STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175403	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HOME	**408 E MAIN , GOESSEL, Kansas, 67053**

(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
F0000	INITIAL COMMENTS The Risk-Based Survey Process was used to conduct a federal recertification survey. The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations in 3117987 and 1536125. The census was 35. The sample included seven residents.	F0000		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons	F0880		

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 reverse for further 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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F0880 SS = E	Continued from page 1 in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and interviews, the facility failed to implement adequate infection control practices when staff failed to ensure respiratory equipment was stored in a sanitary manner for Resident (R)5 and R3's continuous positive airway pressure (CPAP-ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) mask and R36's oxygen nasal cannula. The facility	F0880		

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F0880 SS = E	Continued from page 2 also failed to ensure clean linens were transported in a sanitary manner. Findings included: - On 09/28/2026 at 07:19 AM, the linen cart was parked in Cottonwood Lane the linen cart had three blue chucks on top of the linen cart, uncovered. On 09/28/2026 at 07:25 AM R5's CPAP mask was hung on a hook between her bed and her bedside table. R5's CPAP mask was not in a container. On 09/28/2026 at 08:06 AM, R36's oxygen cannula was wrapped around an oxygen canister in her room. R36's nasal cannula was not stored in a container. On 09/28/2026 at 08:27 AM, R3's CPAP mask lay on his bedside table. R3 stated that the CPAP mask was always laid on his bedside table until he needed the mask again. On 09/28/2026 at 10:27 AM, Administrative Nurse E stated residents CPAP masks were stored on the resident bedside table, or on a hook in the resident's room, it depended on where the resident would prefer the mask. She stated the masks were wiped out daily with a wipe specific to the CPAP mask. Administrative Nurse E stated oxygen nasal cannulas were stored in a blue bag that hung on the oxygen canisters when not in use. She stated linens should be in a bag or covered when being transported down the hall. On 09/28/2026 at 02:05 PM, Administrative Nurse D stated CPAPs were stored on the residents bedside table or hung on a hook in the residents' rooms. She stated oxygen nasal cannulas had their own bag, that were attached to the oxygen canister and were to be placed in the bag when not in use. Administrative Nurse D stated nothing should be placed on top of the linen cart, and the linen cart should stay covered. The facility's "Oxygen Administration" policy dated 06/2026 documented the oxygen concentrator and filter should be cleaned weekly according to annual. Change tubing cannula/mask and humidifier monthly. When oxygen cannula and mask was not in use, place in a container attached to the concentrator or as care planned for each individual resident. The facility's "Laundry Protocol" policy dated	F0880		

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F0880 SS = E	Continued from page 3 01/2022 documented it was the policy of the facility to prevent the spread of infection by appropriate separation, collection, laundry, and storage of laundry. Facility staff would handle, store, process, and transport linens in a method to prevent the spread of infection.	F0880		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to assess Resident (R)6 to ensure the resident was able to safely self-administer medications. Findings Included: - R6's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of hypertension (HTN- elevated blood pressure), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), and abnormalities of gait and mobility. R6's "Annual Minimum Data Set (MDS)" dated 07/09/2026 noted a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented R6 was independent with all activities of daily living (ADL). R6's "Visual Function" (CAA) dated 07/09/2026 documented R6 had a diagnosis of glaucoma (abnormal condition of elevated pressure within an eye caused by obstruction to the outflow), with decreased visual acuity. R6's "Care Plan" documented the following: 05/13/2026-R6 had impaired vision related to her diagnosis of glaucoma. R6 had her own magnifying glass, to use as needed. Staff were to offer R6 facility reading appliance machine as R6 desired. Nursing was to administer R6's eye medication as	F0554		

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F0554 SS = D	Continued from page 4 ordered. Nursing was to ensure R6's glasses were clean and in good repair. R6's EMR lacked evidence of an assessment to ensure R6 could safely administer medications and lacked a physician's order to leave medications at bedside. On 09/28/2026 at 07:19 AM, R6's medication sat in a white paper medication cup, on her end table in her room. R6 stated she needed to take her morning medication before she went to breakfast. On 09/28/2026 at 10:32 AM, Administrative Nurse E stated R6 did not have a self-administration assessment for medication. She stated nursing should not leave medications in a resident room. On 09/28/2026 at 01:26 PM, Licensed Nurse (LN) G stated the facility did not have any residents with assessment for self-administration of medications. She stated staff should stay in the room until the resident takes their medication. On 09/28/2026 at 01:54 PM, Administrative Nurse D stated some residents did have self-administration of mouth washes or creams. She stated the facility did not have any residents with self-administration of medication, and the nurse should stay with the resident until the medication was taken. The facility's "Self-Administration of Medications" dated 03/2026 documented Self-administration of medications by residents was generally allowed by not encouraged. The competency of the resident was assessed prior to allowing a resident to self-administer medications by the interdisciplinary team. A resident who felt to be mentally or physically incompetent or incapacitated would not be allowed to self-administer medications.	F0554		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F0689	"Past Noncompliance - no plan of correction required"	

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F0689 SS = D	Continued from page 5 supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and interviews, the facility failed to provide a safe environment free from accident hazards when staff failed to provide adequate supervision and respond promptly to alarms, which allowed Resident (R) 20 to exit the facility without staff knowledge or supervision. Findings Included: - R20's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), Alzheimer’s disease (progressive mental deterioration characterized by confusion and memory failure), anxiety, and weakness. R20’s “Quarterly Minimum Data Set" (MDS) dated 09/02/2026 documented a Brief Interview of Mental Status (BIMS) score of two, which indicated severely impaired cognition. The MDS documented R20 had no impairments of her upper or lower body and did not use a wheelchair or a walker with ambulation. R20’s "Cognitive Loss/Dementia Care Area Assessment (CAA)” dated 03/26/2026 documented R20 had a diagnosis of dementia and Alzheimer’s disease. The CAA documented R20’s BIMS score indicated severe cognitive impairment and a decreased ability to make herself understood. R20’s “Care Plan” documented the following: O7/02/2926-R20 displayed wandering symptoms, goes into other resident rooms to visit, and followed staff into other residents’ rooms. Staff were to redirect R20 out of other residents’ rooms as needed. 09/24/2026- R20 was an elopement risk. R20 wore a WanderGuard (a bracelet that helps monitor residents who are at risk of wandering) on her right wrist. Staff were to keep R20 safe and free of elopement episodes. Staff were to provide R20 with one to one after lunch if she was restless, provide her baby doll she	F0689		

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F0689 SS = D	Continued from page 6 enjoys holding, put on a movie, or look out the window at the clouds. Staff take R20 outside and let her walk around every day. A review of R20's EMR under "Orders" documented the following physician order: WanderGuard check on the right wrist every shift dated 07/27/2026. A Review of R20's EMR under "Assessments" documented R20's Elopement Risk Assessment" dated 06/16/2026 documented R20 had a score of 12 which indicated a high risk of wander or elope. A review of R20's EMR under "Assessments" documented R20's "Elopement Risk Assessment" dated 07/27/2026 documented R20 had a score of 17 which indicated a high risk to wander or elope. Certified Medication Aide (CMA) R witness statement documented on 07/26/2026 at 12:43 PM the assisted living unit (ALU) door alarm started going off. The Licensed Nurse (LN) on duty went to reset the door. At 12:49 PM, the ALU north door alarm was going off. CMA R went to reset the alarm. CMA R went to "Willow" to check on the resident with the WanderGuard alarm and did not find the resident in her room. CMA R talked to the LN on duty to let her know she could not find the resident, and at that time, the resident CMA R had looked for came down the hall in her wheelchair. CMA R went down to the ALU hall again to reset the north door, they looked outside through the doors and did not see anyone. LN H's witness statement documented on 07/26/2026 at 12:45 PM LN H observed the ALU door, and the wander alarm was going off for two minutes. LN H instructed CMA R to check the doors. The doors did not automatically reset. LN H observed another resident with a WanderGuard walking in the hall. At 12:50 PM down the hall the door was still alarming and showed it had been for eight minutes. Upon arrival at the South door dining room, LN H observed a visitor ask Certified Nurse's Aide (CNA) N if R20 was supposed to be outside. LN H observed R20 in the grass near the bird house pole next to the patio. CNA N and LN H went outside to assist R20 inside with a wheelchair. LN H observed R20's cheeks were red. LN H informed the charge nurse of the incident. LN H documented R20 was taken to her room. CNA O assisted R20 with a clothing change. At 01:00 PM LN H called Administrative Nurse D and the resident's durable	F0689		

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F0689 SS = D	Continued from page 7 power of attorney (DPOA- a legal document that names a person to make healthcare decisions when the resident is no longer able to). LN I's witness statement dated 07/26/2026 at 12:50 PM documented LN H brought R20 into the "Sunflower" dining room from the patio in a wheelchair. LN H reported to LN I R20 was observed outside by a visitor, and the ALU alarm had gone off. LN I helped R20 to her room, where she vomited. CNA O took R20 to the shower, R20's vital signs were obtained blood pressure 130/62, temperature 97.2, respirations 20, pulse 74, and oxygen saturation 93 percent. R20's skin was warm to touch, R20 stated she felt fine. Neuro checks were done, LN I documented R20 acted her normal self. Education was provided to all staff on WanderGuard and door alarms. CNA O's witness statement documented on 07/26/2026 at 01:00 PM, CNA O was in the residents' room down the hall and observed R20 sitting in a wheelchair in front her room with LN I and LN H. CNA O took her to the shower. R20 was acting her normal self-able to visit per her normal. R20 did not appear to be in any distress. R20's skin felt normal to the touch. CNA O cleaned R20 and took her to the dining room, CNA O gave R20 ice water to drink. CNA N's witness stated documented on 07/26/2026 at 12:45 PM, the WanderGuard alarm for ALU came over the pager. LN H and CMA R went to the ALU doors; CNA N went to "Sunflower" hall. CNA N was in the dining room talking to residents and at 12:52 PM a resident's family alerted CNA N that R20 was outside the "Sunflower" door by the first tree. CNA N alerted LN I, CNA N, and LN I went out to help R20 inside with a wheelchair. On 07/26/2026 a fax was sent to the physician with a summary of R20's incident of elopement. A review of R20's EMR dated 07/26/2026 at 03:05 PM documented under "Progress Note" R20 went outside after lunch the ALU doors and door locked behind R20. R20 was outside for approximately two to four minutes. R20 walked to the "Sunflower" patio and staff assisted R20 into the building in a wheelchair. Assessment revealed R20 was within her baseline. Staff notified Administrative Nurse D and R20's DPOA and physician. On 07/26/2026 a root cause analysis was done, the root cause was the staff reset the WanderGuard alarm but failed to go outside and search of the	F0689		

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F0689 SS = D	Continued from page 8 property with accounting or all warder guard residents. On 09/28/2026 at 01:38 PM, CNA M stated all staff were educated on WanderGuards and door alarms in the last few months due to a resident who had eloped. On 09/28/2026 at 01:42 PM, LN G stated all nursing were checking WanderGuards every shift, and all nursing had education on WanderGuards and door alarms. On 09/28/2026 at 02:05 PM, Administrative Nurse D stated a full investigation was performed, with a root cause and analysis. She stated all staff had been educated on WanderGuards and the importance of door alarms. Administrative Nurse D stated CMA R stated she looked out the big window, did not see anyone outside. Administrative Nurse D stated the CMA R stated she did not go outside because she did not know how she would get back in the facility. Administrative Nurse D stated all staff were educated on elopement risk, nursing was checking WanderGuards daily per shift, and maintenance were doing weekly door alarm/WanderGuard checks. The facility's "Elopement Protocol" dated 07/2026 documented the facility would ensure the safety of the residents who have been identified as being at risk for elopement. It was the policy to identify that residents were at risk for elopement and take precautions to ensure their safety and well-being. The facility had WanderGuard/ protect Point for locking system throughout the facility.	F0689		