STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015739	A. BUILDING: _____ B. WING _____	C 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL OAKS MEMORY CARE HOME	620 S GARFIELD AVENUE VIROQUA, WI 54665

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N 000	Initial Comments On 10/24/2024, Surveyors conducted an abbreviated survey and complaint investigation at Bethel Oaks Memory Care Home. Data collection continued through 10/31/2024. The complaint was substantiated. Three deficiencies were identified. One of the 3 was a repeat violation. See Statement of Deficiency (SOD) 5KXE11, dated 07/02/2021. Census: 27	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written report was sent to the department when law enforcement was called to the facility as a result of an incident that jeopardized the safety of Resident 1 on 10/07/2024. Findings include:	N 164		

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

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N 164	Continued From page 1 On 10/11/2024, the department received a complaint regarding alleged sexual abuse of a resident by another resident. The provider is licensed to care for up to 29 residents in the client groups of advanced aged and irreversible dementia/Alzheimer's. On 10/24/2024, at approximately 10:00 AM, Surveyors interviewed Administrator B. Administrator B stated Resident 2 was discharged from the facility on 10/23/2024 after Resident 2 was witnessed touching Resident 1 inappropriately. Administrator B stated law enforcement was called immediately after the incident and arrived at the provider on 10/07/2024. Surveyor stated a review of the provider's self-report folder kept by the department did not show a self-report was sent by the provider to the department. Administrator B stated the situation was hectic and s/he did not send a self-report to the department.	N 164		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement	N 389		

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N 389	Continued From page 2 with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 2's Individual Service Plan (ISP) was updated upon changes. Findings include: The provider is licensed to care for up to 29 residents in the client groups of advanced aged and irreversible dementia/Alzheimer's. On 10/11/2024, the department received a complaint regarding alleged sexual abuse of a resident by another resident. On 10/24/2024 at approximately 10:00 AM, Surveyors interviewed Administrator B and Manager C. Administrator B stated Resident 2 was discharged from the facility the day prior after an incident occurred and Resident 2 had been working through some sexual issues. Administrator B stated Resident 2 had started estrogen medication and was requiring redirection from staff. Administrator B stated Resident 2 had been a "little touchy" with a certain sex of staff. Administrator B stated the provider conducted an investigation and concluded the allegations were true, and Resident 2 did touch another resident inappropriately. At approximately 11:30 AM, Surveyor reviewed Resident 2's records. Resident 2 was admitted on 06/06/2023 and had multiple diagnoses, including moderate late onset	N 389		

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N 389	Continued From page 3	N 389		

Alzheimer's dementia. Resident 2 had an activated power of attorney for healthcare (POAHC.)

Staff observations notes, dated 09/10/2024 - 10/07/2024, documented the following:

09/13/2024 at 9:15 PM: "Tried to give resident [his/her] new 8:00 med (medication) and [s/he] was combative and refused. I tried several times, and [s/he] came across very aggressive with kicking and hitting, so med was destroyed."
09/13/2024 at 2:45 PM: " ...several staff tried to get [him/her] changed. Was combative with staff."
09/14/2024 at 1:30 AM: " ...staff went over to help assist the resident up and resident got very angry and started to swat at staff ..."
09/16/2024 at 9:45 AM: "Both staff attempted to do cares on this resident [sic] [s/he] refused each time we asked."
09/17/2024 at 1:30 PM: "This resident spit out [his/her] medication onto the floor in [his/her] room ..."
09/18/2024 at 9:00 AM: Staff noted during medication administration, Resident 2 would take his/her medications and place them inside of a tissue or napkin if one was available.
10/02/2024 at 9:45 PM: "VERY feisty and combative at HS (bedtime.) Refused to get to go to bed or take meds. Slapping and kicking at staff. Responded when staff was stern with [him/her,] but still refused."

Resident 2's ISP, signed and dated 07/11/2024, contained a section titled "Behavior Patterns." Under the "Aggressive/Combative" subsection it stated, "Not applicable." Under the "Mental Health" section was a subsection titled, "Interaction," and it read, "[Resident 2] mainly keeps to [his/herself] but does find comfort in

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friends..." The following subsections were included: Attitude, Maturation, Mental Illness, Self-Concepts and Verbal. The subsections all indicated, "Not applicable." Under a section titled, "Social Participation," with a subsection titled, "Leisure Time Activities," it read, " ...If [s/he] begins undressing or touching [him/herself] inappropriately in a public area, please direct [him/her] to [his/her] room ..." Under the "Medication Management" section, it stated, "Tenant requires staff to manage/administer medications."

At approximately 1:00 PM, Surveyor interviewed Administrator B and Manager C. When asked about documenting a resident's change in condition and new behaviors, Manager C stated s/he would enter flagged observation notes into their system to ensure staff received updates. Manager C stated staff might not always have access to a resident's plan of care. When asked if Resident 2's ISP was updated to include the behaviors mentioned in the staff observations, Administrator B stated s/he would not describe Resident 2 as combative. Administrator B stated they did observe a decline with Resident 2 and s/he started a new estrogen medication to address some of the sexual behaviors. Administrator B stated there may have been a lack of updating the ISP related to those behaviors.

On 10/31/2024, at 1:00 PM, Surveyor interviewed Administrator B by phone. Surveyor shared concerns related to the ISP not reflecting Resident 2's reported decline, new medication to address sexual behaviors, and multiple staff observations regarding combative and aggressive behaviors. Administrator B acknowledged Surveyor's concerns and stated they would

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N 389	Continued From page 5 continue to review ISPs to ensure they are comprehensive. Administrator B stated Resident 2's estrogen medication was started on 06/07/2024 in hopes of reducing Resident 2's sexual urges. The provider did not ensure Resident 2's ISP included information regarding Resident 2's combative and aggressive behaviors. The ISP did not contain information regarding Resident 2's medication refusals and refusals to accept assistance from caregivers. The ISP did not contain information regarding Resident 2's estrogen medication, its intended purpose, and direction for staff regarding any monitoring recommendations.	N 389		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the clothes dryer vents were rigid metal material. This is a repeat deficiency. See Statement Of Deficiency (SOD) 5KXE11, dated 07/02/2021. Findings include: The provider is licensed to care for up to 29	N 488		

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N 488	Continued From page 6 residents in the client groups of advanced aged and irreversible dementia/Alzheimer's. On 10/24/2024, at approximately 10:40 AM, Surveyor observed 2 laundry rooms. Surveyor noted the dryer venting for 2 of 4 dryers was flexible vent tubing and not rigid metal material. On 10/24/2024, at approximately 11:30 AM, Surveyor re-toured the laundry rooms with Maintenance Person (MP) A. MP A acknowledged the concern and stated 2 clothes dryers were not replaced with rigid dryer venting and the venting would immediately be replaced.	N 488		