STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017955	A. BUILDING: _____ B. WING _____	R-C 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL MENASHA I	1645 CENTURY OAKS COURT MENASHA, WI 54952

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{N 000}	Initial Comments On 08/25/2025, Surveyor conducted a verification visit at Bethel Menasha I. The previous deficiency was corrected and 2 new deficiencies were identified. Census: 8 Under statutory provisions of WI Stat. Ch. 50 a $200 revisit fee is being assessed.	{N 000}		
N 356	83.32(3)(l) Rights of Residents: Least restrictive env In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Least restrictive environment. Have the least restrictive conditions necessary to achieve the purposes of the resident ' s admission. The CBRF may not impose a curfew, rule or other restriction on a resident ' s freedom of choice. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure the least restrictive conditions necessary to achieve the purposes of Resident 2's admission. The provider restricted Resident 2's access to his/her gaming device in response to behaviors. The provider did not document how long ago the device was taken away, the circumstances that prompted the restriction or the conditions under which the restriction could end. The restriction was not part of a behavioral support plan with agreement of the guardian or managed care organization. Caregivers also denied Resident 2 food because s/he just ate dinner which triggered a behavior,	N 356		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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and then threatened to make Resident 2 spend the night in a sister facility if the behavior did not stop.

Findings include:

On 08/25/2025 at approximately 10:55 AM, Surveyor observed Resident 2 approach Caregiver D and ask if s/he could talk with Administrator A. Caregiver D replied Administrator A was very busy, but s/he would check. Resident 2 said, "I really would like my play station back. I proved to [Administrator A] I can behave over the weekend."

Surveyor asked Caregiver D why Resident 2 did not have access to his/her play station (gaming device) and s/he said, "I don't really know why it is gone." Caregiver D and Surveyor looked in Resident 2's record. There were no incident reports on file. The last observation notes were dated 08/15/2025 and 08/17/2025 and read,

--08/15: was "being disrespectful" by "blasting some piano that sounded like a car alarm going off." Was "talking smart and cursing" at the caregiver. Said s/he "wants [his/her] f [sic] Play Station back" and the caregiver "told [him/her] to go to [his/her] room." Administrator A was notified. Resident 2 went to his/her room and was "banging stuff on the walls."
--08/17: at 5:30 PM after dinner, Resident 2 asked for a sandwich and staff "refused [him/her]" because s/he just ate. Resident 2 "became so mad" and had a behavior. Administrator A was notified. At 6:30 PM it was documented Resident 2 was "not nice" to staff. Caregiver F from a sister building (building 2) was called to assist. Caregiver F wrote that s/he had a "very firm conversation with [Resident 2]...asked [him/her]

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to apologize to the staff... (building 1 staff) decided to watch [him/her] for a while and keep [him/her] in the dining room. I told [Resident 2], if I'm called again, [s/he] will come and sit with me for the night."

At 11:05 AM, Caregiver D told Resident 2 s/he could go talk to Administrator A in his/her office (sister building 3). Surveyor accompanied Resident 2 and asked how s/he liked living at the facility. Resident 2 said s/he was "bored" and his/her Play Station had been taken away for "a couple of weeks" for "misbehaving."

Surveyor, Resident 2 and Administrator A all met in Administrator A's office. Administrator A told Resident 2 s/he could have his/her Play Station back and Resident 2 retrieved it from the top of a cabinet. Surveyor asked Administrator A how long ago the Play Station was taken away and s/he said it has been "on and off" and volunteered "there is a restriction signed by the guardian."

Resident 2 again said the gaming device was taken "a couple of weeks ago."

Surveyor asked why the device was taken and Administrator A said it was because Resident 2 was "being disrespectful to staff and residents" and taking food from residents.

Resident 2 then returned to his/her facility and Surveyor continued the interview with Administrator A.

Administrator A further explained when the device is restricted, it remains restricted until Resident 2 "can listen and earn" it back. Surveyor asked if there is a written plan to speaks to this and Administrator A said there was a "signed HCBS

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N 356	Continued From page 3 (home and community based settings) form stating everyone agrees to the play station rules...to help with behaviors." Administrator A said the form was signed, "probably about 6 months ago" by the managed care organization (MCO) and the guardian. Surveyor asked to review the signed HCBS form or anything signed by the guardian to show this was an agreed upon intervention. Administrator A said s/he did not have a copy of the documentation. Surveyor raised concern about the punitive nature of the intervention. Administrator A stated, "We don't punish [him/her], [s/he] is not a 2 year old." Administrator A did not offer additional information about a rewards system for reaching goals or encouraging positive behavior. During the interview, Surveyor reviewed the portions of Resident 2's record with Administrator A, including the individual service plan (ISP) and observation notes. --Administrator A said Resident 2 has diagnoses to include autism and ADHD and has a legal guardian. --Administrator A said Resident 2 moved from building 2 to building 1 sometime in January 2025, but s/he did not know the exact date. --Administrator A said the most current individual service plan (ISP) was developed when Resident 2 was still in building 2, it was dated 12/04/2024 and was signed by the MCO care team (including MCO Care Manager G) and Guardian E. Administrator A agreed the ISP was silent to behaviors of being disrespectful to staff or peers and did not identify any interventions related to restricting access to Resident 2's gaming device. --Administrator A said Resident 2 should not have been denied a sandwich on 08/17 even though s/he just ate dinner. Administrator A said Resident	N 356		

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N 356	Continued From page 4 2 did eventually get the sandwich because staff called him/her and s/he told them to make the sandwich. Administrator A acknowledged that was not documented. Administrator A agreed Resident 2 had a behavior in response to the food restriction. Administrator A also acknowledged Caregiver F's note about threatening to make Resident 2 come "sit with" Caregiver F in a different building for the night, was inappropriate. --Administrator A confirmed there were no incident reports in the record, no documentation of when the gaming device was taken away, under what circumstances it was taken away or the conditions necessary for Resident 2 to get it back. Surveyor interviewed Guardian E on 08/25/2025 at 2:34 PM and MCO Care Manager G on 08/25/2025 at 2:51 PM; they did not corroborate Administrator A's statements that they were in agreement with the restriction: --When Surveyor asked Guardian E and asked about the gaming device restriction, Guardian E said, "They know they are not supposed to do that" and said in the past s/he has spoken with Administrator A about concerns with caregivers doing that. Guardian E also said, "2 weeks is way too long anyway for something to be taken away...I'll contact [Administrator A] again and tell [him/her] that's not allowed." Guardian E confirmed s/he did not sign any forms agreeing to the restriction. --Care Manager G said the only HCBS rights waiver form on file was related to caregivers having the ability to enter Resident 2's room without knocking during sleeping hours to do wellness checks. Care Manager G said Resident	N 356		

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N 356	Continued From page 5 2 does not have or need a behavioral support plan because s/he is easily redirectable. Care Manager G said restricting Resident 2's access to his/her gaming device is not an agreed upon intervention, is punitive and s/he would consider it a rights violation.	N 356		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the facility was safe, comfortable and well maintained. There was a tripping hazard near the entry way and furniture and kitchen counters were in poor repair. Findings include: At 10:20 AM, Surveyor observed the following: --A metal transition strip between the entry way and living room was cracked in the center. The crack was approximately 6 inches long and slightly raised, presenting a tripping hazard. --A brown faux leather couch in the living room was badly worn with rips and tears. One of the cushions was missing approximately 75% of the brown material, exposing the yellow foam cushion. --a blue faux leather couch in the living room was worn with cracks and small tears.	N 481		

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N 481	Continued From page 6 --The dark blue kitchen countertops were scratched and chipped. Approximately 30% of the blue counter space was so badly scratched and chipped, it appeared white. NOTE: during the previous survey ending 04/24/2025, Surveyor provided technical assistance to Licensee H regarding the condition of the countertops. --The wooden face of the kitchen cabinets and drawers were badly scraped and worn. --The entire face of the stainless steel dishwasher was water stained. Surveyor interviewed Caregiver D at 10:53 AM. S/he confirmed Surveyor's observations of the countertops, transition strip and couch. Caregiver D confirmed the brown couch was in especially bad repair. S/he said the couch had been like that for a while. Caregiver D said they were covering it with a blanket or sheet, but that became a tripping hazard, so for the past month the couch has had no covering. Surveyor interviewed Administrator A at 11:25 AM. S/he acknowledged the aforementioned observations and did not offer additional information.	N 481		