STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155607	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethel Manor	6015 Kratzville Rd Evansville, IN 47710

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store and prepare food under sanitary conditions during 3 of 3 kitchen observations. Food was not labeled correctly, expired food was not disposed of, hairnets were not worn properly, and staff placed their fingers in their mouth during food service. (Main Kitchen, Cottage Kitchen, Dietary [NAME] 9)Findings include: 1. On 8/19/25 at 8:55 A.M., the following was observed during the initial tour of the Main Kitchen:In large reach-in refrigerator:1 gallon jug of coleslaw, dated 7/2 with a best by date of 6/5/25.On the spice rack at the preparation table:2 bottles of chili pepper with no open date1 bottle of lemon pepper with no open date1 bottle of sage with no open date1 bottle of pepper with no open date1 bottle of nutmeg with no open date1 bottle of cinnamon with no open date1 bottle of ginger with no open date1 jar black pepper with no lid or openIn the dry storage area:bag of chips with no open date1 bag of sprinkles with no open date1 bottle of oregano with no open date1 bottle of white vinegar, best by date 11/3/22 and dated 6/63 jugs of salsa, best by date 1/25/25The following staff were observed in the Main Kitchen with improper hairnet placement:Dietary Aide 13 - hair at base of neck was not coveredDietary Aide 7 - hair on side of head by ears was not coveredDietary Manager - bangs on forehead was not covered 2. On 8/19/25 at 9:35 A.M., during the initial tour of the Cottage Kitchen the following was observed:In the dry storage:1 bag of stuffing with no open date1 container of garlic, best by date 6/2022 and open date 3/251 bottle of pepper with no open dateReach-in Refrigerator:1 container of turkey bacon with no open date3. On 8/19/25 at 12:05 P.M., during a random dining observation in the Cottage Kitchen, Dietary [NAME] 9 was observed wiping a drizzle of gravy off a resident's plate with her finger. She put the finger in her mouth and then served the resident the plate without washing her hands.During an interview on 8/19/25 at 9:30 A.M., the Dietary Manager indicated that she should date items when opened.During an interview on 8/22/25 at 9:00 A.M., the Dietary Manager indicated that hair nets should completely cover the hair. At that time, she indicated that no one should use bare fingers to wipe off food drizzles from resident plates. On 8/22/25 at 10:53 A.M., the Administrator provided a current Date Marking for Food Safety policy, dated 3/26/25, that indicated .the individual opening or preparing the food shall date mark the item at the time of opening .On 8/22/25 at 10:56 A.M., the Administrator provided a current Dietary Employee Personal Hygiene policy, dated 3/26/25, that indicated all dietary staff must wear hair restraints .hairnets .to prevent contact with food .3.1-21(i)(2)3.1-21(i)(3)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop a plan of care related to recurrent urinary tract infections (UTIs), or medication used to treat recurrent UTIs, for 1 of 1 resident reviewed for UTIs. (Resident 3) Finding includes:On 8/20/25 at 1:06 P.M., Resident 3's clinical record was reviewed. Resident 3 was admitted on [DATE]. Diagnoses included, but were not limited to, Alzheimer's disease. The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 5/27/25, indicated Resident 3's cognition was too low to be assessed, and that Resident 3 was dependent on staff (staff does all of the work) for eating, toileting, bathing, and transfers. Physician orders included, but were not limited to: D-Mannose Oral Capsule 500 MG (milligrams) Give one capsule by mouth one time a day for UTI prevention, Start date 8/9/25 Laboratory results indicated Resident 3 had positive urinary tract infection cultures on 10/17/24, 7/24/25, 8/7/25. A nursing progress note, dated 8/20/25 at 12:56 P.M., indicated Resident 3 was admitted to the hospital for a urinary tract infection and encephalopathy. The clinical record, including care plan, progress notes, and assessments, lacked a plan of care related to Resident 3's recurrent urinary tract infections, monitoring, or the medication used to treat recurrent urinary tract infections. During an interview on 8/22/25 at 9:46 A.M., the Infection Preventionist Nurse indicated Resident 3 had frequent UTIs causing an ongoing decline in condition. On 8/22/25 at 10:56 A.M., the Administrator provided a policy titled Comprehensive Care Plans, dated 2/5/25, indicated The care plan must include services to maintain the Resident's highest practicable well-being .and individualized interventions. 3.1-35(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care plans were revised after a fall for 3 of 6 residents reviewed for falls. (Resident 7, Resident 54, Resident 3)Findings include:1. On 8/21/25 at 8:39 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The most current Annual Minimum Data Set (MDS) Assessment, dated 8/5/25, indicated Resident 7 was not assessed for cognitive impairment due to being rarely or never understood, was independent for transfers and required supervision of staff for toileting, and had no falls since the prior assessment. A care plan conference was completed on 7/29/25. Notes indicated to continue with the current plan of care. A current risk for falls care plan, revised on 6/25/25, indicated Resident 7 had a history of falls with multiple risk factors. A nursing progress note, dated 4/14/25 at 3:44 P.M., indicated Resident 7 sustained a witnessed fall while pacing the hallway faster than her usual pace. The clinical record lacked documentation to indicate that the Interdisciplinary Team (IDT) met to review that fall. The care plan was not updated with a new intervention following that fall. On 8/22/25 at 8:30 A.M., the Administrator provided a document that indicated the IDT requested a medication review in relation to the fall on 4/14/25. A psychiatric assessment, dated 4/18/25, indicated medications were reviewed and no changes were made.On 8/22/25 at 8:56 A.M., the Administrator indicated the root cause of the resident's fall was anxiety. Visits from the mental health provider were increased, but it was not put into the plan of care. 2. On 8/20/25 at 12:55 P.M., Resident 54's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease. The most current Annual Minimum Data Set (MDS) Assessment, dated 6/10/25, indicated Resident 54 was not assessed for cognitive impairment due to being rarely or never understood, was dependent on staff (staff does all of the work) for transfers and toileting, and had no falls since the prior assessment. A care plan conference was completed on 6/4/25. Notes indicated to continue with the current plan of care. A current risk for falls care plan, dated 7/8/22, indicated Resident 54 had a history of falls with multiple risk factors. A nursing progress note, dated 1/27/25, indicated that Resident 54 sustained an unwitnessed fall in his room. The resident was unable to voice why he fell. The clinical record lacked documentation to indicate that the Interdisciplinary Team (IDT) met to review that fall. The care plan was not updated with a new intervention following that fall. On 8/22/25 8:30 A.M., the Administrator provided a written statement that indicated no new intervention was initiated at the time of the fall on 1/27/25. 3. On 8/20/25 at 1:06 P.M., Resident 3's clinical record was reviewed. Resident 3 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, Alzheimer's disease. The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 5/27/25, indicated Resident 3's cognition was too low to be assessed, was dependent on staff (staff does all of the (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	work) for eating, toileting, bathing, and transfers, and had no falls since the prior assessment. The care plan included, but was not limited to: Resident is a risk for falls characterized by history of falls/injury, multiple risk factors related to: impaired mobility, weakness, unsteadiness, polyneuropathy, use of psychotropic medications, cognitive status, use of assistive device. Date Initiated: 3/12/24 Revision on: 6/2/25 The clinical record indicated Resident 3 experienced falls on 1/28/25 and 7/3/25. The plan of care lacked new interventions added to the plan of care for the falls occurring on 1/28/25 and 7/3/25. On 8/22/25 at 8:56 A.M., the Administrator indicated that staff didn't always put interventions in the plan of care, but they should because it could be used as a tracking tool to make previously tried interventions easier to find. On 8/22/25 at 10:56 A.M., the Administrator provided a policy titled Care Plan Revisions Upon Status Change, dated 9/18/24, that indicated It is the policy of this facility to maintain a consistent process for reviewing and revising the care plan whenever a resident experiences a status change. Upon identification of a change in status .the care plan will be updated with new or modified interventions. 3.1-35(d)(2)(B)3.1-35(e)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure food was correctly prepared during 1 of 1 observation of puree altered diet preparation. (Dietary [NAME] 9)Finding includes: On 8/19/25 at 12:07 P.M., Dietary [NAME] 9 was observed preparing one serving of pureed meat loaf. Dietary [NAME] 9 added the following ingredients to the blender:1 slice of meat loaf unknown amount of milk The recipe for Meatloaf Pureed Thick was reviewed. Ingredients for 20 servings included:5 pounds and 12 ounces meatloaf2 and 5/8 teaspoon beef base2 3/4 cup hot water1/3 cup and 2/3 teaspoon food thickener During an interview on 8/19/25 at 12:10 P.M., Dietary [NAME] 9 indicated she should follow the recipe instead of using milk. On 8/22/25 at 10:56 A.M., the Administrator provided a current Puree Recipe policy, dated 3/26/25, that indicated .all pureed items will be prepared using facility-approved, standardized recipes . 3.1-21(a)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure infection control practices and standards were performed during 2 of 2 random observations. Staff did not use Personal Protective Equipment (PPE) for a resident on Enhanced Barrier Protection (EBP) and did not clean blood pressure equipment between residents. (Resident 2, Resident 63, and Resident 64)Findings include: 1. On 8/19/25 at 11: 52 A.M., during a random observation of care for Resident 2, Certified Nursing Aide (CNA) 3 was observed transferring Resident 2 from the bed to a Broda chair without wearing a gown. An Enhanced Barrier Precaution (EBP) sign was observed on the resident's door. On 8/22/25 at 8:22 A.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's Disease and unspecified protein-calorie malnutrition. The most current Significant Change Minimum Data Set (MDS) Assessment, dated 8/19/25, indicated Resident 2 was severely cognitively impaired. Resident 2 was dependent on staff for eating, transferring, hygiene, and dressing. The resident had a Percutaneous Endoscopic Gastrostomy Tube (PEG) for nutrition. Current physician orders included, but were not limited to:Enhanced Barrier Precautions due to PEG tube per facility protocol every day and night shift for PEG tube, dated 6/30/25 A care conference was conducted on 8/13/25 and the care plan was reviewed. The current care plan for skin impairment was revised on 8/13/25. Interventions included, but were not limited to:Enhanced Barrier Precautions in high contact activities, dated 8/6/25. During an interview on 8/20/25 at 9:46 A.M., CNA 3 indicated the equipment outside of Resident 2's room was for Transmission Based Precautions (TBP) and a gown should have been applied before entering the room. 2. During an observation on 8/22/25 at 7:16 A.M., Licensed Practical Nurse (LPN) 14 used a blood pressure cuff to obtain a blood pressure from Resident 63. LPN 14 then went to the medication room and gathered medications. LPN 14 then used the blood pressure cuff to obtain a blood pressure from Resident 64 without sanitizing the blood pressure cuff. During an interview on 8/22/25 at 9:10 A.M., the Infection Preventionist Nurse indicated shared medical equipment should be cleaned after each use. On 8/22/25 at 10:56 A.M., the Administrator provided a policy titled Cleaning and Disinfection of Resident-Care Equipment, dated 7/1/25, that indicated Multi-resident use items are cleaned and disinfected between each use. On 8/22/25 at 10:56 A.M., the Administrator provided a current Enhanced Barrier Precautions policy, dated 4/24/25, that indicated .EBP are implemented for residents who have a . indwelling device . gloves and gloves should be used when performing high-contact activities with residents . 3.1-18(b)(1)3.1-18(b)(2)