STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N078020	A. BUILDING: _____ B. WING _____	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - THE LODGE	816 E 30TH AVE HUTCHINSON, KS 67502

(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) COMPLETE DATE
S 000	INITIAL COMMENTS The following represent the findings of an initial certification survey for the above named Assisted Living facility conducted on 10/08/25 and 10/09/25.	S 000		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1) The facility reported a census of 10 residents with three residents included in the sample. Based on interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) was fully developed based on	S3085		

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
	N078020	A. BUILDING: _____ B. WING _____	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - THE LODGE	816 E 30TH AVE HUTCHINSON, KS 67502

(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) COMPLETE DATE
S3085	Continued From page 1 the resident's "Functional Capacity Screen" (FCS), service needs, and preferences for resident (R)101, R102 and R103. Findings included: - R101's medical record revealed she moved into the facility on 04/12/25 with a diagnosis of macular degeneration. R101's FCS dated 04/03/25 triggered for falls and impaired vision. R101's NSA dated 04/12/25 did not address what services or interventions staff provided R101 concerning her risk for falls or her impaired vision. On 10/09/25 at 12:15 PM Administrative Staff A stated R101's NSA did not describe what services staff provided her concerning falls and impaired vision. The administrator failed to ensure R101's NSA was fully developed to include all items that triggered on the FCS, her service needs, and preferences. - R102's medical record revealed she moved into the facility on 12/03/24 with a diagnosis of diabetes mellitus. R102's FCS dated 10/23/24 triggered for falls, impaired vision, and impaired hearing. R102's NSA dated 11/19/24 did not address what	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N078020	A. BUILDING: _____ B. WING _____	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - THE LODGE	816 E 30TH AVE HUTCHINSON, KS 67502

(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) COMPLETE DATE
S3085	Continued From page 2 services or interventions staff provided R102 concerning her risk for falls, impaired vision or impaired hearing. On 10/09/25 at 12:37 PM Administrative Staff A confirmed R102's NSA did not address all that triggered on her FCS. The operator failed to ensure R102's NSA was fully developed to include all items that triggered on the FCS, her service needs, and preferences. - R103's medical record revealed she moved into the facility on 02/02/25 with diagnoses of glaucoma and muscle weakness. R103's FCS dated 01/29/25 revealed she was independent with transfers and mobility using a four wheeled walker and that she triggered for falls. R103's NSA dated 02/02/25 did not address what services or interventions staff provided R103 concerning her risk for falling. On 10/09/25 at 12:00 PM Administrative Staff A stated R103's NSA did not address all that triggered on her FCS. The operator failed to ensure R103's NSA was fully developed to include all items that triggered on the FCS, her service needs, and preferences.	S3085		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N078020	A. BUILDING: _____ B. WING _____	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - THE LODGE	816 E 30TH AVE HUTCHINSON, KS 67502

(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) COMPLETE DATE
S3092	Continued From page 3	S3092		

negotiated service agreement according to the following requirements:(1) At least once every 365 days;
(2) following any significant change in condition, as defined in K.A.R. 26-39-100;
(3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and
(4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-202(d)(2)

The facility reported a census of 10 residents. The sample included three residents. Based on interview, observation, and record review the operator failed to ensure designated staff revised a "Negotiated Service Agreement" (NSA) when a new fall intervention involving services provided by facility staff was implemented for resident (R)103.

Findings included:

- R103's medical record revealed she moved into the facility on 02/02/25 with diagnoses of glaucoma and muscle weakness.

R103's FCS dated 01/29/25 revealed she was independent with transfers and mobility using a four wheeled walker and that she triggered for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N078020	A. BUILDING: _____ B. WING _____	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - THE LODGE	816 E 30TH AVE HUTCHINSON, KS 67502

(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) COMPLETE DATE
S3092	Continued From page 4 falls. R103's NSA dated 02/02/25 did not address what services or interventions staff provided R103 concerning her risk for falling. Review of the "Resident Event" form dated 07/13/25 revealed R103 experienced a fall in her kitchen apartment with an intervention for staff to put a sign on her walker to remind her to keep it with her at all times. On 10/09/25 at 11:25 AM an observation of R103's apartment revealed there was a sign on her walker and on the wall in the living room to reminder her to use her walker. On 10/09/25 at 12:00 PM Administrative Staff A stated R103's NSA did not include that staff were to place a sign on her walker to remind her to use it. The operator failed to ensure designated staff revised the NSA with new fall interventions involving services provide by facility staff for R103.	S3092		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N078020	A. BUILDING: _____ B. WING _____	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - THE LODGE	816 E 30TH AVE HUTCHINSON, KS 67502

(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) COMPLETE DATE
S3211	Continued From page 5 be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g)(3) The facility reported a census of 10 residents. Based on observation and interview the operator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the original package of all "Over the Counter" (OTC) medications. Findings included: - On 10/07/25 at 11:03 AM an observation of the medication cart revealed the following OTC medications without the full name of the resident on them: One bottle Tylenol Extra Strength One 15-ounce container of Metamucil One bottle of Phillips Milk of Magnesia One bottle of Walgreens brand of Milk of Magnesia On 10/07/25 at approximately 11:05 AM Certified Medication Aide B acknowledged that there were some OTC medications that were not labeled with the full name of the resident on them.	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N078020	A. BUILDING: _____ B. WING _____	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - THE LODGE	816 E 30TH AVE HUTCHINSON, KS 67502

(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) COMPLETE DATE
S3211	Continued From page 6 The "Medication Administration and Supporting Processes- Hutchinson AL" policy reviewed on 04/03/25 documented, "Pharmacy or RN will label any OTC medications..." The operator failed to ensure all OTC medications were labeled by a pharmacist or licensed nurse with the resident's full name.	S3211		
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be	S3215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N078020	A. BUILDING: _____ B. WING _____	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - THE LODGE	816 E 30TH AVE HUTCHINSON, KS 67502

(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) COMPLETE DATE
S3215	Continued From page 7 stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h)(1) The facility reported a census of 10 residents. Based on observation and interview, the operator failed to ensure resident medications were securely stored. Findings included: - On 10/08/25 at 11:55 AM an observation of the "Med Room" refrigerator located in the unlocked activities room revealed the locking mechanism was locked but not securely attached to the refrigerator allowing the door to be opened. There were some medications stored in the refrigerator which were accessible to anyone without the use of a key. On 10/08/25 at 12:25 PM Certified Medication Aide B stated the refrigerator had been in this condition for several years. The "Medication Administration and Supporting Processes" policy reviewed on 04/03/25 documented, "Only authorized personnel designated by the facility shall have access to medications."	S3215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N078020	A. BUILDING: _____ B. WING _____	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - THE LODGE	816 E 30TH AVE HUTCHINSON, KS 67502

(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) COMPLETE DATE
S3215	Continued From page 8 The operator failed to ensure medications were securely stored to ensure only licensed nurses and medication aides had access to stored medications.	S3215		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 10 residents. The sample included three residents. Based on interview and record review the operator failed to ensure one of three sampled Residents (R)101's record contained documentation of all incidents, symptoms, and other indications of illness or injury. Findings included: -R101's medical record revealed she moved into the facility on 04/12/25 with a diagnosis of chronic obstructive pulmonary disease. The 04/03/25 "Functional Capacity Screen" (FCS) revealed R101 was independent with	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N078020	A. BUILDING: _____ B. WING _____	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - THE LODGE	816 E 30TH AVE HUTCHINSON, KS 67502

(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) COMPLETE DATE
S3261	Continued From page 9 transfers and mobility and required supervision with management of treatments. The 04/12/25 "Negotiated Service Agreement" (NSA) lacked documentation R101 had a wound to her leg and did not include documentation of who treated this wound. R101's medical record lacked documentation of an assessment for a leg wound, treatment provided and any follow-up on the condition of the wound. On 10/09/25 at 11:15 AM R101 stated she had a wound on her leg that she has had for years. R101 stated the wound was getting worse and would like the nurse to take a look at it. On 10/09/25 at 12:15 PM Administrative Staff A stated that it was possibly the week before that R101 scratched open an old leg wound and a nurse from the associated skilled nursing facility came over to treat the wound. Administrative Staff A stated it was her expectation that the nurse documented this incident in the nursing notes. The operator failed to ensure designated staff included documentation of all incidents, symptoms and other indications of illness or injury including the dated, time of occurrence, action taken, and results of the action.	S3261		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N078020	A. BUILDING: _____ B. WING _____	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - THE LODGE	816 E 30TH AVE HUTCHINSON, KS 67502

(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) COMPLETE DATE
S3280	Continued From page 10 ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility reported a census of 10 residents. Based on record review and interview for all residents and all facility employees, the operator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's "Emergency Management Plan" (EMP) with employees and residents that included all eight required topics. Findings included: - On 10/08/25 Administrative Staff A provided documentation of the quarterly EMP reviews with staff and residents which revealed the following: The "Resident Council Meeting September 18,	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N078020	A. BUILDING: _____ B. WING _____	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - THE LODGE	816 E 30TH AVE HUTCHINSON, KS 67502

(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) COMPLETE DATE
S3280	Continued From page 11 2024" form documented only fire evacuation and tornado procedures were reviewed. The "Resident Council Meeting December 24, 2024" form documented only thunderstorm policies were reviewed. The "Resident Council Meeting March 27, 2025" form documented only tornados and severe storms policies were reviewed. The "Resident Council Meeting June 19, 2025" form documented only tornados and severe storms policies were reviewed. The "Resident Council Meeting September 5th, 2025" form documented only severe storm warning policies were reviewed. On 10/08/25 at 12:40 PM Administrative Staff A stated the EMP was reviewed with residents and staff during resident council meetings and acknowledged that not all eight required topics were reviewed on a quarterly basis. The operator failed to ensure the completion of quarterly reviews covering all the required items of the emergency management plan with employees and residents.	S3280		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious;	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N078020	A. BUILDING: _____ B. WING _____	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - THE LODGE	816 E 30TH AVE HUTCHINSON, KS 67502

(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) COMPLETE DATE
S3310	Continued From page 12 (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) The facility reported a census of three residents. Based on record review and interview the operator failed to ensure the facility was in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings include: - Resident (R)101 admitted to the facility on 04/12/25. Review of medical records revealed R101 did not have a TB Symptom Screen Questionnaire completed upon admission to the facility. On 10/09/25 at 12:15 PM Administrative Staff A stated it was her understanding that TB Symptom Screen Questionnaires were completed on an annual basis after the resident had been at the facility for a year and confirmed one was not	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N078020	A. BUILDING: _____ B. WING _____	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - THE LODGE	816 E 30TH AVE HUTCHINSON, KS 67502

(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) COMPLETE DATE
S3310	Continued From page 13 completed for R101 upon admission. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident ...shall have an initial TB symptom screen ...within 7 days of residency ..." The operator failed to ensure the compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. - R102 admitted to the facility on 12/03/24. Review of medical records revealed R102 did not have a TB Symptom Screen Questionnaire completed upon admission to the facility and that the first step of the two-step "TB skin test" (TST) was administered on 12/17/24 which was seven days late. On 10/09/25 at 12:37 PM Administrative Staff A stated a TB Symptom Screen Questionnaire was not completed upon admission for R102 and confirmed the two-step TST was administered seven days late. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident ...shall have an initial TB symptom screen ...within 7 days of residency ...Each new resident ...shall receive a two-step TST or an IGRA for Mycobacterium tuberculosis within 7 days of residency ..." The operator failed to ensure the compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R.	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N078020	A. BUILDING: _____ B. WING _____	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - THE LODGE	816 E 30TH AVE HUTCHINSON, KS 67502

(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) COMPLETE DATE
S3310	Continued From page 14 26-39-105. - R103 admitted to the facility on 02/02/25. Review of medical records revealed R103 did not have a TB Symptom Screen Questionnaire completed upon admission to the facility. On 10/09/25 at 12:00 PM Administrative Staff A stated it was her understanding that TB Symptom Screen Questionnaires were completed on an annual basis after the resident had been at the facility for a year and confirmed one was not completed for R103 upon admission. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident ...shall have an initial TB symptom screen ...within 7 days of residency..." The operator failed to ensure the compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. - "Certified Medication Aide" (CMA) C was hired on 06/03/25 with her first day of work being 06/11/25. Review of CMA C's employee records revealed she did not complete a TB Symptom Screen Questionnaire until 09/26/25 which was 100 days late. Employee records also revealed the first step of the two-step TST was not administered until 06/24/25 which was six days late. On 10/08/25 at 02:10 PM Administrative Staff A stated a two-step TST should be administered	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N078020	A. BUILDING: _____ B. WING _____	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - THE LODGE	816 E 30TH AVE HUTCHINSON, KS 67502

(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) COMPLETE DATE
S3310	Continued From page 15 upon hire but only completed the TB Symptom Screen Questionnaire on an annual basis and not upon hire. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new ...employee shall have an initial TB symptom screen ...within 7 days of ...employment ...Each new ...employee shall receive a two-step TST or an IGRA for Mycobacterium tuberculosis within 7 days of ...employment." The operator failed to ensure the compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		