STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175336	A. BUILDING _____ B. WING _____	08/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LYONS	1311 S DOUGLAS AVENUE LYONS, KS 67554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was electronically sent to the facility on 8/20/19.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility had a census of 34 residents. The sample included 12 residents, with one reviewed for compromised skin and pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interview, the facility failed to provide necessary care and services to prevent the development of pressure ulcers for Residents (R) 31. Findings included: - R31's "Physician Order Sheet", dated	F 686		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/20/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175336	A. BUILDING _____ B. WING _____	08/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LYONS	1311 S DOUGLAS AVENUE LYONS, KS 67554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 1	F 686		

08/09/2019, documented the resident had diagnoses of diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and hypertension (elevated blood pressure).

The quarterly Minimum Data Set (MDS), dated 04/30/2019 and 07/30/2019, recorded the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact. The MDS documented the resident independent with locomotion on and off the unit, and walking in room and corridor. The MDS recorded the resident used a walker for mobility and had no pressure ulcers or skin issues.

The 11/03/2018 Activities of Daily Living (ADL) Care Area Assessment (CAA) recorded the resident had a self-performance deficit related to behaviors and directed staff to remind and encourage the resident to perform some tasks.

The 07/08/2019 care plan instructed staff to inspect the resident's body for breaks in skin and treat promptly as ordered by health care provider. The care plan directed the nurse to provide foot and nail care routinely, ensure the resident was wearing non-slip footwear when out of bed, and his toes were protected.

The 08/04/2019 revised care plan documented the resident had impairment to skin integrity evidenced by an open area to the left third toe on his left foot. The care plan documented the facility staff would educate the resident and family of causative factors and measures to prevent skin injury. The care plan documented staff would monitor location, size and treatment of the skin injury, report abnormalities, failure to heal, signs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175336	A. BUILDING _____ B. WING _____	08/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LYONS	1311 S DOUGLAS AVENUE LYONS, KS 67554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 2	F 686		

and symptoms of infection, and maceration (softening and breaking down of skin as a result from prolonged exposure to moisture, such as sweat, urine, or feces (or wounds for extended periods) to the health care provider. The care plan documented staff would apply Duoderm (wafer type moisture-retentive wound dressing used for partial and full-thickness wounds leaking fluids) to the open areas and change the dressing every three days and as needed for wound healing. The care plan documented the resident would wear tennis shoes with socks for protection to feet, and to protect the skin.

The 07/09/2019, physical therapy notes documented the resident would use a front wheeled walker for ambulation, wear tennis shoes every morning and remove before bed.

The 08/04/2019 at 03:47 PM, nurse's notes documented the resident had a circular open area to his left third toe and looked like his sandal had possibly caused the open area. The nurse's noted documented staff would place tennis shoes on the resident daily with socks. The nurse's notes documented the resident's tennis shoes were presently in the laundry. The nurse's notes documented the open area was 0.5 centimeters (cm) by 0.7 cm. The nurse applied a thin Duoderm to the open area, educated the resident to wear closed toed shoes and risks of poor skin integrity due to diagnoses of diabetes, and staff faxed the physician.

The 08/05/2019 at 04:20 PM, nurse's notes documented the physician returned the fax and ordered an extra thin Duoderm, change every three days and as needed, and ensure the resident was wearing tennis shoes and socks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175336	A. BUILDING _____ B. WING _____	08/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LYONS	1311 S DOUGLAS AVENUE LYONS, KS 67554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 3	F 686		

everyday.

The 08/07/2019 at 01:36 PM, nurse's notes documented the physician was in the facility and had no new orders.

The 08/18/2019 "Wound Data Collection" documented the resident's left third toe with an open area 0.5 cm by 0.7 cm by 0.1 cm, and a non pressure wound, measuring 0.5 cm by 0.4 cm.

The 08/20/2019 "Clinic Referral Visit Form" documented the physician saw the resident and documented the resident had sores on his left third and fourth toes, dorsal (top) side, and the resident had noticed for approximately one month after wearing sandals that caused friction rub to the toes. On 8/04/2019 the nursing staff notified the physician of the sore to the resident's left third toe, had the resident stop wearing sandals, changed to socks and tennis shoes, and applied Duoderm. The physician documented the exam today - friction rub sores of 1 cm to third toe and 5 millimeters(mm) to fourth toe on the dorsum (back or top of the toe) side. The physician ordered staff to discontinue the Duoderm on the third toe, apply dry gauze daily, and continue to apply Duoderm on the fourth toe. The physician ordered Septra (antibiotic) Double Strength one tablet daily for 10 days, wear shoes and socks daily, and return to office in one week.

On 08/15/2019 at 02:25 PM, observation revealed Licensed Nurse (LN) G removed the Duoderm from the resident's left third toe, cleansed the area with wound cleanser then applied a thin layer of Duoderm over the two open areas on the inside and the top of the toe. Continued observation revealed the resident's left fourth toe

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175336	A. BUILDING _____ B. WING _____	08/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LYONS	1311 S DOUGLAS AVENUE LYONS, KS 67554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 4	F 686		

had a pinpoint area on the top of the toe with no open areas. Observation revealed the resident had croc (slip on shoe) shoes on and no socks.

On 08/15/2019 at 02:30 PM, the resident verified he had a pair of sandals he wore for six months before he purchased the crocs with an open heel the end of June. The resident stated he thought the crocs allowed his foot to move back and forth when walking, causing the open areas on his toes.

On 08/15/2019 at 02:35 PM, LN G verified the resident got a new pair of crocs a few weeks ago and thought this may have caused the open areas on his toes, and verified he walked with a shuffle and recently started using a walker due to leaning forward and shuffling with walking.

On 08/19/2019 at 10:30 AM, Administrative Nurse D verified the resident had a pair of sandals that rubbed along his toe area, shuffled his feet and leaned forward when walking. Administrative Nurse D verified the resident started wearing tennis shoes, then he had an incontinent episode and got his tennis shoes soiled, so staff took the shoes to the laundry, and he wore his crocs during that time. Administrative Nurse D stated the physician had not documented if the area was a diabetic ulcer or pressure area.

The facility's September 2016 "Pressure Ulcer Prevention Requirements" policy documented to use appropriate prevention techniques and pressure redistribution surfaces on residents at risk for pressure ulcers. Prevention strategies are ongoing and are individualized based on the areas or the level of risk determined. At risk residents are those residents with decreased

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175336	A. BUILDING _____ B. WING _____	08/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LYONS	1311 S DOUGLAS AVENUE LYONS, KS 67554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 5 mobility. Weekly skin checks are recommended to be performed on all residents but especially those identified at risk. Once a resident has been identified to be at risk for skin breakdown the interdisciplinary team needs to assess and determine appropriate action for the prevention of pressure . The facility failed to provide necessary care and services to prevent the development of a pressure area on R 31's left fourth toe, placing the resident at risk for further pressure ulcers.	F 686		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility had a census of 34 residents. The sample included 12 residents. Based on	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175336	A. BUILDING _____ B. WING _____	08/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LYONS	1311 S DOUGLAS AVENUE LYONS, KS 67554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 6	F 812		

observation, record review, and interview, the facility failed to prepare, store, distribute, and serve food under sanitary conditions for the 34 residents who resided in the facility, and received their meals from the kitchen.

Findings included:

- On 08/13/2019 at 01:30 PM, during the initial kitchen tour, observation revealed a five foot by four foot area of concrete in front of the dishwasher that lacked any flooring cover.

On 08/13/2019 at 01:35 PM, Dietary Manager (DM) BB verified the kitchen flooring had been missing for a few weeks after a water line break and repair.

On 08/19/2019 at 10:00 AM, interview with Administrative Staff D verified the kitchen had a water line break in front of the dishwashing area, the water line had to be dug up and replaced, and the hole was filled with concrete. Administrative Staff D verified the facility received a bid to replace the vinyl flooring from a contractor, however they were awaiting the corporation to authorize the repair work since June 5, 2019.

The facility's April 2016, "Safety Inspection" policy documented the purpose is to inspect, on a scheduled basis, the departments to identify unsafe working conditions and make corrections as necessary to provide a safe and healthy working environment for employees and residents.

The facility failed to prepare, store, distribute and serve food under sanitary conditions for the 34 residents who resided in the facility, and received

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175336	A. BUILDING _____ B. WING _____	08/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LYONS	1311 S DOUGLAS AVENUE LYONS, KS 67554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 7 meals from the kitchen, placing the residents at risk to ingest contaminated food or beverages.	F 812		