STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017959	A. BUILDING: _____ B. WING _____	R-C 04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL MENASHA II	1650 CENTURY OAKS COURT MENASHA, WI 54952

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{N 000}	Initial Comments On 04/23/2025, Surveyor conducted an onsite visit to investigate one complaint and complete a verification visit. Additional information was collected through 04/28/2025. Two (2) of the previous 4 deficiencies were uncorrected. The complaint was unsubstantiated. Two (2) new deficiencies were identified. Census: 7 Under statutory provisions of WI Stat. Ch. 50 a $200 revisit fee is being assessed.	{N 000}		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident received all prescribed medications in the dosages and intervals prescribed by their practitioner. Resident 2 had diagnoses to include chronic obstructive lung disease and during April 2025, did not receive all doses of prescribed albuterol or Anoro Ellipta inhalers. This is a repeat deficiency. See Statement of Deficiency (SOD) R1F012, dated 10/28/2024. Findings include:	{N 352}		

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

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{N 352}	Continued From page 1 On 04/23/2025 at 9:20 AM, Surveyor and Manager B reviewed portions of Resident 2's records, including his/her medication administration records (MAR.) Manager B said Resident 2 has a legal guardian and acknowledged s/he relies on facility staff to manage and administer his/her medications. EXAMPLE 1: Resident 2's April 2025 MAR documented the following: ALBUTEROL HFA 90MCG 8.5G - inhale 2 puffs twice daily for chronic obstructive lung disease, scheduled 8:00 AM and 8:00 PM. A total of 12 doses scheduled at 8:00 PM were not documented as administered on the following dates; 04/02-04/03, 04/06-04/07, 04/12-04/13, 04/15-04/17. Of the 12 missed doses, Caregiver C documented 11 times the reason was because the medication was "on order." At approximately 9:25 AM, Manager B called Administrator A and placed the call on speaker. Administrator A said Resident 2 went without the medication because s/he was trying to get an updated order from the doctor and the doctor's office is "very slow at getting that stuff back to us." Administrator A said there were also issues with insurance and the MCO (managed care organization - funding source.) Surveyor inquired if it was a new medication and Administrator A said it was not and s/he could not explain what prompted concerns with payment. Surveyor and Manager B went through all of	{N 352}		

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{N 352}	Continued From page 2 Resident 2's medications in the cart, located in the left side of the top drawer. Surveyor observed there were 3 albuterol inhalers with pharmacy labels identifying the dispensed date and the inhalers themselves had meters showing the number of doses remaining: Inhaler dispensed 02/07/2025 with 80 of 200 doses remaining Inhaler dispensed 03/28/2025 with 200 remaining doses (full) Inhaler dispensed 04/17/2025 with 200 remaining doses (full) Manager B confirmed that based on the dispensed dates and the number of doses remaining in inhalers dispensed on 02/07 and 03/28, Resident 2 should have had albuterol available between 04/02 - 04/17/2025. At 10:05 AM, Surveyor interviewed Caregiver D and Manager B was present. Surveyor and Manager B reviewed the MAR with Caregiver D and asked about the times s/he documented administration of the 8:00 AM dose of albuterol, when 2nd shift staff were documenting the medication was not available and on order. Surveyor asked if Resident 2 was receiving the medication at 8:00 AM. Caregiver D replied, "I can't remember honestly." Caregiver D paused for about 1 minute then said, "Maybe. Or maybe the other shifts didn't see it in the cart and thought it was on order. Somebody might put something in the cart and somebody else might not see it." Caregiver D explained sometimes if a medication is delivered and there is an existing supply of the medication, s/he will store it in the bottom drawer of the cart. (Surveyor noted this would not explain why the existing supply of the medication would not have been in the usual location.)	{N 352}		

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{N 352}	Continued From page 3 At 3:46 PM, Surveyor interviewed Caregiver C who works 2nd shift. S/he confirmed Resident 2 did not receive prescribed albuterol for approximately 2 weeks earlier in April. Caregiver C said s/he did not look other places in the cart for the inhaler because it should only be stored in the same section of the top drawer where Resident 2's other medications are. On 04/24/2025 at 12:47 PM, Administrator A emailed Surveyor Resident 2's current signed physician orders for albuterol. It was dated 03/28/2025 with 1 remaining refill. The medication was prescribed twice daily "in the morning and late afternoon" for "uncontrolled coughing, SOB (shortness of breath), chest tightness, or wheezing. (May sub levalbuterol for insurance purposes.)" [sic - all] Administrator A also sent delivery receipts from the pharmacy confirming the medication was delivered on 03/28/2025 at 3:59 PM and again on 04/17/2025 at 7:40 PM. On 04/24/2025 at 3:02 PM, Surveyor interviewed Administrator A. Surveyor noted based on the pharmacy delivery information and the medication observed in the cart, the medication was available for Resident 2 between 04/02 and 04/17/2025. Administrator A acknowledged Surveyor's review and did not offer additional insight about the reason Resident 2 did not receive the medication. EXAMPLE 2: Resident 2's April 2025 MAR documented - Anoro Ellipta 62.5-25 MCG - inhale 1 puff once daily. Note: "Once-daily ANORO is a prescription medicine used long term to treat chronic obstructive pulmonary disease (COPD), including	{N 352}		

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chronic bronchitis, emphysema, or both, for better breathing and to reduce the number of flare-ups." Source: https://www.anoro.com/#:~:text=Once%2Ddaily%20ANORO%20is%20a%20prescription%20medicine%20used%20long%20term,the%20number%20of%20flare%2Dups, retrieval date 04/28/2025.

On 04/23/2025 at approximately 9:20 AM, Surveyor and Manager B observed the Anoro Ellipta inhaler was not present in the medication cart. Resident 2's record included documentation Administrator A requested a refill from the pharmacy on 04/17/2025 and the pharmacy replied, "Refill Request Sent to: [physician]."

At 10:05 AM, Surveyor interviewed Caregiver D. Caregiver D said the medication had not been available for approximately 1 week.

Surveyor conducted two interviews with Administrator A on 04/23/2025. During the first interview at 9:25 AM, Administrator A said the medication should be there and s/he was unaware of problems with obtaining the medication. During the second interview at 3:35 PM, Administrator A said there was an insurance issue "at first" and then a delay because the doctor "refused" to refill it until Resident 2 came in for an appointment. Administrator A said, "I can't do much if the doctor is refusing to refill it. I talked to [the guardian] and [the guardian] makes appointments." Administrator A said s/he called the guardian once but "probably" didn't document it. Surveyor requested Administrator A send copies of the medication order and documentation of any efforts to ensure Resident 2 received the medication.

On 04/24/2025 at 12:47 PM, Administrator A

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{N 352}	Continued From page 5	{N 352}		

emailed Surveyor the following:
03/15/2024 - order for Anoro Ellipta Ellipta signed by the physician with 11 refills
02/03/2025 - pharmacy delivery receipt for 60 doses of the medication.
03/24/2095 - documentation from the pharmacy titled, "RX RENEWAL RESPONSE" which read, "PLEASE NOTE PROVIDER WILL NOT SEND UNTIL AFTER APPOINTMENT. IF NEEDED SOONER, CONTACT MD." Contrary to Administrator A's statement during the previous interviews, the documented included handwritten notes s/he authored indicating s/he "left messages" at the physician's office on 03/28, 04/18 and 04/24/2025.

The documentation did not include evidence of efforts between 04/19/2025 and 04/23/2025 to facilitate any necessary appointments so a refill could be obtained. As of the close of the survey on 04/24/2025, Administrator A did not provide an indication of when the appointment would occur or documentation of clear communication to the physician informing him/her Resident 2 had been out of the medication for approximately 1 week.

On 04/28/2025 at 11:16 AM, Surveyor interviewed Guardian E. Guardian E said s/he was not contacted by Administrator A regarding the need to schedule an appointment so a medication could be refilled and was unaware of concerns with the availability of either inhaler. Guardian E recalled on 04/02/2025, facility staff transported Resident 2 to an appointment with his/her "pulmonary doctor." S/he said after the appointment, the doctor's office called Guardian E to say the provider did not send a medication list or accompany Resident 2 to the appointment so in the future they wanted Guardian E present at appointments. Guardian E said Resident 2 is at

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{N 352}	Continued From page 6 risk for ending up in the emergency room if s/he is without either the long lasting Anoro inhaler or the fast acting albuterol inhaler. Guardian E said the communication from Administrator A about medications and other concerns is "lousy." Cross Reference: N0352 DHS 83.37(1)(d) Documentation of Medication Administration	{N 352}		
{N 415}	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not accurately document administration of medications. On 04/23/2025, Caregiver D documented administration of Resident 2's Anoro Ellipta inhaler when s/he did not administer it because it was not available. Caregiver D said the medication had been unavailable for approximately one week. The medication records	{N 415}		

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{N 415}	Continued From page 7 in the 7 days preceding 04/23/2025, documented the medication was administered a total of 5 times (including 04/23/2025.) This is a repeat deficiency. See Statement of Deficiency (SOD) R1F012, dated 10/28/2024. Findings include: On 04/23/2025 at 9:20 AM, Surveyor and Manager B reviewed portions of Resident 2's records, including his/her medication administration records (MAR.) Manager B said Resident 2 has a legal guardian and acknowledged s/he relies on facility staff to manage and administer his/her medications. Resident 2's April 2025 MAR documented the following: Anoro Ellipta 62.5-25 MCG - inhale 1 puff once daily. A total of 4 doses were documented as not administered on the following dates; 04/12, 04/13, 04/18 and 04/21. For each date the reason was "other problems" with no further explanation. Surveyor and Manager B observed the anoro inhaler was not present in the medication cart. However, earlier in the day at 7:30 AM, Caregiver D documented on the MAR that s/he administered the medication. At 10:05 AM, Surveyor interviewed Caregiver D. Caregiver D confirmed s/he documented administration of the medication earlier in the morning, but the medication was not given because it was not available. Surveyor asked how long Resident 2 has gone without the medication and Caregiver D replied, "Maybe a week, I'm not sure."	{N 415}		

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{N 415}	Continued From page 8 Surveyor noted the medication was documented as administered 5 of the 7 previous days (04/17, 04/19, 04/20, 04/22 and 04/23), during the timeframe Caregiver D estimated the medication was not available. Cross Reference: N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication	{N 415}		