STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175507	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Home Association	321 N Chestnut Street Lindsborg, KS 67456

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 75 residents. The sample included three residents, with one reviewed for a change of condition. Based on observation, record review, and interview, the facility failed to notify Resident (R) 1's representative when R1 had a change in condition. This deficient practice placed R1 at risk for a lack of required decision from her representative for treatment.Findings included:- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) and thrombophilia (blood disorder that makes the blood in your veins (blood vessels that carry oxygen filled blood towards the heart) and arteries (blood vessels that carry blood away from the heart) more likely to clot).R1's Quarterly Minimum Data Set (MDS) dated [DATE], documented the resident had a Brief Interview of Mental Status (BIMS) of nine, which indicated moderately impaired cognition. The MDS documented R1 had no upper or lower extremity impairment and used a walker for mobility. The MDS documented R1 required supervision with transfers and ambulation 10 feet (ft).R1's Care Plan, revised 08/05/25, documented R1 required limited one staff assistance with mobility in the room with a walker. The Nurse's Note dated 07/12/25 at 10:34 PM documented the nurse observed R1 with vomiting and diarrhea throughout the day. Staff administered Maalox (antacid medication), 10 milliliters (ml), and two Imodium (over-the-counter medication used to treat diarrhea), 2 milligrams (mg), tablets to R1. Review of R1's clinical record revealed a lack of documentation. R1's representative was informed of the change in condition.The Nurse's Note dated 07/14/25 at 01:17 PM documented R1 had a rough weekend with nausea, vomiting, and diarrhea, and had a hard time transferring. The note documented R1 slept in, took her morning medications, got up for lunch, and ate some of her meal. The note documented staff checked her vitals, and they were within normal limits for R1. The nurse assessed R1's hand grasp, and they were equal on both sides. The note documented R1 had a hard time cutting up her meat, and the nurse notified the physician and R1's representative three days after R1's initial change in condition.On 09/02/25 at 10:22 AM, Administrative Nurse D verified a lack of documentation in R1's clinical record, regarding staff notifying the resident's representative of R1's change of condition on 07/12/25. Administrative Nurse D stated she would expect staff to notify the representative as soon as R1 had nausea, vomiting, and diarrhea.Upon request, the facility failed to provide a change in condition policy.

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
	175507	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Home Association	321 N Chestnut Street Lindsborg, KS 67456

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 75 residents. The sample included three residents. Based on observation, record review, and interview, the facility failed to notify the physician regarding issues with red drainage from a urinary catheter (a tube inserted into the bladder to drain urine) and the lack of urine output for the night shift for one resident, Resident (R) 2. This placed the resident at risk for physical decline and urinary tract infections (UTI-infection in any part of the urinary system).Findings included:- The Electronic Medical Record (EMR) for R2 documented diagnoses of urinary retention (lack of the ability to urinate and empty the bladder), benign prostatic hyperplasia (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), and chronic kidney disease (a long term condition characterized by the gradual loss of kidney function over time).The admission Minimum Data Set (MDS) dated [DATE] documented R2 had intact cognition. R2 was dependent upon staff for assistance with toileting hygiene, transfers, and lower-body dressing. The MDS further documented R2 had a catheter and no UTIs during the observation period.The Quarterly MDS, dated 08/14/25, documented R2 had intact cognition. R2 was dependent upon staff for toileting hygiene, lower body dressing, and transfers. The MDS further documented R2 had a catheter and no UTIs during the observation period. R2's Care Plan dated 08/26/25, initiated on 11/27/24, directed staff to monitor for signs and symptoms of discomfort on urination and frequency, change the catheter as ordered by the physician, and monitor and document intake and output as per facility policy. The care plan further directed staff to monitor for pain/discomfort due to the catheter, monitor and report to the physician for signs and symptoms of UTIs, frequency, no output, altered mental status, and change in eating patterns. The Physician's Orders dated 02/16/25 directed staff to change the catheter using a 16 French, 10 cc (cubic centimeter) balloon, every one hour as needed, and on the night shift, every 30 days.The Nurse's Note dated 06/17/25, at 12:59 PM, documented that the nurse placed a 16 French catheter in the resident as it was due to be changed. The resident tolerated it well, and urine was returned once the catheter was inserted. The note further documented staff emptied out 600 milliliters (ml) of urine from the previous catheter and would continue to monitor.The Nurse's Note dated 06/18/25 at 02:41 PM, documented R2 complained of pain and little urine output. Nursing staff attempted to flush the catheter with 30 cc of sterile water, with no relief. Nursing staff attempted to advance the catheter with no output and removed 10cc of sterile water from the balloon. The catheter was removed, and a large amount of dark red drainage came out. The note further documented the nursing staff changed the catheter, and there was an immediate cloudy yellow return. Nursing staff inflated the bulb with 10 cc of sterile water per order, and the resident stated he felt better, but the red drainage continued.The Nurse's Note dated 06/18/25 at 07:34 PM, documented that R2's Foley catheter was changed yesterday, and then he complained of pain. The day shift staff changed the Foley catheter this morning, and a moderate amount of red drainage was noted, with some in the drainage bag as well. The resident stated he felt ok and the red drainage was probably caused by trauma.The Nurse's Note dated 06/19/25 at 08:52 AM, documented that nursing staff reported to the nurse that R2 had not had any urine output all night. The nurse went in and put in a new Foley catheter. When she removed the old Foley catheter, the nurse did notice some blood-tinged color. The note further documented that R2 tolerated it well, and the urine was yellow in the tube. The note documented that the nurse would continue to monitor. The EMR lacked documentation that the physician or responsible party was notified of the lack of urine output or the red drainage.The Nurse's Note dated 06/19/25 at 10:26 AM, documented that staff reported R2 had emesis (vomit) at breakfast. R2 stated he was nauseous and felt his medication caused this; no temperature was noted, and nursing staff would continue to monitor R2. The Nurse's Note dated 06/19/25 at 02:00 PM, documented that staff reported to the physician that R2 had increased drowsiness, was hard to arouse, had vital signs on the lower end, urine output and color, and the physician directed staff to send him to the emergency room for evaluation.The Nurse's Note dated 06/19/25 at 05:28 PM, documented R2's spouse reported that he was transferred from the local hospital to the hospital in [NAME], where he was admitted for a UTI.On 09/02/25 at 01:15 PM, R2 was in his room, in bed. His catheter bag was fastened to his bed. On 09/02/25 at 12:05 PM, Certified Nurse Aide (CNA) M stated she would contact the nurse if the resident did not act right or out of his normal behaviors. On 09/02/25 at 12:17 PM, Licensed Nurse (LN) G stated that if she had to change R2's catheter more than once in a short time, she would contact the physician. LN G further stated R2's spouse was very involved with his care, and she would