STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525554	A. Building B. Wing	09/10/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection for 2 residents (R) (R26 and R64) as well as staff, volunteers, visitors, and other individuals providing resident services. This practice had the potential to affect more than 4 of the 70 residents residing in the facility.The facility did not implement transmission-based precautions (TBP) for residents at the onset of respiratory symptoms to prevent the spread of contagious illness. R26 was not placed on droplet precautions at the onset of respiratory symptoms on 8/11/25. R26 was admitted to the hospital on [DATE] and diagnosed with sepsis due to pneumonia of right lower lobe due to infectious organism. In addition, R64 was diagnosed with pneumonia on 9/3/25 and was not placed on TBP. Findings include: The facility's Influenza-Like Illness Control and Surveillance policy, updated 1/2025, indicates: It is the facility's policy to implement infection control measures to identify, control, and notify the appropriate agencies of influenza–like illnesses .Isolation Precautions: Caregivers and visitors should adhere to the appropriate precautions in the presence of a resident with suspected or confirmed respiratory illness until the cause of an acute respiratory infection outbreak is determined. Both droplet and contact precautions should be initiated in addition to standard precautions. Droplet precautions: Illness with pathogens transmitted by respiratory droplets that are generated by a resident who is coughing, sneezing, or talking. Personal protective equipment (PPE) includes a mask and gloves. Working guidance and approval from the campus Medical Director, unless pneumonia is secondary to an infectious agent and conforms to already established Centers for Disease Control and Prevention (CDC) recommendations for common respiratory viruses, pneumonia will be addressed with standard precautions. The facility indicated they refer to CDC Appendix A, dated 2/7/25, for guidance on precautions. Appendix A contains the type and duration of precautions recommended for selected infections and conditions, including numerous pneumonia diagnoses. The facility also indicated they refer to the Department of Health Services (DHS) Transmission-Based Precautions Reference Guide for guidance on precautions which indicates: Transmission-Based Precautions in Health Care Settings: This reference guide may be used for common diseases to prevent transmission of infectious agents in healthcare settings. CDC Appendix A: Type and Duration Recommended for Selected Infections and Conditions. For a general list of clinical syndromes or conditions warranting empiric transmission-based precautions, refer to CDC Appendix A: Table 2. Standard Precautions: Standard precautions are a set of infection control practices used to prevent (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transmission of diseases that can be acquired by contact with blood, body fluids, non-intact skin (including rashes), and mucous membranes. Standard precautions apply at all times and in all locations of healthcare. Practice hand hygiene. Hand hygiene refers to cleaning your hands, either by washing with soap and water or by using alcohol-based hand rub (ABHR); Use PPE whenever there is an expectation of possible exposure to infectious material; Properly clean and disinfect resident-care equipment following products' manufacturer's instructions for use, including amount, dilution, and contact time; Promote respiratory hygiene or cough etiquette among staff and residents. Contact Precautions: Wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. [NAME] PPE upon room entry and discard before exiting the room to contain pathogens, especially those that have been implicated in transmission through environmental contamination; Use disposable or dedicated resident-care equipment (for example, blood pressure cuffs). If common use of equipment for multiple residents is unavoidable, clean and disinfect such equipment before use on another resident; The resident should perform hand hygiene and wear clean clothing when leaving the room; Limit movement of the resident outside their room to medically necessary purposes only. Transmission-Based Precautions: Transmission-based precautions are used in addition to standard precautions. They are used for residents who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. There are three categories of transmission-based precautions including: contact precautions, droplet precautions, and airborne precautions. Wear a surgical or procedure mask for close contact with an infectious resident. The mask is generally donned upon room entry; Limit movement of the resident outside their room to medically necessary purposes only. Residents on droplet precautions who must be transported outside their room should wear a surgical or procedure mask if tolerated and practice respiratory hygiene and cough etiquette. 1.On 9/9/25, Surveyor reviewed R26's medical record. R26 was admitted to the facility on [DATE] and had diagnoses including infection and inflammatory reaction due to internal left knee prosthesis, chronic obstructive pulmonary disease (COPD), and obstructive sleep apnea. R26's Minimum Data Set (MDS) assessment, dated 8/11/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R26 had intact cognition. R26 had an activated Power of Attorney for Healthcare (POAHC) to assist with medical decision making. R26's medical record indicated R26 was on enhanced barrier precautions (EBP) since admission. A progress note, dated 8/11/25, indicated R26 felt cold, was hypotensive, had chattering teeth, and had a temperature of 100.4 degrees. R26 was admitted to the hospital on [DATE] and diagnosed with sepsis due to pneumonia of right lower lobe due to infectious organism. R26 was readmitted to the facility on [DATE]. On 9/8/25 at 2:00 PM, Surveyor interviewed Infection Preventionist (IP)-D who indicated the facility follows standard precautions for residents diagnosed with pneumonia and continues to follow standard precautions if there is an infectious agent associated with the resident's pneumonia. IP-D verified the facility follows CDC Appendix A as a reference for PPE protocol and indicated CDC Appendix A indicates to follow standard precautions for residents diagnosed with pneumonia. IP-D verified the facility does not obtain a sputum sample for residents with respiratory symptoms suspected of having pneumonia and indicated residents are placed on standard precautions when (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	respiratory symptoms are present. IP-D indicated the facility does not have a TBP policy and follows the DHS Transmission-Based Precautions reference guide. On 9/8/25 at 3:28 PM, Surveyor interviewed Medical Director (MD)-H who recommended residents be placed on droplet precautions at the onset of respiratory symptoms to protect themselves and others. MD-H indicated staff should wear a mask, gown, and gloves while working with residents suspected to have pneumonia and stated it is important to use good hand hygiene. MD-H indicated a sputum culture is indicated when pneumonia is suspected and stated a resident should be contained to their room until fever free for 24 hours and on antibiotics for 24 hours if antibiotics are necessary to reduce transmission. MD-H indicated it is the facility's responsibility to contain respiratory illness by limiting residents' transport to medically necessary purposes. On 9/9/25 at 12:05 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R26 was not placed on TBP or droplet precautions at the onset of respiratory symptoms. DON-B indicated the facility follows standard precautions for residents who are suspected to have and diagnosed with pneumonia and does not culture residents for pneumonia. 2. From 9/8/25 to 9/10/25, Surveyor reviewed R64's medical record. R64 was admitted to the facility on [DATE] and had diagnoses including diabetes and chronic kidney disease. R64's MDS assessment, dated 7/2/25, had a BIMS score of 15 out of 15 which indicated R64 had intact cognition. R64 made R64's own healthcare decisions. R64's medical record indicated R64 was diagnosed with pneumonia on 9/3/25 per a chest X-ray. R64 did not have a sputum test which would have determined R64's type of pneumonia. R64 had an order for Augmentin (an antibiotic medication) oral tablet 875-125 milligrams (mg), give 1 tablet by mouth two times daily for pneumonia for 7 days (start date 9/3/25). On 9/8/25 at 2:32 PM, Surveyor noted there was not a TBP sign or PPE cart near R64's door that indicated staff should wear PPE while caring for R64 to prevent the transmission of infection. Surveyor interviewed R64 who indicated staff do not wear PPE during cares except for gloves. On 9/9/25 at 12:10 PM, Surveyor interviewed DON-B who indicated the facility's policy indicates standard precautions are used for pneumonia and droplet precautions are not required. On 9/9/25 at 12:55 PM, Surveyor interviewed IP-D who indicated R64 was not placed on TBP because R64 was not deemed to have an infectious disease after a COVID-19 test was negative. IP-D confirmed a sputum culture was not obtained and R64's pneumonia was diagnosed via X-ray. On 9/10/25 at 9:48 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-E who verified R64 was not on TBP.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, staff and resident interview, and record review, the facility did not ensure 2 residents (R) (R44 and R3) of 2 sampled residents were accurately assessed for self-administration of medication. Theraworks pain relief spray was observed at R44's bedside. R44's most recent Self-Administration of Medication assessment, dated 9/3/25, indicated R44 was unable to self-administer medication. Oral medication and eye drops were observed at R3's bedside. A Self-Administration of Medication assessment for R3 was not thoroughly completed. In addition, R3 signed consent to self-administer medication while incapacitated. Findings include: The facility's Self-Administration of Medications policy, dated January 2025, indicates: It is the policy of Bethel Home to support residents' rights to self-administer medication when it is safe and clinically appropriate. Self-administration of medication must be authorized by the provider, assessed by nursing staff, and consented to by the resident or their legal representative. Nursing staff remain responsible for ensuring resident safety, compliance with treatment, and regulatory requirements .Purpose: To promote resident independence and dignity while also ensuring medication safety and adherence .Eligibility requirements: .1. Assessment: A licensed nurse will complete and document an assessment of the resident's ability to self-administer medication safely .3. Consent: The resident (or legal representative) must sign a consent form acknowledging understanding and acceptance of the responsibilities. Nursing Staff Responsibilities: 1. Verify which residents are authorized for self-administration .2. Report any concerns or missed doses immediately to the charge nurse/supervisor. 3. Maintain ongoing evaluation of the resident's ability . 1.From 9/8/25 to 9/10/25, Surveyor reviewed R44's medical record. R44 had diagnoses including neurocognitive disorder with Lewy Body dementia, depression, and insomnia. R44's Minimum Data Set (MDS) assessment, dated 5/5/25, had a Brief Interview for Mental Status (BIMS) score of 7 out of 15 which indicated R44 had severely impaired cognition. R44 had an activated Power of Attorney for Healthcare (POAHC). On 9/8/25 at 9:05 AM, Surveyor observed R44 in R44's room and noted there was a bottle of Theraworks pain relief spray on the cabinet next to R44's recliner. R44's medical record contained a Self-Administration of Medication assessment, dated 4/7/25, that indicated R44 was capable of self-administering topical medications. A Self-Administration of Medication assessment, dated 9/3/25, indicated R44 was not capable of administering any medications, including topical medications. On 9/9/25 at 10:49 AM, Surveyor interviewed Director of Nursing (DON)-B and Registered Nurse House Manager (RNHM)-C. DON-B completed the initial assessment on 4/7/25 that indicated R44 was capable of self-administering topical medications and stated R44 has been self-administering topical medications since that time. RNHM-C stated RNHM-C filled out the assessment on 9/3/25 but did not complete an actual assessment because R44 resides on the dementia unit. DON-B indicated an additional assessment was completed on 9/9/25 and R44 was assessed as capable of self-administering topical medications and can keep them at the bedside. DON-B indicated the 9/3/25 Self-Administration of Medication assessment was not completed per policy and R44 was not accurately assessed at that time. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. From 9/8/25 to 9/10/25, Surveyor reviewed R3's medical record. R3 had diagnoses including diabetes, atrial fibrillation, hypertension, anxiety, and depression. R3's MDS assessment, dated 7/5/25, had a BIMS score of 14 out of 15 which indicated R3 had intact cognition. R3 had an activated POAHC who assisted R3 with medical decisions. R3's medical record indicated R3 was deemed incapacitated on 7/7/22 but signed a Self-Administration of Medication form on 8/7/23. R3's medical record did not contain a Self-Administration of Medication form signed by R3's POAHC. R3's medical record contained a Self-Administration of Medication assessment that indicated R3 wished to self-administer medication per verbal request on 5/20/25. The bottom of the assessment indicated the Interdisciplinary Team (IDT) determined R3 was cognitively, physically, and visually able to self-administer medications and contained an illegible signature dated 5/20/25. An assessment completed on 5/21/25 indicated R3 was not capable of storing, opening, or closing medication containers, needed assistance with time for medication administration, and could not correctly state the proper dosage for medication. Correct dispensing of medication and medication by route were not assessed. The assessment indicated R3 was fully capable of accurately documenting self-administration of medication. On 9/8/25 at 9:43 AM, Surveyor observed 2 pills at R3's bedside and a bottle of eye drops in a labeled container. Surveyor interviewed R3 who thought the pills were Tylenol from the night before and stated R3 fell asleep before taking them. R3 stated R3 had to keep the eye drops at bedside but preferred staff administer the eye drops in the evening. On 9/8/25 at 10:00 AM, Surveyor interviewed RN-G who indicated R3 can keep the eye drops at bedside. RN-G indicated the pills at R3's bedside were from the previous night and could be acetaminophen and Gas-X. RN-G was not sure if acetaminophen should be at the bedside but thought Gas-X could be. On 9/8/25 at 10:06 AM, RN-G approached Surveyor and indicated R3 could have medications at the bedside. Surveyor reviewed R3's Medication Administration Record (MAR) which indicated R3's scheduled acetaminophen 1000 milligrams (mg) by mouth at bedtime (HS) was last administered on 9/7/25 at 7:09 PM. The order did not indicate the medication could be left at the bedside. R3's MAR contained an order for dry eyes ophthalmic solution 0.5% Povidone instill 1 drop in right eye three times a day unsupervised self-administration and indicated the eye drops could be kept at the bedside. R3's September 2025 MAR contained documentation 3 times per day from 9/1/25 to 9/8/25 that indicated the eye drops were administered unsupervised. On 9/9/25 at approximately 8:00 AM, Surveyor was provided a Self-Administration of Medication assessment for R3 that contained a new order (with a start date of 9/8/25 at 7:00 PM) for staff to check R3's room twice daily to ensure R3 had taken all self-administered medications. R3's care plan was updated on 9/8/25 to reflect the physician order for self-administration of medication; however, the description indicated to specify the medications and if they were administered supervised or unsupervised. The medications and type of supervision were not specified. The facility provided a copy of education that was being provided to nursing staff to ensure staff visually verify residents who self-administer medication take the medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/10/25 at 9:19 AM, Surveyor interviewed DON-B who completed R3's Self-Administration of Medication assessment and indicated R3 can have medication at the bedside after the medication is prepared by a nurse. DON-B indicated R3 fell asleep the night before without taking medications that were signed out by the nurse. DON-B stated nursing staff should verify residents take medications left at the bedside and should do so prior to documenting their administration on the MAR. On 9/10/25 at 12:53 PM, Surveyor interviewed DON-B who indicated consent for self-administration of medication is not re-done if a resident is later identified as incapacitated and requires assistance with medical decision making. DON-B was unsure if R3's POAHC knew that R3 self-administers medication but thought so since care plans are reviewed at care conferences. (Of note: self-administration of medication was not added to R3's care plan until 9/8/25.) On 9/10/25 at 12:59 PM, Surveyor interviewed R3's POAHC who did not recall being informed that R3 self-administers medication.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 2 residents (R) (R26 and R39) of 5 sampled residents were provided pneumococcal vaccines.R26 was eligible to receive a pneumococcal vaccine. The facility did not obtain R26's consent or declination to receive the vaccine in a timely manner.R39 was eligible for and signed consent to receive a pneumococcal vaccine. The facility did not administer the vaccine in a timely manner.Findings Include: The facility's Infection Control-Immunizations policy, revised 1/2025, indicates: The facility will ensure each resident is offered a pneumococcal immunization unless the immunization is medically contraindicated or the resident has already been immunized. The resident's medical record includes documentation that indicates, at a minimum, the following: That the resident or the resident's representative was provided education regarding the benefits and potential side effects of the pneumococcal immunization; and The resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal .Utilize the flow chart when offering pneumococcal immunizations.Pneumococcal vaccine schedule guidelines indicate if there is no history of a PCV13 or PPSV23 vaccine, a Prevnar 20 vaccine should be administered. 1.On 9/8/25, Surveyor reviewed R26's medical record. R26 was admitted to the facility on [DATE] and had diagnoses including infection and inflammatory reaction due to internal left knee prosthesis, chronic obstructive pulmonary disease (COPD), and obstructive sleep apnea. R26's Minimum Data Set (MDS) assessment, dated 8/11/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R26 had intact cognition. R26 had an activated Power of Attorney for Healthcare (POAHC) to assist with medical decision making. R26's medical record indicated R26 was admitted to the hospital on [DATE] and diagnosed with sepsis due to pneumonia of right lower lobe due to infectious organism.R26's 8/20/25 MDS documentation for vaccines indicated R26's pneumococcal vaccine was up to date. A Vaccine Administration Record-Immunization Consent Form for R26 contained a signature line that indicated R26 gave consent to receive the pneumococcal vaccine when offered on 9/8/25. R26's medical record indicated R26 received the pneumococcal vaccine on 9/8/25. On 9/9/25 at 9:50 AM, Surveyor interviewed Infection Preventionist (IP)-D who indicated consent for vaccines is obtained upon admission and is part of the admission paperwork. IP-D indicated R26 should have been offered and administered the pneumococcal vaccine within one or two days of admission.2. On 9/8/25, Surveyor reviewed R39's medical record. R39 was admitted to the facility on [DATE] and had diagnoses including acute osteomyelitis, cellulitis of right upper limb, and type 2 diabetes. R39's MDS assessment, dated 8/7/25, had a BIMS score 15 out of 15 which indicated R39 had intact cognition. R39 was responsible for R39's medical decisions. R39's medical record indicated R39 was admitted to the hospital on [DATE] and diagnosed with cellulitis. R39 returned to the facility on 8/18/25.R39's 8/5/25 MDS documentation for vaccines indicated R39's pneumococcal vaccine was up to date. An Authorization and Release for Pneumococcal Vaccine, signed by R39 and dated 8/5/25, indicated R39 consented to receive the pneumococcal vaccine. R39's medical record indicated R39 received the pneumococcal vaccine on 9/8/25. On 9/9/25 at 9:50 AM, Surveyor interviewed IP-D who indicated R39's consent for the vaccine was signed at the time of admission. IP-D indicated R39 should have received the pneumococcal vaccine within one or 2 days after R39 returned from the hospital on 8/18/25.On 9/10/25 at 9:50 AM, Surveyor interviewed MDS Registered Nurse (MDSRN)-I who indicated MDSRN-I documented that R26 and R39's pneumococcal vaccines were up to date because MDSRN-I had reviewed R26 and R39's Wisconsin Immunization Registries in error.