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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525554	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethel Home	225 N Eagle St Oshkosh, WI 54902

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 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** 43361 Based on staff interview and record review, the facility did not ensure the plan of care was revised for 1 resident (R) (R1) of 3 sampled residents. R1's plan of care was not updated to include recommendations from an Advanced Practice Nurse Prescriber (APNP) regarding transfer speed and hydration related to orthostatic hypotension (a condition where blood pressure drops when standing or sitting up) and unresponsive episodes. Findings include: The facility's Comprehensive Care Plans policy, with a review date of August 2024, indicates the comprehensive care plan will describe at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions initially and when changes are made. On 10/23/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including encounter for surgical aftercare following surgery on the nervous system, cervical spine issues, right clavicle fracture, unresponsive episodes, supraventricular tachycardia, and hypertension (high blood pressure). R1's Minimum Data Set (MDS) assessment, dated 9/4/24, 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. On 9/4/24, R1 had an unresponsive/dizzy episode while being transferred in a sit-to-stand lift by therapy staff. The physician was notified and responded with no new orders. On 9/18/24, R1 saw an APNP. A note from the visit indicated R1 had orthostatic hypotension and staff should continue to monitor, assist with slow position changes, and ensure R1 consumed fluids for adequate hydration. (continued on next page)

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 9/19/24, indicated R1 complained of dizziness and not feeling well approximately one hour after R1 received R1's AM medications and 45 minutes after breakfast. R1's blood sugar level was 252 mg/dL (milligrams/deciliter) and R1's blood pressure was 91/45 mmHg (millimeters of mercury). R1 was encouraged to consume fluids which R1 took well. Prior to therapy, R1 continued to complain of dizziness. R1's blood pressure at rest was 79/58 mmHg. Therapy staff had R1 do exercises and R1's blood pressure rose to 97/60 mmHg. Medical Doctor (MD)-C was notified via fax and a medication list was sent. MD-C gave an order to decrease R1's metoprolol extended release (ER) (a medication used to treat high blood pressure) to 25 mg and decrease R1's linisopril (a medication used to treat high blood pressure) to 10 mg daily. A care plan, initiated on 9/20/24, indicated R1 had the potential to have unresponsive episodes due to a history of syncopal (fainting or passing out) and unresponsive episodes. The care plan indicated R1 displayed symptoms of increased confusion, disorientation, and not responding to staff when prompted. The care plan contained interventions to acknowledge and accept R1's feelings, help R1 find other ways to communicate, assess R1 for unmet needs (such as pain, toileting hunger, or thirst) and note how R1 communicates nonverbally, have Certified Nursing Assistants (CNAs) acknowledge that they understand R1, face R1 and speak clearly when talking to R1, tell R1's nurse about any pain R1 has, allow time for R1 to respond, and ask R1 questions that can be answered with yes or no. On 10/23/24 at 3:54 PM, Surveyor interviewed Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A and asked them to review R1's plan of care related to unresponsive episodes. DON-B and NHA-A confirmed R1's care plan interventions did not include the APNP's recommendation on 9/18/24 to transfer R1 slowly and confirmed the care plan should include that recommendation. When NHA-A asked how staff would know what slow was because it was subjective, Surveyor indicated it could be a cue to nursing staff to take more caution.

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility did not ensure a physician saw and responded to radiological records for 1 resident (R) (R1) of 3 sampled residents. R1 had X-rays of the shoulder and clavicle completed on 10/9/24 after R1 passed out during a transfer and complained of right shoulder/clavicle pain. R1's shoulder X-ray showed normal findings. R1's clavicle X-ray indicated R1 had a fracture. The facility did not ensure a physician received the results of R1's clavicle X-ray. Findings include: On 10/23/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including encounter for surgical aftercare following surgery on the nervous system, cervical spine issues, right clavicle fracture, unresponsive episodes, osteopenia, supraventricular tachycardia, and hypertension. R1's Minimum Data Set (MDS) assessment, dated 9/4/24, 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 the following: ~ R1 was admitted to the facility for rehabilitation after surgery due to surgical spine issues. ~ On 9/17/24, therapy staff changed R1's transfer status from Hoyer lift to sit-to-stand lift with 1 assist. In the weeks leading up to the change in transfer status, therapy staff worked with R1 on using a sit-to-stand lift and trained staff to transfer R1 with a sit-to-stand lift. R1's care plan was updated on 9/19/24. ~On 9/20/24, a care plan was initiated related to unresponsive episodes. ~ A progress note, dated 10/8/24 at 12:50 PM, indicated R1 had an unresponsive episode in a stand up lift. R1 complained of severe right shoulder/clavicle pain with limited range of motion (ROM). Staff applied ice to the area and as needed (PRN) Norco (a combination of acetaminophen and hydrocodone) was administered per R1's request with minimal relief. Staff called the physician's office and were asked to fax an update which Medical Doctor (MD)-C would address as soon as MD-C returned. R1 and R1's spouse were aware. ~ A physician contact note, dated 10/8/24, indicated R1 had an unresponsive episode while in a stand up lift. R1 complained of severe pain in the right shoulder/clavicle which was slightly swollen. The physician ordered X-rays of the right shoulder and clavicle due to limited mobility. ~ On 10/9/24, the X-rays were completed. (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ On 10/9/24, the facility received the results for R1's shoulder X-ray via fax at 11:00 AM which indicated there was no acute fracture. A handwritten note on the X-ray results indicated the same. The results were signed by MD-C on 10/10/24. ~ On 10/9/24, the facility received the results for R1's right clavicle X-ray via fax at 11:11 AM. The results indicated R1 had an age-indeterminate fracture of the mid-right clavicle with mild displacement of the distal fragment that correlated with the timing of the transfer and pain. The X-ray results did not contain a handwritten note or MD-C's signature. ~ A progress note, written by Registered Nurse (RN)-E on 10/9/24 at 1:51 PM, indicated R1's right shoulder/scapula X-ray was negative for fracture. R1 was updated and a report was faxed to the physician. ~ An orthopedic appointment note, dated 10/15/24, indicated R1 had a closed non-displaced fracture of the right clavicle shaft, point tenderness over the clavicle, and right shoulder pain. R1 had a history and physical exam finding of an acute right clavicle fracture that occurred approximately one week ago. R1 was asked to work on ROM as tolerated and apply ice. The note indicated the physician would follow-up with R1 to determine if R1 needed a rehab program and repeat the X-ray in 1 month. On 10/23/24 at 11:45 AM, Surveyor interviewed RN-E who verified RN-E was working on R1's unit when R1's X-ray results were received. RN-E recalled faxing 2 pieces of paper to MD-C on 10/9/24. RN-E documented in R1's medical record that there were no findings for R1's shoulder X-ray and faxed the results to MD-C. RN-E did not recall receiving R1's clavicle X-ray results. On 10/23/24 at 12:10 PM, Surveyor interviewed MD-C who indicated MD-C must not have seen the results of R1's clavicle X-ray because MD-C did not sign or date the results. MD-C wasn't sure if the results were faxed or if MD-C missed them. MD-C indicated when MD-C reviews X-ray results, MD-C dates and signs the document and sends it back to the facility. MD-C indicated MD-C wouldn't have ordered anything different had MD-C seen R1's clavicle X-ray results. MD-C indicated the treatment for a clavicle fracture was rest, ice, and use as tolerated. There was no surgery or casting needed. MD-C indicated R1 was already taking pain medication which was strong and addictive. On 10/23/24 at 2:09 PM, Surveyor interviewed Occupational Therapist (OT)-D who saw R1 on 10/10/24 due to R1's complaint of shoulder pain. OT-D indicated when OT-D entered R1's room, R1 had an ice pack on R1's shoulder. OT-D was under the impression that R1's shoulder X-ray was negative and was not sure if the X-ray included R1's clavicle. Based on OT-D's assessment, OT-D recommended R1 see Orthopedics due to clavicle pain. OT-D indicated that R1 felt instability and popping when R1 moved R1's right arm. OT-D indicated if OT-D had known R1 had a clavicle fracture, OT-D would have recommended R1 not use the arm and use a sling if R1 was up. OT-D would have also recommended that staff use a Hoyer lift to transfer R1 (which staff were already using). OT-D indicated it was okay for R1 to use R1's elbow and hand when in bed. OT-D indicated the treatment for R1's type of fracture was rest and let it heal (continued on next page)

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