

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2026
NAME OF PROVIDER OR SUPPLIER Bethany Home Association		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on observation, record review, and interview, the facility failed to maintain an in-service training program for Certified Nurse Aide (CNA) M, specific to the needs of the resident population. Findings included:- Review of CNA M's in-service education totals revealed CNA M did not complete Psychosocial Needs of the Older Adult scheduled to be completed 02/28/2026, Abuse Prevention in Persons with Dementia scheduled to be completed 03/31/2026, and Challenging Behaviors: Care and Interventions for Individuals Experiencing Dementia scheduled to be completed 05/31/2026. On 07/14/2026 at 11:30 AM, Administrative Nurse D verified CNA M had not completed her mandatory CNA trainings Abuse Prevention with Persons with Dementia, Challenging Behaviors: Care and Interventions for Individuals Experiencing Dementia, and Psychosocial Needs of an Older Adult. Administrative Nurse D stated the education was due at the end of the month they were assigned. Upon request, the facility did not provide a CNA Education 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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review, interview, and observation, the facility failed to ensure Resident (R) 1, who was severely cognitively impaired and on hospice, remained free from staff to resident abuse. Findings included:- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of malignant (a medical condition, especially tumors, to become progressively worse, most familiar as a characteristic of cancer) melanoma (a serious type of skin cancer) of overlapping skin sites, hyperlipidemia (condition of elevated blood lipid levels), hypothyroidism (a condition characterized by decreased activity of the thyroid gland), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and traumatic subdural hematoma (SDH-serious condition, typically caused by head injury, where blood collects between the skull and the surface of the brain). The Significant Change in Status Minimum Data Set (MDS), dated 06/29/2026, documented R1 had a Brief Interview for Mental Status (BIMS) score of seven, which indicated severely impaired cognition. The MDS documented R1 required setup/cleanup assistance for eating. The MDS documented R1 required moderate to substantial staff assistance with all other activities of daily living (ADLs). The MDS documented R1 did not have any swallowing difficulty or a mechanically altered diet. The Functional Abilities Care Area Assessment (CAA), dated 06/16/2026, documented R1 required staff assistance with dressing, personal hygiene, and bathing. The CAA documented R1 could dress her upper body with minimal staff assistance but needed extensive staff assistance with dressing her lower body. The CAA documented R1 could ambulate and transfer with her walker with stand-by assistance to minimal staff assistance of one person. The Cognitive Loss/Dementia CAA, dated 06/16/2026, documented R1 had a memory problem, was hard of hearing, and could make her needs known. The CAA documented R1 had a diagnosis of depression and preferred to stay in her room most of the day. R1's Care Plan, initiated 05/20/2026, documented R1 required assistance with bed mobility, dressing, grooming, mobility, toileting, and transfer. R1's care plan documented R1 could make food choices, was on a regular diet, and required cueing to feed herself (06/05/2026). The care plan documented R1 was on hospice care due to malignant melanoma, and hospice and the facility staff would provide R1 with the highest standards of care concerning R1's physical, mental, psychosocial, and spiritual comfort, and well-being. The care plan documented staff would provide R1 support during R1's dying process (06/12/2026). The Nutrition/Dietary Note, dated 06/16/2026, documented R1 was on a regular diet, ate meals in her room, was able to make food choices, was assisted with set-up, and was able to feed herself. The Facility Incident Report, dated 07/10/2026, documented Administrative Nurse D was notified on 07/01/2026 by the CNA instructor that one of her students, Nurse Aide (NA) N, had observed Certified Nurse Aide (CNA) M forcefully feeding mandarin oranges to R1 in her room on 06/30/2026. CNA N stated R1 was not chewing the mandarin oranges, and CNA M continued to feed her. NA N reported that when CNA M got R1 up to use the bathroom, CNA M grabbed R1 by the arm forcefully to get her up. CNA O's Notarized Witness Statement, dated 07/10/2026, documented CNA O had witnessed CNA M feeding R1 quickly without pause and did not allow R1 long enough breaks to chew and swallow her food. NA N's Notarized Witness Statement, dated 07/13/2026, documented on 06/30/2026, NA N observed CNA M rapidly feed R1 without allowing R1 breaks to breathe or chew. NA N stated this caused R1 to gag as too much food was in her mouth. NA N stated throughout the day, she observed CNA M did not handle the resident with care but pulled on the resident's arms. On 07/14/2026 at 09:20 AM, observation revealed R1 lay in bed with the lights off. R1 slept. R1 had oxygen on. On 07/14/2026 at 11:00 AM, observation revealed R1 lay in bed with her (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	eyes open. This surveyor went into R1's room. R1 had cloudy, blank eyes. R1 did not look at this surveyor. R1 weakly whispered, Help. On 07/14/2026 at 09:30 AM, CNA P stated she had not really seen CNA M be abusive when she had worked with CNA M, but CNA M always seemed rushed, as if she was trying to get tasks done as quickly as possible and did not take time with residents. On 07/14/2026 at 10:30 AM, R3 stated CNA M had pushed him down into his chair several times when she provided him care. On 07/14/2026 at 11:30 AM, Administrative Nurse D stated she did not find out about the incident until 07/01/2026 when the CNA instructor notified her. Administrative Nurse D stated CNA M had been working at the facility for twenty-four years, and she had even worked with CNA M when she was a CNA. Administrative Nurse D stated CNA M had been suspended pending investigation. Administrative Nurse D stated during the investigation more things came up, which indicated CNA M needed to be terminated. Administrative Nurse D stated after she was notified of the incident, she brought CNA M into the office, and CNA M stated she did not think she had been too rough, and R1 needed to eat. Administrative Nurse D told CNA M staff were never to force-feed residents. Administrative Nurse D stated CNA M refused to write a witness statement. Administrative Nurse D stated she had talked with NA N and CNA O and told them if anything like this happened, they needed to report it immediately. Administrative Nurse D verified CNA M had not completed her mandatory CNA trainings Abuse Prevention with Persons with Dementia, Challenging Behaviors: Care and Interventions for Individuals Experiencing Dementia, and Psychosocial Needs of an Older Adult. Administrative Nurse D stated the education was due at the end of the month they were assigned. The facility's, Abuse, Neglect, and Exploitation Policy, dated 04/22/26, documented the facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of property and exploitation by: Identifying, correcting, and intervening in situations in which abuse, neglect, or exploitation is more likely to occur with the deployment of qualified registered, licensed, and certified staff on each shift that meets the needs of the residents, and assure that staff have knowledge of the individual care needs and behavioral symptoms.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review, interview, and observation, the facility failed to ensure staff reported allegations of staff to resident abuse immediately to the administrator as required. Findings included:- The Facility Incident Report, dated 07/10/2026, documented Administrative Nurse D was notified on 07/01/2026 by the Certified Nurse Aide (CNA) instructor that one of her students, Nurse Aide (NA) N, had observed Certified Nurse Aide (CNA) M forcefully feeding mandarin oranges to R1 in her room on 06/30/2026. CNA N stated R1 was not chewing the mandarin oranges, and CNA M continued to feed her. NA N reported that when CNA M got R1 up to use the bathroom, CNA M grabbed R1 by the arm forcefully to get her up. CNA O's Notarized Witness Statement, dated 07/10/2026, documented CNA O had witnessed CNA M feeding R1 quickly without pause and did not allow R1 long enough breaks to chew and swallow her food. NA N's Notarized Witness Statement, dated 07/13/2026, documented on 06/30/2026, NA N observed CNA M rapidly feed R1 without allowing R1 breaks to breathe or chew. NA N stated this caused R1 to vomit as too much food was in her mouth. NA N stated throughout the day, she observed CNA M did not handle the resident with care but pulled on the resident's' arms. On 07/14/2026 at 09:20 AM, observation revealed R1 lay in bed with the lights off. R1 slept. R1 had oxygen on. On 07/14/2026 at 11:00 AM, observation revealed R1 lay in bed with her eyes open. This surveyor went into R1's room. R1 had cloudy, blank eyes. R1 did not look at this surveyor. R1 weakly whispered, Help. On 07/14/2026 at 09:30 AM, CNA P stated she had not really seen CNA M be abusive when she had worked with CNA M, but CNA M always seemed rushed, as if she was trying to get tasks done as quickly as possible and did not take time with residents. On 07/14/2026 at 10:30 AM, R3 stated CNA M had pushed him down into his chair several times when she provided him care. On 07/14/2026 at 11:30 AM, Administrative Nurse D stated she did not find out about the incident until 07/01/2026 when the CNA instructor notified her. Administrative Nurse D stated CNA M had been working at the facility for twenty-four years, and she had even worked with CNA M when she was a CNA. Administrative Nurse D stated CNA M had been suspended pending investigation. Administrative Nurse D stated she had talked with NA N and CNA O and told them if anything like this happened, they needed to report it immediately. The facility's, Abuse, Neglect, and Exploitation Policy, dated 04/22/26, documented the facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of property and exploitation by: Identifying, correcting, and intervening in situations in which abuse, neglect, or exploitation is more likely to occur with the deployment of qualified registered, licensed, and certified staff on each shift that meets the needs of the residents, and assure that staff have knowledge of the individual care needs and behavioral symptoms.		