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	11/17/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 18 residents. The sample included eight residents, with one reviewed for hospitalization and one reviewed for discharge. Based on observation, interviews and record review, the facility failed to notify the Office of the Long-Term Care Ombudsman (LTCO - a public official who works to resolve resident issues in nursing facilities) and failed to provide one resident, Resident (R) 20, with written information regarding the facility's bed hold policy when they were transferred to the hospital. The facility failed to complete a recapitulation (a concise summary of the resident's stay and course of treatment in the facility) for R22. Findings included: - The Electronic Medical Record (EMR) for R20 documented diagnoses of fracture of the part of the neck of the femur (broken thigh bone), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), and chronic kidney disease (moderate kidney damage) stage 3. The admission Minimum Data Set (MDS) dated [DATE] documented R20 had intact cognition. R20 required partial staff assistance for dressing, toileting, transfers, and personal hygiene. The Medicare 5 Day MDS dated 08/13/25 documented R20 had moderately impaired cognition. R20 required substantial staff assistance for showers, lower body dressing, transfers, and toileting. R20's Care Plan dated 06/26/25 directed staff to monitor R20's condition based on clinical practice guidelines or clinical standards of practice, report significant changes to the health care provider, and administer medication as ordered. R20's Progress Note dated 07/13/25 at 09:57 PM documented R20 admitted to the hospital for a transient ischemic attack (TIA- temporary episode of inadequate blood supply to the brain). R20's clinical record lacked evidence that the family received bed hold notification or that the Ombudsman was notified of the hospital transfer. R20's Progress Note dated 08/03/25 at 08:06 PM documented R20 admitted to the hospital with stroke-like symptoms. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R20's clinical record lacked evidence that the Ombudsman was notified of the hospital transfer. R20's Progress Note dated 08/07/25 at 04:50 PM documented R20 readmitted to the facility after she had received three units of blood. R20's Progress Note dated 08/21/25 at 09:45 AM documented R20 was admitted to the hospital with stroke-like symptoms. R20's clinical record lacked evidence that the family received bed hold notification or that the Ombudsman was notified of the hospital transfer. R20's Progress Note dated 08/25/25 at 12:11 PM documented R20 transferred to another hospital due to her condition having worsened, and she did not return to the facility. On 09/24/25 at 12:27 PM, Administrative Nurse D stated that Administrative Staff B was responsible for the discharge summary. The facility's Bed-Hold policy, dated 12/19/24, documented that at the time of admission, transfer, or therapeutic leave, the facility would provide written information to the resident or resident representative of the duration of the state bed-hold policy. The bed-hold policy would specify the duration, if any, during which the resident was permitted to return and resume residence, the reserve bed payment policy in the plan, and the locations' policies regarding bed-hold periods permitting a resident to return. The policy further documented, the social worker, or designee, would provide the notice of bed hold policy. In case of emergency transfer to the hospital, the facility sent a copy with the resident to the hospital for the resident's representative. The facility's Discharge and Transfer policy, dated 03/28/25, directed staff to complete the discharge summary when the discharge was entered into the medical record. The policy further directed staff to send copies of the transfer to the ombudsman. - R22's Electronic Medical Record (EMR) documented the resident had diagnoses of displaced fractured (traumatic bone break where two ends of the bone separate out of their normal positions) right femur (thigh bone), weakness, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R22's Annual Minimum Data Set (MDS) dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. The MDS documented R22 was independent with most activities of daily living (ADL). The MDS documented R22 had no plan to discharge. R22's Care Plan revised 07/24/25 documented R22 required one staff assist with ambulation and transfers. The plan documented R22 would remain in the facility, and no discharge was planned at this time. The plan documented R22, or her representative, did not want to be asked about returning to the community on any assessments and refused any community referral. R22's Progress Notes dated 07/31/25 at 11:14 AM documented the resident was transferred to another facility to be closer to her family. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Discharge Summary dated 08/07/25 documented that R22 was discharged on 07/31/25 at 11:15 AM. The summary had the condition of resident when discharged , but lacked a recapitulation of R22's stay and reconciliation of medications. On 09/24/25 at 12:27 PM, Administrative Nurse D stated that Administrative Staff B was responsible for filling out the discharge summary. Administrative Nurse D verified the medication reconciliation section was not completed on the summary and stated it should have been completed. The facility's Discharge and Transfer-Rehab/Skilled, Therapy and Rehab Policy, revised 03/28/25, documented the charge nurse or designated individual would complete the discharge summary. This would be triggered in the resident's medical record when the discharge was entered into the census.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 18 residents. The sample included eight residents, with two residents reviewed for activities of daily living (ADL) care. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 18 had a functional pair of glasses needed for her impaired vision. Findings included:- R18's Electronic Medical Record (EMR) documented diagnoses of hypertension (HTN- elevated blood pressure), dementia (a progressive mental disorder characterized by failing memory and confusion), and a history of falling.R18's Annual Minimum Data Set (MDS) dated [DATE] documented she had adequate vision with glasses or other visual appliances and required corrective lenses. R18 had both short and long-term memory problems. R18 had moderately impaired cognitive skills for daily decision making. R18 was dependent on staff for her ADLs. R18 required the use of a wheelchair for mobility that staff propelled. R18's Functional Care Area Assessment (CAA) dated 02/10/25 documented she had a diagnosis of dementia, and the resident was no longer able to care for herself. R18 required full staff assistance with her self cares. R18 required the use of a full mechanical lift for all transfers, and she was unable to make her own decisions. R18's Care Plan, revised on 05/12/25, directed staff to monitor her visual and auditory impairments. The care plan directed staff to assist with the care and use of her glasses. The care plan directed staff that R18 was to wear her glasses during her awake hours.R18's Order Summary in the EMR Orders tab documented an order dated 06/10/23 for the nurse to ensure the residents' glasses were placed on in the morning and removed at bedtime, and the glasses were to be kept in the medication room. R18's Progress Notes tab documented an 'Administration Record note dated 07/10/25 at 08:17 PM documented the Nurse would ensure R18 had glasses placed on in morning and removed at bedtime and should be kept in med room. R18's glasses are still broken and have not been repaired.R18's Progress Notes tab of the EMR documented an 07/16/25 at 09:11 AM Admin Record (Default Note) that documented the nurse was to ensure the resident had glasses placed on in morning and removed at bedtime and kept in the med room. R18's glasses are broken.On 09/24/25 at 11:00 AM, R18's representative stated that she had not been notified by the facility that R18's glasses were broken. R18's representative further stated that she did have a couple of spare pairs at her house that she could bring to the facility.On 09/23/25 at 08:17 AM, R18 did not have her glasses on. R18 was unable to state where her glasses were.On 09/24/25 at 11:17 AM, Administrative Nurse F stated at the time of R18's glasses being broken, Administrative Nurse D had known the glasses were broken since 07/04/25.On 09/24/25 at 11:45 AM, Administrative Staff A stated she had not been made aware that R18's glasses had been broken since July. Administrative Staff A stated had she known the glasses were broken, she would have made sure that R18's representative was notified and that the glasses were replaced or repaired.The facility's Eye Care- Culture, Eyeglasses, Prosthesis, Services policy dated 10/30/24 documented the purpose of this policy was to ensure the resident has access to proper treatment and assistive devices to maintain visual ability. Staff were to report to the licensed nurse any problems with glasses, such as broken or missing lenses.

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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 had a census of 18 residents. Based on the interview and record review, the facility failed to submit complete and accurate staffing information through Payroll Based Journaling (PBJ) as required. Findings included:- The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) Quarter 4 2024 (July 1 - September 30) indicated the facility did not have licensed nurse coverage 24 hours a day on the following dates:07/07/24 (SU), 07/27/24 (SA), 07/28/24 (SU)08/11/24 (SU)09/29/24 (SU).Review of the facility's daily nursing staff coverage revealed the facility had licensed nurse coverage 24 hours a day on the above dates, and revealed the facility had adequate licensed nurse coverage.On 10/21/25 at 08:37 AM, Administrative Staff A stated the human resource staff was responsible for submitting the PBJ during that period of time, and she no longer worked for the facility.The facility's Reporting Direct Care Staffing Information (PBJ) Policy, revised May 2024, documented that complete and accurate direct care staffing information would be reported electronically to the Centers for Medicaid, Medicare Services (CMS) through the PBJ system in a uniform format specified by CMS.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. The facility had a census of 18 residents. The sample included eight residents. Based on observation, interview, and record review, the facility, in coordination with the licensed pharmacist, failed to provide a system of medication records that enabled periodic, accurate reconciliation and accounting for all resident medications when the emergency medication kit (E-Kit) was unlocked in the medication room. The facility staff failed to label and date Resident (R) 6's Insulin aspart (rapid acting) insulin (a hormone that lowers the level of glucose in the blood) pen (a device for giving insulin shots). This placed the residents at risk for being charged for a medication not administered to them from the e-kit. Findings included:- On 09/23/25 at 08:50 AM, during inspection of the facility medication room with Licensed Nurse (LN) G, revealed that the blue E-Kit sat on the counter to the left of the entrance door was unsecured with a note in between the handles which read Stop!! New E-Kit instructions. For all medications taken from the E-kit on the inventory sheet, fill out the bottom of the inventory sheet completely and relock the E-kit with one lock from inside the E-kit. Antibiotics would not have a card use bottle. Fax the resident's order to the pharmacy and notate on the order sheet: TAKEN FROM E-KIT, as well as the quantity used, so the pharmacy knows how much to bill the resident and reimburse the facility for, as well as to re-lock the E-kit. LN G opened the kit, and it lacked an inventory list for the medications in the kit. Observation revealed that LN G was not able to find the inventory list in the medication room. Further observation revealed Administrative Nurse D entered the medication room, verified the E-kit was unlocked, and stated staff should secure the E-kit with a red zip tie on top of the E-kit whenever they open it and use a medication from it. LN G secured the E-kit with one of the ties.On 09/23/25 at 08:58 AM, LN H verified the facility lacked the inventory list for the E-kit and stated it should be inside the E-kit. LN H stated she would call the pharmacy and ask for them to fax the facility the inventory list. LN H stated the procedure staff should take when they open the E-kit and use a medication from it; they are to take the count off the inventory sheet and fax the pharmacy so they can replace it. LN H stated staff were to relock the E-kit after they use a medication.On 09/23/25 at 03:53 PM, LN G stated she was not required to check the E-kit to ensure it was locked.On 09/23/25 at 03:54 PM, Administrative Nurse D stated she had received the E-kit inventory list. Observation revealed Administrative Nurse D conducted an audit of the E-kit and verified the E-kit was missing one vial of Haldol (antipsychotic- a class of medications used to treat major mental conditions that cause a break from reality), 2 vials of lidocaine (medication used to relieve pain), and 2 ampules (glass capsule containing a liquid, especially a measured quantity ready for injecting) of Phenergan (a medication used to manage and treat allergic conditions, nausea and vomiting, motion sickness, and sedation). Administrative Nurse D verified the facility lacked a system for reconciling the medications inside the E-kit and monitoring it to ensure it was locked.On 09/24/25 at 04:31 PM, Consultant GG stated the pharmacist delivers the E-kit to the facility unlocked, due to they have locks in the medication room. Consultant GG stated he provided an inventory list of the medications, placed it inside the E-kit, but did not provide a sheet to reconcile the medications if staff used a medication from it. Consultant GG stated when staff used a medication from the E-kit, they were to fax the resident orders to the pharmacy so the pharmacy could charge the correct resident for the medication.The facility's Emergency Drug Boxes Policy, revised 12/02/24, documented emergency drug boxes are an extension of the providing pharmacists' store and would be kept locked in the medication room, accessible to licensed nurses and medication aides. When a drug is used from the box, the pharmacist or the pharmacist's agent would be notified according to state-specific regulations. A list of emergency medications, including the amounts, dosages/strengths, would be posted on the outside of the box. The pharmacist was responsible for monitoring expiration dates. Record keeping would be in accordance with the state pharmacy system.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 18 residents. The sample included eight residents, with six reviewed for unnecessary medications. Based on observation, interviews, and record review, the facility failed to obtain blood pressure parameters from the physician for one resident, Resident (R) 1, who received medication to treat hypertension (high blood pressure). Findings included:- The Electronic Medical Record (EMR) for R1 documented diagnoses of hypertension, occlusion and stenosis of the right carotid artery (narrowing and blockage of one of the main blood vessels that run up the right side of the neck), and occlusion and stenosis of the right posterior cerebral artery (narrowing and blockage of the artery of the right side of the brain).The admission Minimum Data Set (MDS) dated [DATE] documented R1 had intact cognition. R1 was independent with activities of daily living and did not ambulate. The MDS further documented R1 received antidepressant (a class of medication that calms and relaxes people), anticoagulant (a class of medications used to prevent the blood from clotting), and hypoglycemic (a medication used to lower blood glucose (sugar) levels in the body) medications daily.R1's Care Plan dated 06/24/25 directed staff to monitor, document, and report to the health care provider signs and symptoms of malignant hypertension, administer medication as ordered, and monitor and document any abnormalities for urinary output.The Physician's Order dated 06/25/25 directed staff to administer metoprolol (used to treat hypertension), extended release (ER), 25 milligrams (mg), by mouth, daily for hypertension. The order lacked blood pressure parameters for the resident.On 09/23/25 at 08:30 AM, R1 sat in her room, on her tablet.On 09/24/25 at 12:16 PM, Licensed Nurse (LN) I stated staff obtained R1's blood pressure daily and verified her metoprolol did not have physician-ordered parameters.On 09/24/25 at 12:30 PM, Administrative Nurse D stated there should be physician-ordered parameters for R1's metoprolol and stated LN I would contact the physician for further direction.The facility's Vital Signs-Blood Pressure policy, dated 04/08/25, directed staff to document the resident's vital signs in the medical record. The policy directed staff to recognize significant changes in blood pressure with position changes, and report to the LN if the resident complained of lightheadedness, dizziness, blurred vision, and/or shallow breathing. The policy further directed staff to note if the resident's pulse was regular or irregular.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. The facility had a census of 18 residents. The sample included eight residents. Based on observation, interview, and record review, the facility failed to date Resident (R) 6's Insulin Aspart (rapid acting) insulin (a hormone that lowers the level of glucose in the blood) pen (a device for giving insulin shots).Findings included:- On 09/22/25 at 03:45 PM, observation revealed in the medication cart, R6's Aspart insulin pen was undated when it was opened.On 09/22/25 at 03:45 PM, Licensed Nurse (LN) G verified R6's insulin pen had been used and was undated to indicate when it was opened. LN G stated staff should date the insulin pen when they open it. LN G discarded the pen in a sharps container (a puncture-resistant, rigid plastic receptacle designed to safely collect and dispose of sharp medical objects like needles, syringes, and scalpels, preventing injuries and the spread of infection).On 09/24/25 at 12:21 PM, Administrative Nurse D stated she expected staff to date an insulin pen when they opened it with the expiration date and opened date.The facility did not provide a policy regarding the storage of insulin pens requested on 09/24/25.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. The facility identified a census of 18 residents. The facility had one main kitchen and one main dining room. Based on observation, interview, and record review, the facility failed to ensure that the director of food and nutrition services had the required qualifications of a certified dietary manager (CDM). Findings included:- On 09/22/25 at 08:37 AM, during the initial tour of the facility kitchen, Dietary BB stated that she was currently taking the classes to become certified but had not taken her test yet. Dietary BB further stated that the registered dietician came to the facility twice a month to review the residents' diets and address any weight loss.On 09/23/25 at 09:18 AM, Administrative Staff A stated that Dietary BB would soon be taking her test to become a certified dietary manager.The facility lacked a policy for Certified Dietary Manager as requested on 09/24/25.