| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175507 | A. Building<br>B. Wing | 06/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bethany Home Association | 321 N Chestnut Street<br>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 0945<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program.<br><br>Based on record review and interviews, the facility failed to ensure agency staff received the required infection control training. Findings included:- On 06/09/26 at 01:40 PM, a review of the training provided by the facility for agency Certified Nurse Aide (CNA) M, CNA N, CNA O, and CNA P revealed the following:The facility was unable to provide documentation that CNA M had completed infection control training. The facility was unable to provide documentation that CNA N had completed infection control training. The facility was unable to provide documentation that CNA O had completed infection control training. The facility was unable to provide documentation that CMA P had completed infection control training.On 06/09/26 at 01:51 PM, Administrative Nurse D stated the two agency providers the facility utilized for staffing had stated they ensured their staff had the required education. The facility failed to provide a policy related to ensuring all staff had received the required staff education as requested on 06/10/26. |

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<br>B. Wing | 06/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bethany Home Association | 321 N Chestnut Street<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview, and record review, the facility failed to ensure adequate infection control practices related to urinary catheter (tube inserted into the bladder to drain urine) care, hand hygiene, and the sanitary storage of respiratory equipment. Findings included:- On 06/08/26 at 08:13 AM, Resident (R)38's nasal oxygen cannula laid coiled on his bed. R38's oxygen nasal was not in a sanitary container. On 06/08/26 at 01:00 PM, an observation revealed R18's catheter bag was located on the trash can next to his recliner. There was no privacy bag. On 06/09/26 at 08:25 AM, observation revealed R18's catheter bag hung on the trash can beside his recliner. There was no privacy bag over the indwelling catheter bag, On 06/09/26 at 10:42 AM, R21's oxygen nasal cannula laid on R21's bed. R21's nasal cannula was not contained in a sanitary manner. On 06/09/26 at 02:25 PM, observation revealed R18 sat in his recliner with his feet up. His catheter bag laid on the floor without a privacy bag. On 06/10/26 at 12:40 PM, Certified Medication Aide (CMA) R said staff usually place the catheter bag in the trash can after they place a trash bag. On 06/10/26 at 12:40 PM, Licensed Nurse (LN) G said the catheter bag should be inside the trash can and the bag should never be on the floor. R18's preferences should be on the care plan. On 06/10/26 at 12:40 PM, Administrative Nurse D expected staff to ensure catheter bags were not on the floor and said the staff should wash their hands between the dirty and the clean. The facility policy General Infection Control and Employee Health SOP undated the facility facilitates safe care by establishing and maintaining an infection prevention and control program designed to provide safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable disease and infection. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175507 | A. Building<br>B. Wing | 06/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bethany Home Association | 321 N Chestnut Street<br>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 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure Resident (R)47's call light was within his reach to enable him to call for staff assistance. Findings Included:- R47's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of posttraumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin.The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of three, which indicated severely impaired cognition. The MDS documented R47 needed setup or cleanup assistance with eating and supervision or touching assistance with oral hygiene and toileting. The MDS documented R47 had no falls during the observation period.R47's Falls Care Area Assessment (CAA) dated 04/02/2026 documented R47 was alert to self, his speech was clear, and was able to verbalize his needs, and he usually understands others. The CAA documented R47 did not attend activities. The CAA documented R47 had not had a fall in 90 days.R47's Care Plan documented:10/14/2024-R47 was a high risk for falls related to confusion, deconditioning, gait, and balance problems.04/06/2026-Staff were to anticipate and meet R47's needs. Staff were to ensure R47's call light was within his reach and encourage R47 to use the call light as needed. Staff were to respond promptly to all requests for assistance.On 06/09/2026 at 08:39 AM, R47 sat in his recliner chair with his bedside table in front of him. R47 was unable to find his call light.On 06/10/2026 at 11:36 AM, R47 sat in his blue chair with his bedside table in front of him. R47 stated he did not know where his call light was.On 06/09/2026 at 11:30 AM, Certified Nurse Aide (CNA)Q stated call lights should be placed on the person or clipped to the chair. CNA Q stated R47 was unable to reach his call light and would clip R47's call light on his blue chair. CNA Q informed R47 of placement of his call light.On 06/10/2026 at 12:36 AM, Licensed Nurse (LN)G stated call lights should always be within the resident's reach. She stated the call light should be clipped to the chair or placed across his lap.On 06/03/2026 at 01:31 PM, Administrative Nurse D stated call lights should be within the resident's reach, if the resident was in their room.The facility's Call Light, Accessibility and Timely Response policy undated, documented the purpose of the policy was to ensure the facility was adequately equipped with a call light at each resident's bedside, toilet and bathing facility, to allow residents to call for assistance. Call light would directly relay to staff members or centralized location to ensure appropriate response. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175507 | A. Building<br>B. Wing | 06/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bethany Home Association | 321 N Chestnut Street<br>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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure Resident (R)66 had an appropriate indication, or a documented physician rationale, which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic (class of medications used to treat mental disorders characterized by a gross impairment in reality testing). Findings included:- R66's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and major depressive disorder (major mood disorder that causes persistent feelings of sadness).The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. The MDS documented R66 needed setup or cleanup assistance with eating and oral hygiene, and partial/moderate assistance for bathing and toileting. The MDS documented R66 received an antianxiety (a class of medications that calm and relax people) and an antipsychotic medication during the observationR66s Psychotropic Use Care Area Assessment (CAA) dated 07/03/25 documented R66 had a diagnosis of Alzheimer's, dementia, depression and anxiety and R66 received an antipsychotic (Seroquel) and an antianxiety (Xanax) daily. R66's Care Plan documented:01/28/26-R66 received Seroquel related to major depressive disorder. Staff were to administer psychotropic medications as ordered by the physician, and staff were to monitor side effects and effectiveness every shift. Staff to monitor, document, and report any adverse reactions to psychotropic medications. 06/04/26-R66 received anti-anxiety medication Xanax related to anxiety. Staff were to administer anti-anxiety medication as ordered by the physician, and staff were to monitor side effects and effectiveness. Staff to monitor, document, and report any adverse reactions to anti-anxiety medication with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment thatR66's EMR under Orders documented the following physician order:Seroquel oral tablet 100milligrams (mg) (Quetiapine Fumarate)Give 100 mg by mouth two times a day related to major depressive disorder dated 09/24/25.R66's EMR lacked documentation of a physician's rationale which included the risk versus benefits for R66's Seroquel.On 06/09/26 at 09:22 AM, R66 sat in her chair in her room. R66 ate her breakfast consisting of eggs and toast.On 06/10/26 at 12:36 PM, License Nurse (LN)G stated all nurses take orders from physicians, she stated she had not questioned the physician's diagnoses for psychotropic medication. LN G stated if a diagnosis indication needed to be changed, the director of nursing would call the physician.On 06/10/26 at 12:47 PM, Administrative Nurse D stated she was aware R66 did not have the correct indication for her antipsychotic medication. She stated she had sent information to the physician and educated physicians on indications for long term care facilities for residents with dementia. She stated the facility documented the residents' behaviors or indications prior to placing a resident on psychotropic medication.The facility's Unnecessary Drugs and Psychotropic Drugs Standards of Practice undated documented each resident's entire drug regimen would be free from unnecessary drugs including drugs ordered in excessive does. for excessive duration, without adequate monitoring, and without adequate indications for use. Antipsychotic medications would not be given to residents who have not previously used the drugs unless antipsychotic drug therapy was necessary to treat a specific condition as diagnosed and documented in the clinical record. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175507 | A. Building<br>B. Wing | 06/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bethany Home Association | 321 N Chestnut Street<br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure an environment free of potential accident hazards for Resident (R) 14 when staff failed to use two staff during a Hoyer (full body mechanical lift) as required. Findings include:- R14's Physician's Orders dated 11/03/25 documented a diagnosis of vascular dementia (cognitive mental disorder characterized by failing memory and confusion) anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).R14's Significant Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of three, indicating severely impaired cognition. R14 required substantial to maximal assistance with eating and depended on staff for toileting and showers.R14's Quarterly MDS 5/07//26 revealed a BIMS score of five, which indicated severe cognitive impairment, and no other changes. R14"s Care Plan dated 01/17/25 and revised on 06/04/25 directed staff the resident was totally dependent on staff for transfers- sling lift one to two assist. On 06/08/26 at 08:35 AM, Certified Nurse Aide (CNA) NN obtained the Hoyer lift and proceeded to transfer R14 from the bed to the Broda (specialized wheelchair with ability to tilt and recline) chair without assistance from a second staff member. On 06/08/26 at 08:35 AM, in an interview, CNA NN said R14's Care Plan had the transfer as a one to two person assist and went on to say she had done by herself in the past. On 06/10/26 at 12:30 PM, Licensed Nurse (LN) G said that there needs to be two staff members during Hoyer lift transfers. On 06/10/26 at 12:50 PM, Administrative Nurse D stated she had obtained the information from teaching a CNA class that indicated one to two staff members can transfer a resident using the Hoyer lift but went on to say that the state regulation did say that two staff members are required to transfer a resident with a Hoyer. The facility policy Safe Resident Handling/Transfers dated 2/2006 it is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risk for injury and provide and promote a safe, secure, and comfortable experience for the resident while keeping the employee safe in accordance with current standards and guidelines. All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175507 | A. Building<br>B. Wing | 06/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bethany Home Association | 321 N Chestnut Street<br>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 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>Based on interviews, observations, and record review, the facility failed to address a significant weight loss for Resident (R) 2, which had the potential for physical complications related to nutritional deficits. Findings included:- R2's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), ataxia (impaired ability to coordinate movement), dementia (a progressive mental disorder characterized by failing memory and confusion), and dysphagia (swallowing difficulty).The Significant Change Minimum Data Set (MDS) dated 04/27/26 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R2 had limited range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension) to upper and lower extremities bilaterally. The MDS documented R2 required staff assistance with setup or clean-up during meals. R2's Nutritional Status Care Area Assessment (CAA) dated 05/11/26 documented he could make his food choices and feeds himself after being set up. R2's Care Plan documented the following interventions: 06/12/23 - He had a cushion to help with improved posture and positioning in the dining room.10/14/25 - Staff would obtain a weekly weight. 12/22/25 - He was a regular diet with thin consistency fluids.02/19/26 - He was independent with making food choices and was able to feed himself with set up assistance.R2?s EMR under the Orders tab revealed the following physician orders:Regular diet with liquid consistency dated 08/17/22.R2's EMR under the Progress Notes tab revealed a Dietitian note dated 05/15/26 at 11:32 AM, documenting Dietitian Comments: registered dietician (RD) had reviewed R2's weight loss of 40 pounds in 90 days. R2 had recent hospitalization. He was alert with slurred speech. R2 was able to voice his food preferences. R2 was on a regular diet and was at risk of aspiration. R2 refused the offer of altered consistency. R2 reported he had wanted to lose weight and his appetite had decreased. He remained on a diuretic (a medication to promote the formation and excretion of urine) medication. RD documented he would continue current diet and R2 did not want to regain the weight.The facility was unable to provide a physician order for prescribed weight loss, which included safe weight loss parameters.On 06/09/26 at 11:38 AM, R2 sat in the dining room at the table and ate lunch without assistance.On 06/10/26 at 12:37 PM, Licensed Nurse (LN) G stated if a resident had a weight loss, she would reweigh the resident to verify there had been a loss. LN G stated she would check for edema, ask if the residents had problems with their teeth, and attempt to find the cause for the weight loss. LN G stated she would notify the physician of the weight loss. LN G stated the RD would review the weekly weights in the resident's EMR.On 06/10/26 at 12:50 PM, Administrative Nurse D stated R2 had some weight loss related to R2 edema. Administrative Nurse D stated the physician had not given an order for a prescribed weight loss program.The facility's undated Weight Monitoring policy, documented based on the resident's comprehensive assessment, the facility would ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. |