STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175322	A. Building B. Wing	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Hays	2700 Canal Blvd Hays, KS 67601

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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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 27168 The facility had a census of 41. The sample included 13 residents. Based on record review, interview and observation the facility failed to treat residents with respect, dignity, and privacy during blood glucose testing. This placed the resident at risk for impaired psychosocial wellbeing. Findings included: - On 05/09/23 at 11:25 AM, observation revealed Licensed Nurse (LN) H obtained Resident (R)6's blood sugar reading using a glucometer (a blood glucose meter monitor device that you test the amount of glucose [sugar] in the blood) from R6's right middle finger at the table in the dining room, with two other residents seated at the table and five other residents seated in the dining room eating lunch. On 05/15/23 at 09:30 AM, Administrative Nurse D stated staff should not check residents' blood sugar at the dining room table; they should take the resident to the room or to a private area. The facility's Resident's Right policy, dated November 2016, documented each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. The facility failed to promote care for R6 in a manner to maintain and enhance dignity and respect placing the resident at risk or impaired psychosocial wellbeing.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 32358 The facility had a census of 41 residents. The sample included 13 residents. Based on record review and interview the facility failed to consistently deliver the 41 residents mail on Saturdays. Findings included: - On 05/11/23 at 11:30 AM, during resident council meeting, Resident (R) 26, R19, and R12 reported they had not consistently received their mail on Saturdays. On 5/11/23 at 8:34 AM, Activity Staff AZ verified the residents were not receiving mail on Saturdays. Activity Staff Z stated the mail is delivered on Saturday to the facility and placed in bucket in the entrance foyer. She said she picked it up on Mondays and delivered it to residents. Activity Staff Z stated the managers on duty take turns being in the facility on Saturdays, but some of them do not know who can have their mail or if it goes to the resident's representative. She stated there was a time when she was gone from the facility for two weeks and residents did not receive their mail during that time. Activity Staff Z stated on holiday weekends, there was no management on duty in the facility. She stated management took turns being in facility on weekends and she would go without a turn for three months. She did say if she was in the facility on Saturdays, she would deliver the mail to the residents. The facility's Resident's Rights Policy, dated revised 11/16, documented the residents have the right to send and receive mail and to receive letters, packages and other materials delivered to the facility for the resident through a means other than the postal service. The facility's Resident Mail Policy, revised on 12/13/22 documented mail or other materials sent to the resident would be delivered within 24 hours of delivery by the postal service. The facility failed to consistently deliver the 41 residents or their representatives, who resided in the facility, their mail on Saturdays.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 41 residents. The sample included 13 residents with one reviewed for dialysis (the process of removing waste products and excess fluid from the body when the kidneys are not able to adequately filter the blood). Based on observation, record review, and interview, the facility failed to ensure ongoing fluid restriction implementation for Resident (R) 16, who received dialysis treatment. This placed the resident at risk for complications and health decline. Findings included: - R16's Electronic Medical Record (EMR) recorded diagnoses of end stage renal disease (decline in kidney function.) R16's Admission Minimum Data Set (MDS), dated [DATE], recorded R16 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS recorded he required extensive assistance of two staff for bed mobility, transfers, limited assistance of one staff with personal hygiene, and limited assistance of two staff with toilet use. The MDS further recorded R16 was frequently incontinent of urine and recorded the resident received dialysis treatment. The Dialysis Care Plan, dated 01/25/23, documented R16 received dialysis three times a week on Tuesdays, Thursdays and Saturdays. The Care Plan documented the resident was on a fluid restriction of 1500 millimeters (ml) a day. The Physician Order, dated 12/13/22 resident documented the resident would receive dialysis treatment three times a week. The Physician Order, dated 01/25/23, documented R16 had fluid restriction of 1500 ml a day. The facility's Fluid Intake revealed the following days R16 received greater than the physician ordered 1500 ml/day: Intake: 02/13/23 - 1710 ml 02/15/23 - 1540 ml 02/27/23 - 1560 ml 03/05/23 - 1830 ml 03/17/23 - 1640 ml 04/03/23 - 2280 ml 04/06/23 - 1520 ml (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/11/23 - 2690 ml 04/12/23 - 2175 ml 04/15/23 - 2585 ml 04/16/23 - 2600 ml 04/17/23 - 2200 ml 04/21/23 - 2250 ml 04/29/23 - 2260 ml 05/01/23 - 2040 ml 05/08/23 - 1780 ml On 05/09/23 at 09:15 AM, observation revealed sat in a recliner in the room. Licensed Nurse (LN) G administered a Novolog (fast acting insulin) injection in her right upper arm. Continued observation revealed R16 was dressed in street clothes and nicely groomed. On 05/15/23 at 10:30M, Administrative Nurse D verified R16 received dialysis three times a week on Tuesday, Thursday and Saturday. Administrative Nurse D verified R16 was on a 1500 ml fluid restriction and the facility intake documentation revealed R16 had received greater than the 1500 ml /day multiple time the last few months. The facility's Dialysis - Renal Diets-Food and Nutrition Services, policy, dated 02/21/23, documented the facility would provide residents with nutritional care addressing renal needs to attain or maintain optimal nutrition status. The dietician would individualize nutritional care of each resident to maintain adequate calorie, protein and fluid intake and fluids may be restricted if medically necessary. The facility failed to implement R16's physician ordered 1500 ml fluid restriction, placing the resident at risk for complications and health decline while receiving dialysis treatment.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 41 residents. The sample included 13, with six reviewed for unnecessary medications. Based on record review and interview the facility failed to provide appropriate and adequate narcotic drug reconciliation, when staff failed to accurately record controlled substance doses on the narcotic count record and further failed to immediately report a discrepancy in Resident (R) 142's liquid Ativan (drug used to treat anxiety) count. This placed R142 at risk for missed, doses, misappropriation and/or diversion. Findings included: - R142's Electronic Medical Record (EMR) documented the resident had a diagnosis of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder. R142's Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview of Mental Status (BIMS) score 13, which indicated intact cognition. The MDS documented R142 received an antianxiety medication for six days during the lookback period. R142's Medication Care Plan, revised 1/15/22, documented R142 received Ativan and instructed staff to monitor for side effects from the medication. R142's Physician Order, dated 12/20/21, instructed staff to administer 0.25 milliliters (ml), by mouth, one time a day for anxiety. The facility's Incident Report, dated 01/16/22, documented on 01/16/22 around 08:00 PM, Licensed Nurse (LN) J notified the director of nursing there was a discrepancy in the amount of R142's liquid oral Ativan, with almost nine ml missing. The incident report documented the last signed out dose on the sheet was 01/13/22 but was charted in R142's Medication Administration Record (MAR) as given by LN K on 01/14/22 and 01/15/22 and there were four more instances where doses were charted on the MAR but not deducted from the narcotic book which accounted for 1.5 ml of the Ativan leaving a shortage of 7.75 ml. The incident report documented the director of nursing was unable to find a reason for the missing amount. The incident report documented LN L and LN GG noted on 01/07/22 the count had been off by seven ml. The case was reviewed, and it was decided that since the medication was short a week prior to when the incident initially occurred there was no reason to pursue any further with LN K since the medication had been administered by so many staff during that time and showing a gradual loss of the medication since the first time it was noticed; it was a matter of education with staff. The facility Witness Statement, from LN L and LN GG documented R142's Ativan counted by them on 01/07/22 was off/short by approximately seven mls. R142's Narcotic Record, documented R142's Atvian, first opened on 12/07/21, had missing documentation on the following dates: 12/25/21-12/27/21 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/25/21-12/27/21 12/30/21-12/01/22 01/05/21-01/07/22 01/13/22 - 01/16/22 At the bottom of the narcotic record LN K documented administering R142's Ativan on the missing dates. On 05/15/23 at 12:32 PM, Administrative Nurse D stated she was not the facility's director of nursing at the time of the incident. Administrative Nurse D said staff should report a medication count discrepancy immediately to the director of nursing when they note one. On 05/15/23 at 3:07 PM, Administrative Staff A stated staff should have reported the Ativan count discrepancy immediately and the reconciliation of R142's Ativan was incomplete. The facility's Medications : Controlled, revised 12/5/22, documented the facility would along with their consultant pharmacist establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation that determines that drug records are in order and that an account of all controlled drugs would be maintained and periodically reconciled and meet all state and federal requirements for controlled medications. Each time the keys, that secure controlled medications, change from one nurse/medication aide to another, the oncoming and off going nurse/medication aide would work together to reconcile all controlled medications, including all discontinued controlled medications and documented the same. If the physical count is not in agreement with the controlled substance bound book the error must be found or an incident report must be completed prior to the end of the shift and reported to the director of nursing services before any staff administering medications for the shift leave the building. The facility failed to provide appropriate and adequate narcotic drug reconciliation, when staff failed to complete the narcotic count record and further failed to report R142's Ativan count discrepancy. This placed R142 at risk for missed medication and diversion.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 41 residents. The sample included 13 residents. Based on observation, record review, and interview the facility failed to ensure one of three residents, reviewed during medication administration pass, remained free of medication errors. This placed the resident at risk for adverse reaction from the medication. Findings included: - Resident (R)16's Electronic Medical Record (EMR) recorded diagnoses of end stage renal disease (decline in kidney function.) R16's Admission Minimum Data Set (MDS), dated [DATE], recorded R16 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS recorded he required extensive assistance of two staff for bed mobility, transfers, limited assistance of one staff with personal hygiene, and limited assistance of two staff with toilet use. The MDS further recorded R16 was frequently incontinent of urine and recorded the resident received dialysis (procedure where impurities or wastes were removed from the blood) treatment. R16's Physician Order, dated 01/26/23 instructed staff to administer Sevelamer Carbonate (medication used to control phosphorus levels for resident's who received dialysis, 800 milligrams (mg) three tablets, three times a day with meals. On 05/10/23 at 08:30 AM, observation revealed License Nurse (LN) I popped two tablets of Sevelamer Carbonate 800 milligrams (mg), in a plastic medication cup and administered to R16. On 05/15/23 at 10:30 AM, Administrative Nurse D verified the physician ordered Sevelamer, 800 mg three tablets, three times a day. Administrative Nurse D verified LN I had administered two tablets on 05/10/23 and verified the blister medication card sent from the pharmacy had the order documented to administer two of the 800 mg tablets not three. Administrative Nurse D confirmed, after investigation, the physician order on 01/26/23 was for three 800 mg tablets and was unsure if the incorrect dose had been administered since January or how long the pharmacy had sent out the incorrect dose. Administrative Nurse D verified the nurses were expected to check the six rights for medication for medication administration (right medication, right dose, right resident, right route, right time and right documentation) and the nurse failed to do so. The facility's Medication Administration policy, dated 03/29/2023, documented medications are administered to the resident according to the Six Rights, right medication, right dose, right resident, right route, right time and right documentation. The policy documented the staff would perform three checks; read the medication ion the medication container and compare with the MAR when removing the container from the supply drawer, when placing the medication in an administration cup/syringe and just before administering the medication. All employees passing medications are familiar with action and adverse reactions of medications. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to prevent a significant medication error when staff administered the incorrect dose of medication to R16. This placed the resident at risk for adverse reaction from the medication.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 27168 The facility had a census of 41 residents. The sample included 13 residents. Based on observation, interview, and record review, the facility failed to label Resident (R)16, and R28's insulin (hormone which allows cells throughout the body to uptake glucose) flex pen with the date opened and expiration date, failed to discard R6's and R38's expired insulin vial and failed to discard expired stock medications on two medication carts. This placed the affected residents at risk for ineffective medications. Findings included: - On 05/09/23 at 08:45 AM, observation of Hall-One medication cart revealed the following: R28's Novolog (a short acting insulin) flex pen lacked a date opened, and date of expiration. R38 's Novolog flex pen opened 03/01/23, expired 03/29/23 (28 days). The medication cart revealed five individualized packets of famotidine (antacid) tablets, expired 09/2022. On 05/09/23 at 09:15 AM, observation of the Hall-Two medication cart revealed the following: R16's Tresiba (long acting insulin) flex pen open and undated. R6's Novolog vial opened 03/26/23, expired 04/23/23 (28 days). The medication cart revealed one bottle of calcium (calcium supplement) 60 (mg) milligram, 60 tablets, expired 03/2023. On 05/09/23 at 08:50 AM, Licensed Nurse (LN) G verified the stock medication on the Hall-One medication cart was expired. LN G stated the nurses were to look at the bottles and verify expiration dates before administering the medications and to the discard expired medications. LN G verified the nurses were to date the insulin pens/vials when opened and discard the expired insulin. On 05/09/23 at 09:20 AM, LN H verified the stock medication won Hall-Two cart was expired. LN H stated the nurses were to look at the bottles and verify expiration dates before administering the medications, and to discard expired medications. LN H verified the nurses were to date the insulin pens/vials when opened and discard expired insulins. On 05/15/23 at 9:30 AM, Administrative Nurse D verified the nurses should label and date the insulin pens and vials with the resident's name and discard expired items. Administrative Nurse D verified expired stock medications were to be discarded. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Storage of Medications policy, dated 04/26/23, documented multi-dose vials should have the open date written on the vial, Refer to Insulin Storage Parameters for storage times based on manufactures recommendations. The staff would ensure the correct type of insulin and date vial was opened. Staff would look at the insulin flex pen physician order, the expiration date and the number of days the pen has been opened. The facility failed to label and date the residents insulin vials, discard expired insulin flex pen and discard expired stock medications, placing the residents at risk for ineffective medication.