

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525538	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/27/2025
NAME OF PROVIDER OR SUPPLIER  Bethany Home		STREET ADDRESS, CITY, STATE, ZIP CODE  1226 Berlin Street Waupaca, WI 54981	

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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on staff interview and record review, the facility did not implement policies and procedures to prevent abuse for 1 (Certified Nursing Assistant (CNA)-C) of 8 staff reviewed for caregiver background checks. The facility did not ensure an out-of-state background check was completed for CNA-C. Findings include: The facility's Abuse Prohibition policy, revised 4/19/21, indicates: Background, reference, and credentials checks shall be conducted on potential employees, contracted temporary staff. On 10/27/25, Surveyor reviewed background check information for agency CNA-C whose first day of work at the facility was 8/26/25. CNA-C's Background Information Disclosure (BID) form was signed and dated 6/11/25. The form was completed when CNA-C began working for Agency (AG)-F and indicated CNA-C lived outside the state of Wisconsin in the previous 3 years. CNA-C's background check information did not indicate an out-of-state or national search was completed. On 10/27/25 at 11:45 AM, Surveyor interviewed Director of Nursing (DON)-B who provided Surveyor with a national search completed on 10/27/25. DON-B indicated the facility relies on the agency to ensure background checks are done correctly prior to staff working at the facility. DON-B indicated Director of Human Resources (DHR)-E handles all of the background check information. On 10/27/25 at 12:00 PM, Surveyor interviewed DHR-E who indicated DHR-E tries to keep agency staff background checks on site and tries to catch anything that looks incorrect. DHR-E verified an out-of-state background check was not provided or completed for CNA-C. DHR-E confirmed the facility should have complete background check information prior to agency staff starting at the facility.</p>

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 0689  Level of Harm - Actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (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 0689  Level of Harm - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on staff interview and record review, the facility did not ensure the resident environment was as free of accident hazards as possible for 1 Resident (R) (R1) of 3 sampled residents. R1 required an EZ stand mechanical lift with the assistance of 2 staff for transfers. On 9/25/25, R1 slipped from the EZ stand, was lowered to the floor, and suffered a left clavicle fracture when agency Certified Nursing Assistant (CNA)-C transferred R1 alone. In addition, agency Registered Nurse (RN)-D did not transfer R1 to the emergency room (ER) per R1's request because RN-D did not know how to complete the paperwork. The facility identified deficient practices but did not provide education to agency staff who worked since the incident. Findings include: The facility's Abuse Prohibition policy, revised 4/19/21, indicates: .VI. Reporting/Response: .Taking all necessary actions as a result of the investigation, which may include, but are not limited to the following: .c. Training of staff on changes made and demonstration of staff competency after training is implemented. The facility's Safe Resident Handling policy, dated 11/13/24, indicates: .C. The transfer method and equipment needs for each resident are indicated in the resident's care plan, individual service plan, or care card .E. The staff at any time can increase the level of transfer from what is stated in their plan .however, staff cannot reduce the level of device use .B. Training will occur: .2. After transfer-related incidents. On 10/27/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including clavicle fracture, left below-the-knee amputation, type 2 diabetes, and hypertensive heart disease with congestive heart failure (CHF). A Significant Change Minimum Data Set (MDS) assessment completed on 10/2/25 indicated R1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. R1 was R1's own decision maker. R1's medical record indicated R1 was lowered to the floor from a sit-to-stand lift on 9/25/25 at approximately 8:00 PM. R1 was transferred to the ER at approximately 10:30 PM due to shoulder pain and decreased range of motion (ROM). R1 returned to the facility on 9/26/25 at approximately 2:30 AM with a diagnosis of fractured non-displaced left clavicle. On 10/27/25, Surveyor reviewed a facility-reported incident related to R1's transfer and left clavicle fracture. Surveyor also reviewed R1's care plan. Prior to the incident, R1's care plan contained an intervention, dated 9/19/25, that indicated R1 required the assistance of 2 staff and a Portable Assisted Lift (PAL) or EZ stand for all transfers. After the incident was reported to Director of Nursing (DON)-B and it was discovered that agency CNA-C did not follow R1's care plan, the facility began an investigation and suspended CNA-C from resident care. Staff interviews indicated the following:~ CNA-C was told in shift report that R1 was weaker and required the assistance of 2 staff for all transfers.~ CNA-C transferred R1 to the bathroom on 9/25/25 with the assistance of 2 staff. When CNA-C then attempted to transfer R1 to R1's chair, R1 started to slide out of the sit-to-stand lift. R1 was hanging in the lift when CNA-C went to get assistance. R1 was lowered to the floor and staff used a Hoyer lift (full body mechanical lift) to assist R1 back to bed.~ R1 indicated to DON-B that 2 staff assisted R1 to the bathroom, however, only CNA-C returned when R1 was finished. CNA-C stated CNA-C could not find another staff and was going to transfer R1 alone. R1 stated that CNA-C needed a second person. When CNA-C again stated that CNA-C could not find another staff, R1 agreed to the transfer but stated it was not going to end well. During the transfer, R1's leg gave out and R1 started to slide. R1 was hanging in the lift when CNA-C left to get help. R1 wanted to go to the hospital due to poor ROM and pain, however, agency RN-D stated RN-D did not know how to do the paperwork. Approximately 2 hours later, a night shift nurse arrived and sent R1 to the ER for an X-ray. Upon discovering the deficient practices, the facility initiated education. CNA-C was educated verbally via phone and was not allowed to return to the facility. On 9/26/25, RN-D was provided with 1:1 education regarding where to find forms to transfer a resident to the hospital, how to use the after-hours physician group, abuse/neglect, critical thinking skills, resident rights, and when to fill out an incident report. The facility initiated the following 4 pieces of education:1. For All Nursing Staff: Ensuring following a resident's care plan related to transfer status. Staff can always use more staff but not less. Where to find care plans if there are questions and asking a co-worker to assist/work together as a team.2. For All Nursing Staff: Transfer training and if a resident gets weak during a transfer, try lowering them to a chair, bed, toilet, shower chair. If unable to lower them to another surface, then lower the resident to the floor.3. For Licensed Staff Only: If a resident requests to go to the ER, the nurse must contact the provider or after-hours group.4. For Licensed Staff Only: Ruling out abuse or neglect as part of a fall investigation. The unit nurse completes the fall investigation and then must</p>		