

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  08/13/2025
NAME OF PROVIDER OR SUPPLIER  Bethel Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689  Level of Harm - Immediate jeopardy to resident health or safety  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)		

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on staff interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible for 1 resident (R) (R1) of 5 sampled residents when staff used a mechanical lift without ensuring a safety latch was in place prior to transferring R1. On 7/30/25 at 11:00 AM, Certified Nursing Assistant (CNA)-C and CNA-D transferred R1 from bed to Broda chair via a Liko Golvo 7007ES full body lift. CNA-C and CNA-D positioned the sling under R1 and hooked all 4 sling loops onto 2 hooks on either end of the sling bar. During the transfer, a sling loop slid down the sling bar, which caused the bar to go vertical. A safety latch that should have been attached to the sling bar hook was missing which caused a sling loop to detach from the lift. CNA-C and CNA-D were aware the safety latch was missing prior to the transfer. R1 fell out of the sling upper body first and hit R1's head on the leg of the lift. CNA-C stayed with R1 while CNA-D notified the nurse. R1 was bleeding from the back of the head and was transferred to the hospital. A computed tomography (CT) scan indicated R1 had a large right-sided acute subdural hematoma, a right scalp laceration, a small scalp hematoma, and a fracture of the C7 spinous process. R1 was admitted to the hospital and passed away on 8/2/25. The failure to identify and correct a known hazard related to the use of a mechanical lift created a finding of immediate jeopardy that began on 7/30/25. Nursing Home Administrator (NHA)-A was notified of the immediate jeopardy on 8/11/25 at 3:18 PM. The immediate jeopardy was corrected and removed on 7/31/25. The immediate jeopardy is being cited at past non-compliance. Findings include: The facility's Fall Risk Assessment and Management policy, dated January 2025, indicates it is the policy of the facility to provide as safe of an environment for our residents as possible. High-risk fall prevention interventions are designed to reduce the severity of injuries due to falls as well as prevent falls from reoccurring, supplementing standard fall prevention interventions, including. Make sure supportive devices are applied properly before leaving the room for any reason. The facility's Safe Resident Handling policy, dated January 2025, indicates: 1. Protect the health and safety of residents and staff; 2. Maintain a high level of resident dignity and a positive resident experience during transfers; 3. Improve quality of care; 4. Maintain the resident's right to be as independent as possible based on their physical and psychological abilities; 6. Standardize resident lifting procedures. The policy also indicates mechanical equipment will be re-evaluated annually to ensure the equipment is adequate to meet the needs of the resident population. Caregivers will do visual inspections of lifts prior to use to ensure they are properly functioning. If equipment is in need of repair, it will not be used and maintenance staff will be contacted. Maintenance staff will complete an inspection of equipment as necessary to ensure it is properly functioning. On 8/11/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, epilepsy, and anxiety disorder. R1's Minimum Data Set (MDS) assessment, dated 6/18/25, indicated R1 was rarely to never understood and R1's cognition was severely impaired. The MDS also indicated R1 was dependent on staff for mobility and transfers. R1 had an activated Power of Attorney for Healthcare (POAHC). A progress note, dated 7/30/25, indicated at approximately 11:00 AM, a CNA approached the nurse and indicated R1 fell out of a full body lift during a transfer and hit the back of R1's head. The nurse assessed R1 and noted R1 was bleeding from the back of the head. The nurse also noted a safety latch on the lift may have been faulty. The nurse called 911 and R1 was transferred to the hospital. A Hospital History and Physical (H&amp;P), dated 7/30/25, indicated R1's CT scan showed a large right-sided acute subdural hematoma up to 2.3 centimeters (cm) thick with localized mass effect and an approximate 7 millimeters (mm) midline shift, as well as a right posterior lateral scalp laceration and a small underlying scalp hematoma. The cervical CT showed a mild displaced acute fracture of the C7 spinous process. The H&amp;P indicated R1's POAHC opted for Hospice services and comfort measures. A Hospital Discharge summary, dated [DATE], indicated R1 passed away on Hospice services on 8/2/25. The primary cause of death was listed as a subdural hematoma with contributing illness of severe dementia. On 8/11/25 at 10:17 AM, Surveyor interviewed Deputy Medical Examiner (DME)-F via phone who stated R1's death certificate indicated the cause of death was an accident resulting in a closed head injury as a result of a fall. On 8/11/25 at 11:12 AM, Surveyor interviewed Maintenance Technician (MT)-E who stated MT-E completes monthly equipment checks on safety latches and other features of the lifts. MT-E stated if there is a concern, the lift is removed from the floor until maintenance repairs it. MT-E stated MT-E checked the lift with the missing safety latch 2 weeks prior to the incident and the latch was in place. MT-F stated MT-F</p>		