was severely cognitively impaired. The Psychosocial Well-Being CAA, dated 12/03/25, documented R3 was no longer able to tell of her favorite activity. The CAA documented that R3 received family visits one to two times a week and would attend morning devotions. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's Care Plan directed staff to reminisce with R3 using photos of family and friends (06/15/22). R3's care plan directed staff R3 preferred to have makeup and perfume on every day (12/08/23). R3's care plan directed R3 required two staff to transfer her with a sit-to-stand lift with the green bordered lift sling. R3's care plan directed staff to assist R3 out of bed at 04:00 PM every day and place R3 in front of the TV (07/14/23), provide weekly one on one visits (12/15/20), and offer weekly visits with the chaplain/attends Catholic mass (12/08/23), and invite and remind R3 of scheduled activities and assist as needed (12/15/20). On 04/28/25 at 09:30 AM, R3 sat in her wheelchair in the activity room with five other wheelchair bound residents. There was no activity for R3 to enjoy. There was no staff in the room. R3's hair had not been combed that morning and was sticking up on end. R3 did not have a bra on, and her left breast and nipple were showing through the blouse she had on. R3 did not have any makeup on. There were dark brown food particles on the sides of R3's wheelchair that appeared to be days old. On 04/28/25 at 10:30 AM, R3 sat in the same position. Someone had placed hymnals to play on the iPad. No staff were in the room interacting with R3. R3 slept with her chin on her chest. On 04/28/25 at 11:00 AM, someone brought a cart into the activity room with cookies, tea, and coffee on it. No one had served R3 a drink or snack. R3 went from 09:30 AM to lunchtime without anything to drink while in the activity room. On 04/28/25 at 01:30 PM, observation revealed CNA N rolled R3 back and forth in bed by herself to provide R3 incontinent care. After CNA N left the room, observation revealed R3 had a dark brown food ring around her mouth that had not been cleaned from lunch. On 04/28/25 at 09:35 AM, Certified Nurse's Aide (CNA) M stated there were not enough CNAs working on the floor for the day shift or evening shift to make sure all resident cares were completed. CNA M stated that over half of the residents were full lifts or sit-to-stand lifts that required two staff, and by the time the staff got all the residents up, there was not enough time to take care of morning personal hygiene before breakfast. CNA M stated she did not know about the activities for that morning. She knew that after breakfast, the wheelchair bound residents were brought into the activity room, and usually, some kind of activity would occur. On 04/28/25 at 10:00 AM, CNA N stated she was responsible for the restorative program. CNA N stated there was not enough staff to make sure the residents were cared for the way they were supposed to be. CNA N stated that when she first started at the facility, the facility was one of the best, and she recommended to her family to place family members who required care in the facility. CNA N stated that it was not the case anymore, and her family was thinking about pulling her family members out of the facility. CNA N stated that there were times when the activity staff was gone, she would cover for her, but she was not aware that there was no activity staff on duty for the day. CNA N stated that overall, the activities were subpar. On 04/28/25 at 11:10 AM, CNA O stated there were not enough CNAs on shift to take care of the residents responsibly. CNA O stated that two CNAs on the floor to take care of all the residents did not leave any extra time to take care of personal hygiene for residents, and a lot of the time, when they finally got everyone out to breakfast food was cold. CNA O stated that just one extra CNA would make a world of difference. CNA O stated administrative staff never came out of their offices to assist with resident care. CNA O stated she did not know anything about activities. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/28/25 at 01:30 PM, Activities Staff/Social Services Staff Z stated she was in charge of activities and social services and was allowed three and a half hours a day for each position. Activities Staff Z stated she was gone on Friday and today, but had a replacement staff member covering for her activities. It was explained to Activities Staff Z that there was no observed staff who took her place that day. Activities Staff Z stated that a normal morning would be for devotions to be read to residents, hymnals played for residents, an exercise group, and a social hour group. Activities Staff Z stated a folding group was also on the schedule for residents who like to fold clothing protectors, but Activity Staff Z stated a lot of those residents had passed on. Activities Staff Z stated she did not make changes to the activity schedule often. Activity Staff Z stated a Catholic priest was scheduled to come into the facility to meet with Catholic residents, but would not come into the facility and had not since COVID. Activity Staff Z stated the Catholic priest was hard to talk to and admitted she had not tried to get anyone but the local pastor to come in for the spirituality of the residents, and admitted the Catholic residents would not want to meet with him. On 04/28/25 at 02:30 PM, Administrative Nurse D stated she had been fighting corporate on staffing for a while, and she would not drop her staffing numbers anymore. Administrative Nurse D stated she thought staffing was okay for staff to take care of the needs of the residents. Administrative Nurse D became emotionally upset when the resident's conditions and activity involvement were described to her. Administrative Nurse D stated she would expect the nursing staff to take care of all the residents' ADLs and personal hygiene needs and not leave them in the condition they were found in. Administrative Nurse D verified that over half of the fourteen residents required a full lift or sit-to-stand lift for transfers, which required two staff for the transfers. Administrative Nurse D stated she was not aware Activity Staff Z was going to be gone today. Administrative Nurse D admitted that the activities provided to the residents were old, redundant, and the activity calendar was rarely changed to meet residents' activity needs. On 04/28/25 at 03:30 PM, Administrative Staff A stated she felt staffing was appropriate for the facility. Administrative Staff A stated she expected staff to make sure all the residents' needs were provided for to ensure the residents' dignity. Administrative Staff A verified that not all the activities on the activity calendar met all of the residents' needs for activity. The facility's Nursing Services Staff Policy, revised 10/29/24, documented the facility must have sufficient nursing staff with the appropriate competencies and skill set to provide nursing and related services to assure resident safety and maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and induvial plans of care and considering the number, acuity, and diagnoses of the facility's resident population. The facility must provide services with the sufficient number of staff to provide nursing care to all residents. - R4's EMR documented R4 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), non-traumatic brain dysfunction (damage to the brain that does not result from an external force, such as a fall or accident), need for assistance with personal care, edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and abnormalities of gait and mobility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Quarterly Minimum Data Set (MDS), dated 01/07/25, documented R4 had a BIMS score of three, which indicated severely impaired cognition. The MDS documented R4 was dependent on staff for toileting, bathing, and transfer. The MDS documented R4 required maximum/substantial assistance from staff for ambulation, dressing, and bed mobility. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 07/07/24, documented R4 had dementia, memory problems, and required assistance with decision making. The Psychosocial Well Being CAA, dated 07/07/24, documented R4 had been a farmer his whole life and rarely socialized. R4's brother visited a few times a week, otherwise, there was no family involvement. R4's Care Plan directed staff R4 preferred to get up and 07:00 AM, eat breakfast, watch TV, and would like to attend morning activities (03/14/25). The care plan directed R4 required a sit-to-stand lift utilizing the yellow bordered sling with two staff assist for transfers and a wheelchair for mobility (02/27/25). On 04/28/25 at 08:45 AM, observation revealed R4 sat in his wheelchair at a table with breakfast in front of him. R4 sat with his head down, his chin on his chest. R4's pants were stained with food particles, his button-down shirt only had two buttons buttoned, and showed a large portion of his chest and stomach. R4's shirt had a large, old orange stain on the cuff. R4 had coughed up some yellow, bloody phlegm on his shirt. On 04/28/25 at 09:30 AM, R4 sat in his wheelchair in the activity room with five other wheelchair bound residents. There was no activity for R4 to enjoy. There was no staff in the room. R4's wheelchair had dark brown dried food particles on the sides of his wheelchair that appeared to have been there for days. On 04/28/25 at 10:30 AM, R4 sat in the same position. Someone had placed hymnals to play on the iPad. No staff were in the room interacting with R4. R4 wrung his hands and played with his fingers. On 04/28/25 at 11:00 AM, someone brought a cart into the activity room with cookies, tea, and coffee on it. No one had served R4 a drink or snack. R4 went from 09:30 AM to lunchtime without anything to drink while in the activity room. On 04/28/25 at 01:40 PM, R4 sat in his wheelchair in his room. The TV was not on, and R4 looked around his room. R4 continued to be in stained, unclean clothing with the large yellow, bloody phlegm on the front of his shirt. On 04/28/25 at 09:35 AM, Certified Nurse's Aide (CNA) M stated there were not enough CNAs working on the floor for the day shift or evening shift to make sure all resident cares were completed. CNA M stated that over half of the residents were full lifts or sit-to-stand lifts that required two staff, and by the time the staff got all the residents up, there was not enough time to take care of morning personal hygiene before breakfast. CNA M stated she did not know about the activities for that morning. She knew that after breakfast, the wheelchair bound residents were brought into the activity room, and usually, some kind of activity would occur. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/28/25 at 10:00 AM, CNA N stated she was responsible for the restorative program. CNA N stated there was not enough staff to make sure the residents were cared for the way they were supposed to be. CNA N stated that when she first started at the facility, the facility was one of the best, and she recommended to her family to place family members who required care in the facility. CNA N stated that it was not the case anymore, and her family was thinking about pulling her family members out of the facility. CNA N stated there were times when the activity staff was gone; she would cover for her, but she was not aware that there was no activity staff on duty for the day. CNA N stated that overall, the activities were subpar. On 04/28/25 at 11:10 AM, CNA O stated there were not enough CNAs on shift to take care of the residents responsibly. CNA O stated that two CNAs on the floor to take care of all the residents did not leave any extra time to take care of personal hygiene for residents, and a lot of the time, when they finally got everyone out to breakfast food was cold. CNA O stated that just one extra CNA would make a world of difference. CNA O stated administrative staff never came out of their offices to assist with resident care. CNA O stated she did not know anything about activities. On 04/28/25 at 01:30 PM, Activities Staff/Social Services Staff Z stated she was in charge of activities and social services and was allowed three and a half hours a day for each position. Activities Staff Z stated she was gone on Friday and today, but had a replacement staff member covering for her activities. It was explained to Activities Staff Z that there was no observed staff who took her place that day. Activities Staff Z stated that a normal morning would be for devotions to be read to residents, hymnals played for residents, an exercise group, and a social hour group. Activities Staff Z stated a folding group was also on the schedule for residents who like to fold clothing protectors, but Activity Staff Z stated a lot of those residents had passed on. Activities Staff Z stated she did not make changes to the activity schedule often. Activity Staff Z stated a Catholic priest was scheduled to come into the facility to meet with Catholic residents, but would not come into the facility and had not since COVID. Activity Staff Z stated the Catholic priest was hard to talk to and admitted she had not tried to get anyone but the local pastor to come in for the spirituality of the residents, and admitted the Catholic residents would not want to meet with him. On 04/28/25 at 02:30 PM, Administrative Nurse D stated she had been fighting corporate on staffing for a while, and she would not drop her staffing numbers anymore. Administrative Nurse D stated she thought staffing was okay for staff to take care of the needs of the residents. Administrative Nurse D became emotionally upset when the resident's conditions and activity involvement were described to her. Administrative Nurse D stated she would expect the nursing staff to take care of all the residents' ADLs and personal hygiene needs and not leave them in the condition they were found in. Administrative Nurse D verified that over half of the fourteen residents required a full lift or sit-to-stand lift for transfers, which required two staff for the transfers. Administrative Nurse D stated she was not aware Activity Staff Z was going to be gone today. Administrative Nurse D admitted that the activities provided to the residents were old, redundant, and the activity calendar was rarely changed to meet residents' activity needs. On 04/28/25 at 03:30 PM, Administrative Staff A stated she felt staffing was appropriate for the facility. Administrative Staff A stated she expected staff to make sure all the residents' needs were provided for to ensure the residents' dignity. Administrative Staff A verified that not all the activities on the activity calendar met all the residents' needs for activity. (continued on next page)

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	175356	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Decatur County	108 E Ash Street Oberlin, KS 67749

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Nursing Services Staff Policy, revised 10/29/24, documented the facility must have sufficient nursing staff with the appropriate competencies and skill set to provide nursing and related services to assure resident safety and maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and induvial plans of care and considering the number, acuity, and diagnoses of the facility's resident population. The facility must provide services with the sufficient number of staff to provide nursing care to all residents. - R5's EMR documented R5 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), atrial fibrillation (rapid, irregular heartbeat), and a history of falling. R5's Annual MDS, dated 02/14/25, documented R5 had a BIMS score of 99, R5 had short and long-term memory deficits, and R5 made poor decisions and required supervision. The MDS documented R5 was dependent on staff for all of her ADLs. The Cognitive Loss/Dementia CAA, dated 02/14/25, documented R5 had dementia, was unable to make decisions appropriately, and had short and long-term memory loss. The Psychosocial Well Being CAA, dated 02/14/25, documented R5 was unable to describe her favorite activity, and family visited often. R5's Care Plan documented R5's preferred activities were devotions, bible study, group exercises, social events, and current events. The care plan directed staff to reminisce with R5 using photos of family and friends. The care plan documented R5 transferred with a full lift using a red-bordered high back sling and two staff. On 04/28/25 at 09:30 AM, R5 sat in her wheelchair in the activity room with five other wheelchair bound residents. There was no activity for R5 to enjoy. There was no staff in the room. R5's hair had not been combed that morning and was sticking up on end. There were dried yellow egg particles on R5's shirt and pants, probably from breakfast. There were dark brown food particles on the sides of R5's wheelchair that appeared to be days old. On 04/28/25 at 10:30 AM, R5 sat in the same position. Someone had placed hymnals to play on the iPad. No staff were in the room interacting with R5. R5 played with the arm protectors on her arms. On 04/28/25 at 11:00 AM, someone brought a cart into the activity room with cookies, tea, and coffee on it. Someone had given R5 a cookie, and R5 broke up the cookie and threw it on the floor. R5 went from 09:30 AM to lunchtime without anything to drink while in the activity room. On 04/28/25 at 01:20 PM, R5 sat in her wheelchair in a living area off the activity room by herself. No staff were interacting with R5. R5 continued to have clothes covered with dried yellow egg particles from breakfast. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/28/25 at 09:35 AM, Certified Nurse's Aide (CNA) M stated there were not enough CNAs working on the floor for the day shift or evening shift to make sure all resident cares were completed. CNA M stated that over half of the residents were full lifts or sit-to-stand lifts that required two staff, and by the time the staff got all the residents up, there was not enough time to take care of morning personal hygiene before breakfast. CNA M stated she did not know about the activities for that morning. She knew that after breakfast, the wheelchair bound residents were brought into the activity room, and usually, some kind of activity would occur. On 04/28/25 at 10:00 AM, CNA N stated she was responsible for the restorative program. CNA N stated there was not enough staff to make sure the residents were cared for the way they were supposed to be. CNA N stated that when she first started at the facility, the facility was one of the best, and she recommended to her family to place family members who required care in the facility. CNA N stated that it was not the case anymore, and her family was thinking about pulling her family members out of the facility. CNA N stated that there were times when the activity staff was gone, she would cover for her, but she was not aware that there was no activity staff on duty for the day. CNA N stated that overall, the activities were subpar. On 04/28/25 at 11:10 AM, CNA O stated there were not enough CNAs on shift to take care of the residents responsibly. CNA O stated that two CNAs on the floor to take care of all the residents did not leave any extra time to take care of personal hygiene for residents, and a lot of the time, when they finally got everyone out to breakfast food was cold. CNA O stated that just one extra CNA would make a world of difference. CNA O stated administrative staff never came out of their offices to assist with resident care. CNA O stated she did not know anything about activities. On 04/28/25 at 01:30 PM, Activities Staff/Social Services Staff Z stated she was in charge of activities and social services and was allowed three and a half hours a day for each position. Activities Staff Z stated she was gone on Friday and today but had a replacement staff member covering for her activities. It was explained to Activities Staff Z that there was no observed staff who took her place that day. Activities Staff Z stated that a normal morning would be for devotions to be read to residents, hymnals played for residents, an exercise group, and a social hour group. Activities Staff Z stated a folding group was also on the schedule for residents who like to fold clothing protectors, but Activity Staff Z stated a lot of those residents had passed on. Activities Staff Z stated she did not make changes to the activity schedule often. Activity Staff Z stated a Catholic priest was scheduled to come into the facility to meet with Catholic residents, but would not come into the facility and had not since COVID. Activity Staff Z stated the Catholic priest was hard to talk to and admitted she had not tried to get anyone but the local pastor to come in for the spirituality of the residents, and admitted the Catholic residents would not want to meet with him. On 04/28/25 at 02:30 PM, Administrative Nurse D stated she had been fighting corporate on staffing for a while, and she would not drop her staffing numbers anymore. Administrative Nurse D stated she thought staffing was okay for staff to take care of the needs of the residents. Administrative Nurse D became emotionally upset when the resident's conditions and activity involvement were described to her. Administrative Nurse D stated she would expect the nursing staff to take care of all the residents' ADLs and personal hygiene needs and not leave them in the condition they were found in. Administrative Nurse D verified that over half of the fourteen residents required a full lift or sit-to-stand lift for transfers, which required two staff for the transfers. Administrative Nurse D stated she was not aware Activity Staff Z was going to be gone today. Administrative Nurse D admitted that the activities provided [TRUNCATED]

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. The facility identified a census of 14 residents, with five residents reviewed for resident rights, activities, staffing, and Activities of Daily Living (ADL). Based on record review, observation, and interview, the facility failed to provide Resident (R) 2, R3, R4, R5, R6, and R7 with a resident-centered activities program that incorporated the resident's interests, hobbies, and cultural preferences to maintain or improve the resident's physical, mental, and psychosocial well-being. This deficient practice placed R2, R3, R4, R5, R6, and R7 at risk for decline in meaningful interaction, meaningful activities, and psychosocial well-being. Findings included: - R2's Electronic Medical Record (EMR) documented R2 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). R2's Quarterly Minimum Data Set (MDS), dated 03/01/25, documented R2 had a Brief Interview for Mental Status score of 99. The MDS documented R2 had short and long-term memory loss, and R2 was severely cognitively impaired. The MDS documented R2 was dependent on the staff for completing all of her activities of daily living (ADL). The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 08/29/24, documented R2 had a diagnosis of dementia, had memory loss, and required a proxy for health care decisions. The Behavioral Symptom CAA, dated 08/29/24, documented R2 had behaviors of physical aggression towards staff during cares, which placed R2 at risk for injury. R2's Care Plan directed staff to engage R2 in simple, structured activities that were not demanding (09/27/23). The care plan directed staff to ensure R2 wore a bra daily and to smooth her shirt so it was not wrinkled (03/18/25). The care plan directed staff to transfer R2 with a full lift with two staff assistance using the high-backed yellow sling (10/04/24). The care plan directed staff to provide weekly one-on-one visits and manicures, and R2's preferred activities were hymns and devotions (09/27/23). On 04/28/25 at 09:30 AM, observation revealed R2 sat in the activity room after breakfast in her wheelchair with a yellow high-backed lift sling under her. R2's hair had not been combed and was mussed. R2 had dried yellow and brown food particles on the sides of her wheelchair that appeared to be days old. R2's blouse was wrinkled. There was no staff in the activity room, and there was no activity for R2 to enjoy. R2 sat and either looked around the room at the five other residents sitting with her or slept in her wheelchair. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/28/25 at 10:30 AM, R2 sat in the same position. Someone had placed hymnals to play on the iPad. No staff were in the room interacting with R2. R2 slept with her head tilted to her right shoulder. On 04/28/25 at 11:00 AM, someone had brought a cart into the activity room that had cookies, tea, and coffee on it. No one had served R2 a drink or snack. R2 went from 09:30 AM to lunchtime without anything to drink while in the activity room. On 04/28/25 at 01:30 PM, observation revealed Certified Nurse's Aide (CNA) M rolled R2 back and forth in bed by herself to provide R2 incontinent care. R2 grabbed CNA M's hands and arms to try and stop her. After CNA M left the room, observation revealed R2 had a dark brown food ring around her mouth that had not been cleaned from lunch. On 04/28/25 at 09:35 AM, Certified Nurse's Aide (CNA) M stated there were not enough CNAs working on the floor for the day shift or evening shift to make sure all resident cares were completed. CNA M stated that over half of the residents were full lifts or sit-to-stand lifts that required two staff, and by the time the staff got all the residents up, there was not enough time to take care of morning personal hygiene before breakfast. CNA M stated she did not know about the activities for that morning. She knew that after breakfast, the wheelchair bound residents were brought into the activity room, and usually, some kind of activity would occur. On 04/28/25 at 10:00 AM, CNA N stated she was responsible for the restorative program. CNA N stated there was not enough staff to make sure the residents were cared for the way they were supposed to be. CNA N stated that when she first started at the facility, the facility was one of the best, and she recommended to her family to place family members who required care in the facility. CNA N stated that was not the case anymore, and her family was thinking about pulling her family members out of the facility. CNA N stated that there were times when the activity staff was gone, she would cover for her, but she was not aware that there was no activity staff on duty for the day. CNA N stated that overall, the activities were subpar. On 04/28/25 at 11:10 AM, CNA O stated there were not enough CNAs on shift to take care of the residents responsibly. CNA O stated that two CNAs on the floor to take care of all the residents did not leave any extra time to take care of personal hygiene for residents, and a lot of the time, when they finally got everyone out to breakfast food was cold. CNA O stated that just one extra CNA would make a world of difference. CNA O stated administrative staff never came out of their offices to assist with resident care. CNA O stated she did not know anything about activities. On 04/28/25 at 01:30 PM, Activities Staff/Social Services Staff Z stated she was in charge of activities and social services and was allowed three and a half hours a day for each position. Activities Staff Z stated she was gone on Friday and today, but had a replacement staff member covering for her activities. It was explained to Activities Staff Z that there was no observed staff who took her place that day. Activities Staff Z stated that a normal morning would be for devotions to be read to residents, hymnals played for residents, an exercise group, and a social hour group. Activities Staff Z stated a folding group was also on the schedule for residents who like to fold clothing protectors, but Activity Staff Z stated a lot of those residents had passed on. Activities Staff Z stated she did not make changes to the activity schedule often. Activity Staff Z stated a Catholic priest was scheduled to come into the facility to meet with Catholic residents, but would not come into the facility and had not since COVID. Activity Staff Z stated the Catholic priest was hard to talk to and admitted she had not tried to get anyone but the local pastor to come in for the spirituality of the residents, and admitted the Catholic residents would not want to meet with him. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/28/25 at 02:30 PM, Administrative Nurse D stated she had been fighting corporate on staffing for a while, and she would not drop her staffing numbers anymore. Administrative Nurse D stated she thought staffing was okay for staff to take care of the needs of the residents. Administrative Nurse D became emotionally upset when the resident's conditions and activity involvement were described to her. Administrative Nurse D stated she would expect the nursing staff to take care of all the residents' ADLs and personal hygiene needs and not leave them in the condition they were found in. Administrative Nurse D verified that over half of the fourteen residents required a full lift or sit-to-stand lift for transfers, which required two staff for the transfers. Administrative Nurse D stated she was not aware Activity Staff Z was going to be gone today. Administrative Nurse D admitted that the activities provided to the residents were old, redundant, and the activity calendar was rarely changed to meet residents' activity needs. On 04/28/25 at 03:30 PM, Administrative Staff A stated she felt staffing was appropriate for the facility. Administrative Staff A stated she expected staff to make sure all the residents' needs were provided for to ensure the residents' dignity. Administrative Staff A verified that not all the activities on the activity calendar met all of the residents' needs for activity. The facility's Nursing Services Staff Policy, revised 10/29/24, documented the facility must have sufficient nursing staff with the appropriate competencies and skill set to provide nursing and related services to assure resident safety and maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and induvial plans of care and considering the number, acuity, and diagnoses of the facility's resident population. The facility must provide services with the sufficient number of staff to provide nursing care to all residents. - R3's EMR documented R3 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R3's Quarterly Minimum Data Set (MDS), dated 03/05/25, documented R3 was rarely/never understood. The MDS documented R3 had short-term and long-term memory loss and had severely impaired cognition. The MDS documented R3 was dependent on staff for all of her activities of daily living (ADL). The MDS documented R3 had physical and verbal behaviors directed towards others for four to six days during the look-back period. R3's Cognitive Loss/Dementia Care Area Assessment (CAA), dated 12/03/24, documented R3 had diagnoses of dementia and Alzheimer's disease and was severely cognitively impaired. The Psychosocial Well-Being CAA, dated 12/03/25, documented R3 was no longer able to tell of her favorite activity. The CAA documented that R3 received family visits one to two times a week and would attend morning devotions. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's Care Plan directed staff to reminisce with R3 using photos of family and friends (06/15/22). R3's care plan directed staff R3 preferred to have makeup and perfume on every day (12/08/23). R3's care plan directed R3 required two staff to transfer her with a sit-to-stand lift with the green bordered lift sling. R3's care plan directed staff to assist R3 out of bed at 04:00 PM every day and place R3 in front of the TV (07/14/23), provide weekly one on one visits (12/15/20), and offer weekly visits with the chaplain/attends Catholic mass (12/08/23), and invite and remind R3 of scheduled activities and assist as needed (12/15/20). On 04/28/25 at 09:30 AM, R3 sat in her wheelchair in the activity room with five other wheelchair bound residents. There was no activity for R3 to enjoy. There was no staff in the room. R3's hair had not been combed that morning and was sticking up on end. R3 did not have a bra on, and her left breast and nipple were showing through the blouse she had on. R3 did not have any makeup on. There were dark brown food particles on the sides of R3's wheelchair that appeared to be days old. On 04/28/25 at 10:30 AM, R3 sat in the same position. Someone had placed hymnals to play on the iPad. No staff were in the room interacting with R3. R3 slept with her chin on her chest. On 04/28/25 at 11:00 AM, someone brought a cart into the activity room with cookies, tea, and coffee on it. No one had served R3 a drink or snack. R3 went from 09:30 AM to lunchtime without anything to drink while in the activity room. On 04/28/25 at 01:30 PM, observation revealed CNA N rolled R3 back and forth in bed by herself to provide R3 incontinent care. After CNA N left the room, observation revealed R3 had a dark brown food ring around her mouth that had not been cleaned from lunch. On 04/28/25 at 09:35 AM, Certified Nurse's Aide (CNA) M stated there were not enough CNAs working on the floor for the day shift or evening shift to make sure all resident cares were completed. CNA M stated that over half of the residents were full lifts or sit-to-stand lifts that required two staff, and by the time the staff got all the residents up, there was not enough time to take care of morning personal hygiene before breakfast. CNA M stated she did not know about the activities for that morning. She knew that after breakfast, the wheelchair bound residents were brought into the activity room, and usually, some kind of activity would occur. On 04/28/25 at 10:00 AM, CNA N stated she was responsible for the restorative program. CNA N stated there was not enough staff to make sure the residents were cared for the way they were supposed to be. CNA N stated that when she first started at the facility, the facility was one of the best, and she recommended to her family to place family members who required care in the facility. CNA N stated that was not the case anymore, and her family was thinking about pulling her family members out of the facility. CNA N stated that there were times when the activity staff was gone, she would cover for her, but she was not aware that there was no activity staff on duty for the day. CNA N stated that overall, the activities were subpar. On 04/28/25 at 11:10 AM, CNA O stated there were not enough CNAs on shift to take care of the residents responsibly. CNA O stated that two CNAs on the floor to take care of all the residents did not leave any extra time to take care of personal hygiene for residents, and a lot of the time, when they finally got everyone out to breakfast food was cold. CNA O stated that just one extra CNA would make a world of difference. CNA O stated administrative staff never came out of their offices to assist with resident care. CNA O stated she did not know anything about activities. (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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/28/25 at 01:30 PM, Activities Staff/Social Services Staff Z stated she was in charge of activities and social services and was allowed three and a half hours a day for each position. Activities Staff Z stated she was gone on Friday and today, but had a replacement staff member covering for her activities. It was explained to Activities Staff Z that there was no observed staff who took her place that day. Activities Staff Z stated that a normal morning would be for devotions to be read to residents, hymnals played for residents, an exercise group, and a social hour group. Activities Staff Z stated a folding group was also on the schedule for residents who like to fold clothing protectors, but Activity Staff Z stated a lot of those residents had passed on. Activities Staff Z stated she did not make changes to the activity schedule often. Activity Staff Z stated a Catholic priest was scheduled to come into the facility to meet with Catholic residents, but would not come into the facility and had not since COVID. Activity Staff Z stated the Catholic priest was hard to talk to and admitted she had not tried to get anyone but the local pastor to come in for the spirituality of the residents, and admitted the Catholic residents would not want to meet with him. On 04/28/25 at 02:30 PM, Administrative Nurse D stated she had been fighting corporate on staffing for a while, and she would not drop her staffing numbers anymore. Administrative Nurse D stated she thought staffing was okay for staff to take care of the needs of the residents. Administrative Nurse D became emotionally upset when the resident's conditions and activity involvement were described to her. Administrative Nurse D stated she would expect the nursing staff to take care of all the residents' ADLs and personal hygiene needs and not leave them in the condition they were found in. Administrative Nurse D verified that over half of the fourteen residents required a full lift or sit-to-stand lift for transfers, which required two staff for the transfers. Administrative Nurse D stated she was not aware Activity Staff Z was going to be gone today. Administrative Nurse D admitted that the activities provided to the residents were old, redundant, and the activity calendar was rarely changed to meet residents' activity needs. On 04/28/25 at 03:30 PM, Administrative Staff A stated she felt staffing was appropriate for the facility. Administrative Staff A stated she expected staff to make sure all the residents' needs were provided for to ensure the residents' dignity. Administrative Staff A verified that not all the activities on the activity calendar met all of the residents' needs for activity. The facility's Nursing Services Staff Policy, revised 10/29/24, documented the facility must have sufficient nursing staff with the appropriate competencies and skill set to provide nursing and related services to assure resident safety and maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and induvial plans of care and considering the number, acuity, and diagnoses of the facility's resident population. The facility must provide services with the sufficient number of staff to provide nursing care to all residents. - R4's EMR documented R4 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), non-traumatic brain dysfunction (damage to the brain that does not result from an external force, such as a fall or accident), need for assistance with personal care, edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and abnormalities of gait and mobility. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Quarterly Minimum Data Set (MDS), dated 01/07/25, documented R4 had a BIMS score of three, which indicated severely impaired cognition. The MDS documented R4 was dependent on staff for toileting, bathing, and transfer. The MDS documented R4 required maximum/substantial assistance from staff for ambulation, dressing, and bed mobility. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 07/07/24, documented R4 had dementia, memory problems, and required assistance with decision making. The Psychosocial Well Being CAA, dated 07/07/24, documented R4 had been a farmer his whole life and rarely socialized. R4's brother visited a few times a week, otherwise, there was no family involvement. R4's Care Plan directed staff R4 preferred to get up and 07:00 AM, eat breakfast, watch TV, and would like to attend morning activities (03/14/25). The care plan directed R4 required a sit-to-stand lift utilizing the yellow bordered sling with two staff assist for transfers and a wheelchair for mobility (02/27/25). On 04/28/25 at 08:45 AM, observation revealed R4 sat in his wheelchair at a table with breakfast in front of him. R4 sat with his head down, his chin on his chest. R4's pants were stained with food particles, his button-down shirt only had two buttons buttoned, and showed a large portion of his chest and stomach. R4's shirt had a large, old orange stain on the cuff. R4 had coughed up some yellow, bloody phlegm on his shirt. On 04/28/25 at 09:30 AM, R4 sat in his wheelchair in the activity room with five other wheelchair bound residents. There was no activity for R4 to enjoy. There was no staff in the room. R4's wheelchair had dark brown dried food particles on the sides of his wheelchair that appeared to have been there for days. On 04/28/25 at 10:30 AM, R4 sat in the same position. Someone had placed hymnals to play on the iPad. No staff were in the room interacting with R4. R4 wrung his hands and played with his fingers. On 04/28/25 at 11:00 AM, someone brought a cart into the activity room with cookies, tea, and coffee on it. No one had served R4 a drink or snack. R4 went from 09:30 AM to lunchtime without anything to drink while in the activity room. On 04/28/25 at 01:40 PM, R4 sat in his wheelchair in his room. The TV was not on, and R4 looked around his room. R4 continued to be in stained, unclean clothing with the large yellow, bloody phlegm on the front of his shirt. On 04/28/25 at 09:35 AM, Certified Nurse's Aide (CNA) M stated there were not enough CNAs working on the floor for the day shift or evening shift to make sure all resident cares were completed. CNA M stated that over half of the residents were full lifts or sit-to-stand lifts that required two staff, and by the time the staff got all the residents up, there was not enough time to take care of morning personal hygiene before breakfast. CNA M stated she did not know about the activities for that morning. She knew that after breakfast, the wheelchair bound residents were brought into the activity room, and usually, some kind of activity would occur. (continued on next page)

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	175356	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Decatur County	108 E Ash Street Oberlin, KS 67749

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/28/25 at 10:00 AM, CNA N stated she was responsible for the restorative program. CNA N stated there was not enough staff to make sure the residents were cared for the way they were supposed to be. CNA N stated that when she first started at the facility, the facility was one of the best, and she recommended to her family to place family members who required care in the facility. CNA N stated that it was not the case anymore, and her family was thinking about pulling her family members out of the facility. CNA N stated that there were times when the activity staff was gone, she would cover for her, but she was not aware that there was no activity staff on duty for the day. CNA N stated that overall, the activities were subpar. On 04/28/25 at 11:10 AM, CNA O stated there were not enough CNAs on shift to take care of the residents responsibly. CNA O stated that two CNAs on the floor to take care of all the residents did not leave any extra time to take care of personal hygiene for residents, and a lot of the time, when they finally got everyone out to breakfast food was cold. CNA O stated that just one extra CNA would make a world of difference. CNA O stated administrative staff never came out of their offices to assist with resident care. CNA O stated she did not know anything about activities. On 04/28/25 at 01:30 PM, Activities Staff/Social Services Staff Z stated she was in charge of activities and social services and was allowed three and a half hours a day for each position. Activities Staff Z stated she was gone on Friday and today, but had a replacement staff member covering for her activities. It was explained to Activities Staff Z that there was no observed staff who took her place that day. Activities Staff Z stated that a normal morning would be for devotions to be read to residents, hymnals played for residents, an exercise group, and a social hour group. Activities Staff Z stated a folding group was also on the schedule for residents who like to fold clothing protectors, but Activity Staff Z stated a lot of those residents had passed on. Activities Staff Z stated she did not make changes to the activity schedule often. Activity Staff Z stated a Catholic priest was scheduled to come into the facility to meet with Catholic residents, but would not come into the facility and had not since COVID. Activity Staff Z stated the Catholic priest was hard to talk to and admitted she had not tried to get anyone but the local pastor to come in for the spirituality of the residents, and admitted the Catholic residents would not want to meet with him. On 04/28/25 at 02:30 PM, Administrative Nurse D stated she had been fighting corporate on staffing for a while, and she would not drop her staffing numbers anymore. Administrative Nurse D stated she thought staffing was okay for staff to take care of the needs of the residents. Administrative Nurse D became emotionally upset when the resident's conditions and activity involvement were described to her. Administrative Nurse D stated she would expect the nursing staff to take care of all the residents' ADLs and personal hygiene needs and not leave them in the condition they were found in. Administrative Nurse D verified that over half of the fourteen residents required a full lift or sit-to-stand lift for transfers, which required two staff for the transfers. Administrative Nurse D stated she was not aware Activity Staff Z was going to be gone today. Administrative Nurse D admitted that the activities provided to the residents were old, redundant, and the activity calendar was rarely changed to meet residents' activity needs. On 04/28/25 at 03:30 PM, Administrative Staff A stated she felt staffing was appropriate for the facility. Administrative Staff A stated she expected staff to make sure all the residents' needs were provided for to ensure the residents' dignity. Administrative Staff A verified that not all the activities on the activity calendar met all the residents' needs for activity. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Nursing Services Staff Policy, revised 10/29/24, documented the facility must have sufficient nursing staff with the appropriate competencies and skill set to provide nursing and related services to assure resident safety and maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and induvial plans of care and considering the number, acuity, and diagnoses of the facility's resident population. The facility must provide services with the sufficient number of staff to provide nursing care to all residents. - R5's EMR documented R5 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), atrial fibrillation (rapid, irregular heartbeat), and a history of falling. R5's Annual MDS, dated 02/14/25, documented R5 had a BIMS score of 99, R5 had short and long-term memory deficits, and R5 made poor decisions and required supervision. The MDS documented R5 was dependent on staff for all of her ADLs. The Cognitive Loss/Dementia CAA, dated 02/14/25, documented R5 had dementia, was unable to make decisions appropriately, and had short and long-term memory loss. The Psychosocial Well Being CAA, dated 02/14/25, documented R5 was unable to describe her favorite activity, and family visited often. R5's Care Plan documented R5's preferred activities were devotions, bible study, group exercises, social events, and current events. The care plan directed staff to reminisce with R5 using photos of family and friends. The care plan documented R5 transferred with a full lift using a red-bordered high back sling and two staff. On 04/28/25 at 09:30 AM, R5 sat in her wheelchair in the activity room with five other wheelchair bound residents. There was no activity for R5 to enjoy. There was no staff in the room. R5's hair had not been combed that morning and was sticking up on end. There were dried yellow egg particles on R5's shirt and pants, probably from breakfast. There were dark brown food particles on the sides of R5's wheelchair that appeared to be days old. On 04/28/25 at 10:30 AM, R5 sat in the same position. Someone had placed hymnals to play on the iPad. No staff were in the room interacting with R5. R5 played with the arm protectors on her arms. On 04/28/25 at 11:00 AM, someone brought a cart into the activity room with cookies, tea, and coffee on it. Someone had given R5 a cookie, and R5 broke up the cookie and threw it on the floor. R5 went from 09:30 AM to lunchtime without anything to drink while in the activity room. On 04/28/25 at 01:20 PM, R5 sat in her wheelchair in a living area off the activity room by herself. No staff were interacting with R5. R5 continued to have clothes covered with dried yellow egg particles from breakfast. (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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/28/25 at 09:35 AM, Certified Nurse's Aide (CNA) M stated there were not enough CNAs working on the floor for the day shift or evening shift to make sure all resident cares were completed. CNA M stated that over half of the residents were full lifts or sit-to-stand lifts that required two staff, and by the time the staff got all the residents up, there was not enough time to take care of morning personal hygiene before breakfast. CNA M stated she did not know about the activities for that morning. She knew that after breakfast, the wheelchair bound residents were brought into the activity room, and usually, some kind of activity would occur. On 04/28/25 at 10:00 AM, CNA N stated she was responsible for the restorative program. CNA N stated there was not enough staff to make sure the residents were cared for the way they were supposed to be. CNA N stated that when she first started at the facility, the facility was one of the best, and she recommended to her family to place family members who required care in the facility. CNA N stated that it was not the case anymore, and her family was thinking about pulling her family members out of the facility. CNA N stated there were times when the activity staff was gone, she would cover for her, but she was not aware that there was no activity staff on duty for the day. CNA N stated that overall, the activities were subpar. On 04/28/25 at 11:10 AM, CNA O stated there were not enough CNAs on shift to take care of the residents responsibly. CNA O stated that two CNAs on the floor to take care of all the residents did not leave any extra time to take care of personal hygiene for residents, and a lot of the time, when they finally got everyone out to breakfast food was cold. CNA O stated that just one extra CNA would make a world of difference. CNA O stated administrative staff never came out of their offices to assist with resident care. CNA O stated she did not know anything about activities. On 04/28/25 at 01:30 PM, Activities Staff/Social Services Staff Z stated she was in charge of activities and social services and was allowed three and a half hours a day for each position. Activities Staff Z stated she was gone on Friday and today but had a replacement staff member covering for her activities. It was explained to Activities Staff Z that there was no observed staff who took her place that day. Activities Staff Z stated that a normal morning would be for devotions to be read to residents, hymnals played for residents, an exercise group, and a social hour group. Activities Staff Z stated a folding group was also on the schedule for residents who like to fold clothing protectors, but Activity Staff Z stated a lot of those residents had passed on. Activities Staff Z stated she did not make changes to the activity schedule often. Activity Staff Z stated a Catholic priest was scheduled to come into the facility to meet with Catholic residents, but would not come into the facility and had not since COVID. Activity Staff Z stated the Catholic priest was hard to talk to and admitted she had not tried to get anyone but the local pastor to come in for the spirituality of the residents, and admitted the Catholic residents would not want to meet with him. On 04/28/25 at 02:30 PM, Administrative Nurse D stated she had been fighting corporate on staffing for a while, and she would not drop her staffing numbers anymore. Administrative Nurse D stated she thought staffing was okay for staff to take care of the needs of the residents. Administrative Nurse D became emotionally upset when the resident's conditions and activity involvement were described to her. Administrative Nurse D stated she would expect the nursing staff to take care of all the residents' ADLs and personal hygiene needs and not leave them in the condition they were found in. Administrative Nurse D verified that over half of the fourteen residents required a full lift or sit-to-stand lift for transfers, which required two staff for the transfers. Administrative Nurse D stated she was not aware Activity Staff Z was going to be gone today. Administrative Nurse D admitted that the activit[TRUNCATED]

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. The facility identified a census of 14 residents, with five residents reviewed for resident rights, activities, staffing, and activities of daily living (ADL). Based on record review, observation, and interview, the facility failed to provide sufficient nurse staffing with the appropriate skill sets and competencies to treat Resident (R) 2, R3, R4, R5, and R7 with respect, dignity, and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life to maintain the highest practicable physical, mental, and psychosocial wellbeing. (Refer to F677) Findings included: - R2's Electronic Medical Record (EMR) documented R2 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). R2's Quarterly Minimum Data Set (MDS), dated 03/01/25, documented R2 had a Brief Interview for Mental Status score of 99. The MDS documented R2 had short and long-term memory loss, and R2 was severely cognitively impaired. The MDS documented R2 was dependent on staff for completing all of her activities of daily living (ADL). The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 08/29/24, documented R2 had a diagnosis of dementia, had memory loss, and required a proxy for health care decisions. The Behavioral Symptom CAA, dated 08/29/24, documented R2 had behaviors of physical aggression towards staff during cares, which placed R2 at risk for injury. R2's Care Plan directed staff to engage R2 in simple, structured activities that were not demanding (09/27/23). The care plan directed staff to ensure R2 wore a bra daily and to smooth her shirt so it was not wrinkled (03/18/25). The care plan directed staff to transfer R2 with a full lift with two staff assistance using the high-backed yellow sling (10/04/24). The care plan directed staff to provide weekly one-on-one visits and manicures, and R2's preferred activities were hymns and devotions (09/27/23). On 04/28/25 at 09:30 AM, observation revealed R2 sat in the activity room after breakfast in her wheelchair with a yellow high-backed lift sling under her. R2's hair had not been combed and was mussed. R2 had dried yellow and brown food particles on the sides of her wheelchair that appeared to be days old. R2's blouse was wrinkled. There was no staff in the activity room, and there was no activity for R2 to enjoy. R2 sat and either looked around the room at the five other residents sitting with her or slept in her wheelchair. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/28/25 at 10:30 AM, R2 sat in the same position. Someone had placed hymnals to play on the iPad. No staff were in the room interacting with R2. R2 slept with her head tilted to her right shoulder. On 04/28/25 at 11:00 AM, someone had brought a cart into the activity room that had cookies, tea, and coffee on it. No one had served R2 a drink or snack. R2 went from 09:30 AM to lunchtime without anything to drink while in the activity room. On 04/28/25 at 01:30 PM, observation revealed Certified Nurse's Aide (CNA) M rolled R2 back and forth in bed by herself to provide R2 incontinent care. R2 grabbed CNA M's hands and arms to try and stop her. After CNA M left the room, observation revealed R2 had a dark brown food ring around her mouth that had not been cleaned from lunch. On 04/28/25 at 09:35 AM, Certified Nurse's Aide (CNA) M stated there were not enough CNAs working on the floor for the day shift or evening shift to make sure all resident cares were completed. CNA M stated that over half of the residents were full lifts or sit-to-stand lifts that required two staff, and by the time the staff got all the residents up, there was not enough time to take care of morning personal hygiene before breakfast. CNA M stated she did not know about the activities for that morning. She knew that after breakfast, the wheelchair bound residents were brought into the activity room, and usually, some kind of activity would occur. On 04/28/25 at 10:00 AM, CNA N stated she was responsible for the restorative program. CNA N stated there was not enough staff to make sure the residents were cared for the way they were supposed to be. CNA N stated that when she first started at the facility, the facility was one of the best, and she recommended to her family to place family members who required care in the facility. CNA N stated that was not the case anymore, and her family was thinking about pulling her family members out of the facility. CNA N stated that there were times when the activity staff was gone; she would cover for her, but she was not aware that there was no activity staff on duty for the day. CNA N stated that overall, the activities were subpar. On 04/28/25 at 11:10 AM, CNA O stated there were not enough CNAs on shift to take care of the residents responsibly. CNA O stated that two CNAs on the floor to take care of all the residents did not leave any extra time to take care of personal hygiene for residents, and a lot of the time, when they finally got everyone out to breakfast food was cold. CNA O stated just one extra CNA would make a world of difference. CNA O stated administrative staff never came out of their offices to assist with resident care. CNA O stated she did not know anything about activities. On 04/28/25 at 01:30 PM, Activities Staff/Social Services Staff Z stated she was in charge of activities and social services and was allowed three and a half hours a day for each position. Activities Staff Z stated she was gone on Friday and today but had a replacement staff member covering for her activities. It was explained to Activities Staff Z that there was no observed staff who took her place that day. Activities Staff Z stated that a normal morning would be for devotions to be read to residents, hymnals played for residents, an exercise group, and a social hour group. Activities Staff Z stated a folding group was also on the schedule for residents who like to fold clothing protectors, but Activity Staff Z stated a lot of those residents had passed on. Activities Staff Z stated she did not make changes to the activity schedule often. Activity Staff Z stated a Catholic priest was scheduled to come into the facility to meet with Catholic residents, but would not come into the facility and had not since COVID. Activity Staff Z stated the Catholic priest was hard to talk to and admitted she had not tried to get anyone but the local pastor to come in for the spirituality of the residents, and admitted the Catholic residents would not want to meet with him. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/28/25 at 02:30 PM, Administrative Nurse D stated she had been fighting corporate on staffing for a while, and she would not drop her staffing numbers anymore. Administrative Nurse D stated she thought staffing was okay for staff to take care of the needs of the residents. Administrative Nurse D became emotionally upset when the resident's conditions and activity involvement were described to her. Administrative Nurse D stated she would expect the nursing staff to take care of all the residents' ADLs and personal hygiene needs and not leave them in the condition they were found in. Administrative Nurse D verified that over half of the fourteen residents required a full lift or sit-to-stand lift for transfers, which required two staff for the transfers. Administrative Nurse D stated she was not aware Activity Staff Z was going to be gone today. Administrative Nurse D admitted that the activities provided to the residents were old, redundant, and the activity calendar was rarely changed to meet residents' activity needs. On 04/28/25 at 03:30 PM, Administrative Staff A stated she felt staffing was appropriate for the facility. Administrative Staff A stated she expected staff to make sure all the residents' needs were provided for to ensure the residents' dignity. Administrative Staff A verified that not all the activities on the activity calendar met all of the residents' needs for activity. The facility's Nursing Services Staff Policy, revised 10/29/24, documented the facility must have sufficient nursing staff with the appropriate competencies and skill set to provide nursing and related services to assure resident safety and maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and induvial plans of care and considering the number, acuity, and diagnoses of the facility's resident population. The facility must provide services with the sufficient number of staff to provide nursing care to all residents. - R3's EMR documented R3 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R3's Quarterly Minimum Data Set (MDS), dated 03/05/25, documented R3 was rarely/never understood. The MDS documented R3 had short-term and long-term memory loss and had severely impaired cognition. The MDS documented R3 was dependent on staff for all of her activities of daily living (ADL). The MDS documented R3 had physical and verbal behaviors directed towards others for four to six days during the look-back period. R3's Cognitive Loss/Dementia Care Area Assessment (CAA), dated 12/03/24, documented R3 had diagnoses of dementia and Alzheimer's disease and was severely cognitively impaired. The Psychosocial Well-Being CAA, dated 12/03/25, documented R3 was no longer able to tell of her favorite activity. The CAA documented that R3 received family visits one to two times a week and would attend morning devotions. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R3's Care Plan directed staff to reminisce with R3 using photos of family and friends (06/15/22). R3's care plan directed staff R3 preferred to have makeup and perfume on every day (12/08/23). R3's care plan directed R3 required two staff to transfer her with a sit-to-stand lift with the green bordered lift sling. R3's care plan directed staff to assist R3 out of bed at 04:00 PM every day and place R3 in front of the TV (07/14/23), provide weekly one on one visits (12/15/20), and offer weekly visits with the chaplain/attends Catholic mass (12/08/23), and invite and remind R3 of scheduled activities and assist as needed (12/15/20). On 04/28/25 at 09:30 AM, R3 sat in her wheelchair in the activity room with five other wheelchair bound residents. There was no activity for R3 to enjoy. There was no staff in the room. R3's hair had not been combed that morning and was sticking up on end. R3 did not have a bra on, and her left breast and nipple were showing through the blouse she had on. R3 did not have any makeup on. There were dark brown food particles on the sides of R3's wheelchair that appeared to be days old. On 04/28/25 at 10:30 AM, R3 sat in the same position. Someone had placed hymnals to play on the iPad. No staff were in the room interacting with R3. R3 slept with her chin on her chest. On 04/28/25 at 11:00 AM, someone brought a cart into the activity room with cookies, tea, and coffee on it. No one had served R3 a drink or snack. R3 went from 09:30 AM to lunchtime without anything to drink while in the activity room. On 04/28/25 at 01:30 PM, observation revealed CNA N rolled R3 back and forth in bed by herself to provide R3 incontinent care. After CNA N left the room, observation revealed R3 had a dark brown food ring around her mouth that had not been cleaned from lunch. On 04/28/25 at 09:35 AM, Certified Nurse's Aide (CNA) M stated there were not enough CNAs working on the floor for the day shift or evening shift to make sure all resident cares were completed. CNA M stated that over half of the residents were full lifts or sit-to-stand lifts that required two staff, and by the time the staff got all the residents up, there was not enough time to take care of morning personal hygiene before breakfast. CNA M stated she did not know about the activities for that morning. She knew that after breakfast, the wheelchair bound residents were brought into the activity room, and usually, some kind of activity would occur. On 04/28/25 at 10:00 AM, CNA N stated she was responsible for the restorative program. CNA N stated there was not enough staff to make sure the residents were cared for the way they were supposed to be. CNA N stated that when she first started at the facility, the facility was one of the best, and she recommended to her family to place family members who required care in the facility. CNA N stated that was not the case anymore, and her family was thinking about pulling her family members out of the facility. CNA N stated that there were times when the activity staff was gone; she would cover for her, but she was not aware that there was no activity staff on duty for the day. CNA N stated that overall, the activities were subpar. On 04/28/25 at 11:10 AM, CNA O stated there were not enough CNAs on shift to take care of the residents responsibly. CNA O stated that two CNAs on the floor to take care of all the residents did not leave any extra time to take care of personal hygiene for residents, and a lot of the time, when they finally got everyone out to breakfast food was cold. CNA O stated that just one extra CNA would make a world of difference. CNA O stated administrative staff never came out of their offices to assist with resident care. CNA O stated she did not know anything about activities. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/28/25 at 01:30 PM, Activities Staff/Social Services Staff Z stated she was in charge of activities and social services and was allowed three and a half hours a day for each position. Activities Staff Z stated she was gone on Friday and today, but had a replacement staff member covering for her activities. It was explained to Activities Staff Z that there was no observed staff who took her place that day. Activities Staff Z stated that a normal morning would be for devotions to be read to residents, hymnals played for residents, an exercise group, and a social hour group. Activities Staff Z stated a folding group was also on the schedule for residents who like to fold clothing protectors, but Activity Staff Z stated a lot of those residents had passed on. Activities Staff Z stated she did not make changes to the activity schedule often. Activity Staff Z stated a Catholic priest was scheduled to come into the facility to meet with Catholic residents, but would not come into the facility and had not since COVID. Activity Staff Z stated the Catholic priest was hard to talk to and admitted she had not tried to get anyone but the local pastor to come in for the spirituality of the residents, and admitted the Catholic residents would not want to meet with him. On 04/28/25 at 02:30 PM, Administrative Nurse D stated she had been fighting corporate on staffing for a while, and she would not drop her staffing numbers anymore. Administrative Nurse D stated she thought staffing was okay for staff to take care of the needs of the residents. Administrative Nurse D became emotionally upset when the resident's conditions and activity involvement were described to her. Administrative Nurse D stated she would expect the nursing staff to take care of all the residents' ADLs and personal hygiene needs and not leave them in the condition they were found in. Administrative Nurse D verified that over half of the fourteen residents required a full lift or sit-to-stand lift for transfers, which required two staff for the transfers. Administrative Nurse D stated she was not aware Activity Staff Z was going to be gone today. Administrative Nurse D admitted that the activities provided to the residents were old, redundant, and the activity calendar was rarely changed to meet residents' activity needs. On 04/28/25 at 03:30 PM, Administrative Staff A stated she felt staffing was appropriate for the facility. Administrative Staff A stated she expected staff to make sure all the residents' needs were provided for to ensure the residents' dignity. Administrative Staff A verified that not all the activities on the activity calendar met all of the residents' needs for activity. The facility's Nursing Services Staff Policy, revised 10/29/24, documented the facility must have sufficient nursing staff with the appropriate competencies and skill set to provide nursing and related services to assure resident safety and maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and induvial plans of care and considering the number, acuity, and diagnoses of the facility's resident population. The facility must provide services with the sufficient number of staff to provide nursing care to all residents. - R4's EMR documented R4 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), non-traumatic brain dysfunction (damage to the brain that does not result from an external force, such as a fall or accident), need for assistance with personal care, edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and abnormalities of gait and mobility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175356	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Decatur County	108 E Ash Street Oberlin, KS 67749

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Quarterly Minimum Data Set (MDS), dated 01/07/25, documented R4 had a BIMS score of three, which indicated severely impaired cognition. The MDS documented R4 was dependent on staff for toileting, bathing, and transfer. The MDS documented R4 required maximum/substantial assistance from staff for ambulation, dressing, and bed mobility. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 07/07/24, documented R4 had dementia, memory problems, and required assistance with decision making. The Psychosocial Well Being CAA, dated 07/07/24, documented R4 had been a farmer his whole life and rarely socialized. R4's brother visited a few times a week, otherwise, there was no family involvement. R4's Care Plan directed staff R4 preferred to get up and 07:00 AM, eat breakfast, watch TV, and would like to attend morning activities (03/14/25). The care plan directed R4 required a sit-to-stand lift utilizing the yellow bordered sling with two staff assist for transfers and a wheelchair for mobility (02/27/25). On 04/28/25 at 08:45 AM, observation revealed R4 sat in his wheelchair at a table with breakfast in front of him. R4 sat with his head down, his chin on his chest. R4's pants were stained with food particles, his button-down shirt only had two buttons buttoned, and showed a large portion of his chest and stomach. R4's shirt had a large, old orange stain on the cuff. R4 had coughed up some yellow, bloody phlegm on his shirt. On 04/28/25 at 09:30 AM, R4 sat in his wheelchair in the activity room with five other wheelchair bound residents. There was no activity for R4 to enjoy. There was no staff in the room. R4's wheelchair had dark brown dried food particles on the sides of his wheelchair that appeared to have been there for days. On 04/28/25 at 10:30 AM, R4 sat in the same position. Someone had placed hymnals to play on the iPad. No staff were in the room interacting with R4. R4 wrung his hands and played with his fingers. On 04/28/25 at 11:00 AM, someone brought a cart into the activity room with cookies, tea, and coffee on it. No one had served R4 a drink or snack. R4 went from 09:30 AM to lunchtime without anything to drink while in the activity room. On 04/28/25 at 01:40 PM, R4 sat in his wheelchair in his room. The TV was not on, and R4 looked around his room. R4 continued to be in stained, unclean clothing with the large yellow, bloody phlegm on the front of his shirt. On 04/28/25 at 09:35 AM, Certified Nurse's Aide (CNA) M stated there were not enough CNAs working on the floor for the day shift or evening shift to make sure all resident cares were completed. CNA M stated that over half of the residents were full lifts or sit-to-stand lifts that required two staff, and by the time the staff got all the residents up, there was not enough time to take care of morning personal hygiene before breakfast. CNA M stated she did not know about the activities for that morning. She knew that after breakfast, the wheelchair bound residents were brought into the activity room, and usually, some kind of activity would occur. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/28/25 at 10:00 AM, CNA N stated she was responsible for the restorative program. CNA N stated there was not enough staff to make sure the residents were cared for the way they were supposed to be. CNA N stated that when she first started at the facility, the facility was one of the best, and she recommended to her family to place family members who required care in the facility. CNA N stated that was not the case anymore, and her family was thinking about pulling her family members out of the facility. CNA N stated that there were times when the activity staff was gone; she would cover for her, but she was not aware that there was no activity staff on duty for the day. CNA N stated that overall, the activities were subpar. On 04/28/25 at 11:10 AM, CNA O stated there were not enough CNAs on shift to take care of the residents responsibly. CNA O stated that two CNAs on the floor to take care of all the residents did not leave any extra time to take care of personal hygiene for residents, and a lot of the time, when they finally got everyone out to breakfast food was cold. CNA O stated that just one extra CNA would make a world of difference. CNA O stated administrative staff never came out of their offices to assist with resident care. CNA O stated she did not know anything about activities. On 04/28/25 at 01:30 PM, Activities Staff/Social Services Staff Z stated she was in charge of activities and social services and was allowed three and a half hours a day for each position. Activities Staff Z stated she was gone on Friday and today but had a replacement staff member covering for her activities. It was explained to Activities Staff Z that there was no observed staff who took her place that day. Activities Staff Z stated that a normal morning would be for devotions to be read to residents, hymnals played for residents, an exercise group, and a social hour group. Activities Staff Z stated a folding group was also on the schedule for residents who like to fold clothing protectors, but Activity Staff Z stated a lot of those residents had passed on. Activities Staff Z stated she did not make changes to the activity schedule often. Activity Staff Z stated a Catholic priest was scheduled to come into the facility to meet with Catholic residents, but would not come into the facility and had not since COVID. Activity Staff Z stated the Catholic priest was hard to talk to and admitted she had not tried to get anyone but the local pastor to come in for the spirituality of the residents, and admitted the Catholic residents would not want to meet with him. On 04/28/25 at 02:30 PM, Administrative Nurse D stated she had been fighting corporate on staffing for a while, and she would not drop her staffing numbers anymore. Administrative Nurse D stated she thought staffing was okay for staff to take care of the needs of the residents. Administrative Nurse D became emotionally upset when the resident's conditions and activity involvement were described to her. Administrative Nurse D stated she would expect the nursing staff to take care of all the residents' ADLs and personal hygiene needs and not leave them in the condition they were found in. Administrative Nurse D verified that over half of the fourteen residents required a full lift or sit-to-stand lift for transfers, which required two staff for the transfers. Administrative Nurse D stated she was not aware Activity Staff Z was going to be gone today. Administrative Nurse D admitted that the activities provided to the residents were old, redundant, and the activity calendar was rarely changed to meet residents' activity needs. On 04/28/25 at 03:30 PM, Administrative Staff A stated she felt staffing was appropriate for the facility. Administrative Staff A stated she expected staff to make sure all the residents' needs were provided for to ensure the residents' dignity. Administrative Staff A verified that not all the activities on the activity calendar met all the residents' needs for activity. (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Nursing Services Staff Policy, revised 10/29/24, documented the facility must have sufficient nursing staff with the appropriate competencies and skill set to provide nursing and related services to assure resident safety and maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and induvial plans of care and considering the number, acuity, and diagnoses of the facility's resident population. The facility must provide services with the sufficient number of staff to provide nursing care to all residents. - R5's EMR documented R5 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), atrial fibrillation (rapid, irregular heartbeat), and a history of falling. R5's Annual MDS, dated 02/14/25, documented R5 had a BIMS score of 99, R5 had short and long-term memory deficits, and R5 made poor decisions and required supervision. The MDS documented R5 was dependent on staff for all of her ADLs. The Cognitive Loss/Dementia CAA, dated 02/14/25, documented R5 had dementia, was unable to make decisions appropriately, and had short and long-term memory loss. The Psychosocial Well Being CAA, dated 02/14/25, documented R5 was unable to describe her favorite activity, and family visited often. R5's Care Plan documented R5's preferred activities were devotions, bible study, group exercises, social events, and current events. The care plan directed staff to reminisce with R5 using photos of family and friends. The care plan documented R5 transferred with a full lift using a red-bordered high back sling and two staff. On 04/28/25 at 09:30 AM, R5 sat in her wheelchair in the activity room with five other wheelchair bound residents. There was no activity for R5 to enjoy. There was no staff in the room. R5's hair had not been combed that morning and was sticking up on end. There were dried yellow egg particles on R5's shirt and pants, probably from breakfast. There were dark brown food particles on the sides of R5's wheelchair that appeared to be days old. On 04/28/25 at 10:30 AM, R5 sat in the same position. Someone had placed hymnals to play on the iPad. No staff were in the room interacting with R5. R5 played with the arm protectors on her arms. On 04/28/25 at 11:00 AM, someone brought a cart into the activity room with cookies, tea, and coffee on it. Someone had given R5 a cookie, and R5 broke up the cookie and threw it on the floor. R5 went from 09:30 AM to lunchtime without anything to drink while in the activity room. On 04/28/25 at 01:20 PM, R5 sat in her wheelchair in a living area off the activity room by herself. No staff were interacting with R5. R5 continued to have clothes covered with dried yellow egg particles from breakfast. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/28/25 at 09:35 AM, Certified Nurse's Aide (CNA) M stated there were not enough CNAs working on the floor for the day shift or evening shift to make sure all resident cares were completed. CNA M stated that over half of the residents were full lifts or sit-to-stand lifts that required two staff, and by the time the staff got all the residents up, there was not enough time to take care of morning personal hygiene before breakfast. CNA M stated she did not know about the activities for that morning. She knew that after breakfast, the wheelchair bound residents were brought into the activity room, and usually, some kind of activity would occur. On 04/28/25 at 10:00 AM, CNA N stated she was responsible for the restorative program. CNA N stated there was not enough staff to make sure the residents were cared for the way they were supposed to be. CNA N stated that when she first started at the facility, the facility was one of the best, and she recommended to her family to place family members who required care in the facility. CNA N stated that was not the case anymore, and her family was thinking about pulling her family members out of the facility. CNA N stated that there were times when the activity staff was gone; she would cover for her, but she was not aware that there was no activity staff on duty for the day. CNA N stated that overall, the activities were subpar. On 04/28/25 at 11:10 AM, CNA O stated there were not enough CNAs on shift to take care of the residents responsibly. CNA O stated that two CNAs on the floor to take care of all the residents did not leave any extra time to take care of personal hygiene for residents, and a lot of the time, when they finally got everyone out to breakfast food was cold. CNA O stated that just one extra CNA would make a world of difference. CNA O stated administrative staff never came out of their offices to assist with resident care. CNA O stated she did not know anything about activities. On 04/28/25 at 01:30 PM, Activities Staff/Social Services Staff Z stated she was in charge of activities and social services and was allowed three and a half hours a day for each position. Activities Staff Z stated she was gone on Friday and today, but had a replacement staff member covering for her for activities. It was explained to Activities Staff Z that there was no observed staff who took her place that day. Activities Staff Z stated that a normal morning would be for devotions to be read to residents, hymnals played for residents, an exercise group, and a social hour group. Activities Staff Z stated a folding group was also on the schedule for residents who like to fold clothing protectors, but Activity Staff Z stated a lot of those residents had passed on. Activities Staff Z stated she did not make changes to the activity schedule often. Activity Staff Z stated a Catholic priest was scheduled to come into the facility to meet with Catholic residents, but would not come into the facility and had not since COVID. Activity Staff Z stated the Catholic priest was hard to talk to and admitted she had not tried to get anyone but the local pastor to come in for the spirituality of the residents, and admitted the Catholic residents would not want to meet with him. On 04/28/25 at 02:30 PM, Administrative Nurse D stated she had been fighting corporate on staffing for a while, and she would not drop her staffing numbers anymore. Administrative Nurse D stated she thought staffing was okay for staff to take care of the needs of the residents. Administrative Nurse D became emotionally upset when the resident's conditions and activity involvement were described to her. Administrative Nurse D stated she would expect the nursing staff to take care of all the residents' ADLs and personal hygiene needs and not leave them in the condition they were found in. Administrative Nurse D verified that over half of the fourteen residents required a full lift or sit-to-stand lift for transfers, which required two staff for the transfers. Administrative Nurse D stated she was not aware Activity Staff Z was going to be gone today. Administrative Nurse D admitted that the activities provided to the residents were ol[TRUNCATED]