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 08/12/2025

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 08/11/2025, Surveyor conducted an onsite visit to investigate 2 complaints and complete a verification visit of 2 deficiencies from the previous survey. Additional information was collected through 08/12/2025. Two (2) of 2 deficiencies were corrected. One (1) of 2 complaints was substantiated and 7 new deficiencies were identified. One (1) of the 7 new deficiencies was a repeat deficiency. Census: 7 Under statutory provisions of WI Stat. Ch. 50 a $200 revisit fee is being assessed.	{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 send a written report to the department within 3 working days after law enforcement was called to the facility as a result of an incident that jeopardized the health, safety, or welfare of residents.	N 164		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BETHEL MENASHA II	1650 CENTURY OAKS COURT MENASHA, WI 54952

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N 164	Continued From page 1 The police responded to the facility on 07/15/2025 and 07/17/2025 to investigate alleged incidents impacting Resident 2's safety and welfare. The provider did not send written reports to the Department within 3 days to report the police response. Findings include: The Department received a complaint alleging concerns the police had been called to the facility. Prior to conducting the onsite visit, Surveyor reviewed Department records for the facility. During 2025, the provider did not submit any self-reports regarding incidents when law enforcement was called to the facility. On 08/11/2025 at 8:39 AM, Surveyor reviewed Resident 2's facility records. The observation notes documented two times in July 2025 when s/he called the police and they responded to the facility. --07/15: Resident 2 called the police to report concerns about "two other residents and a former resident...The office [sic] spoke with me (Caregiver C), and I shared what [Resident 2] told [Guardian E] yesterday that another resident had beat me up...showed the office [sic] I had no bruises and or [sic] scratches on me..." --07/17: Resident 2 called police and "claimed additional accusations towards myself (Caregiver C) and management." On 08/11/2025, Surveyor requested records from the Fox Crossings Police Department (FCPD) regarding police response during 2025. FCPD indicated there was more than 1 time officers	N 164		

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N 164	Continued From page 2 responded, but the only record they were able to release was from 07/17/2025: --07/17 at approximately 6:13 PM, a police officer was dispatched to facility after Resident 2 called to report the owner had taken away his/her food and water. Upon arrival the officer observed Resident lying on the grass. An officer interviewed Caregiver C who explained Resident 2 was refusing to come in the facility after work. Caregiver C said the owner brought in Resident 2's lunch box from work, and that may be the food Resident 2 was referring to. The officer convinced Resident 2 to go back inside the facility with the agreement Caregiver C and the owner would leave him/her alone for the rest of the night. On 08/11/2025 at 1:52 AM, Surveyor conducted an interview with Administrator A and asked about the July 2025 incidents. Administrator A confirmed the police responded to the facility on 07/15 and 07/17/2025. Surveyor asked Administrator A if s/he submitted a report to the department. Administrator A initially said, "I don't know if I sent that." and then said, "I did not report it because I was not here for the whole thing. " Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 164		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily	N 214		

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 08/12/2025

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BETHEL MENASHA II	1650 CENTURY OAKS COURT MENASHA, WI 54952

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N 214	Continued From page 3 operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on observation, interview and record review, Administrator A did not supervise the daily operation of the CBRF to ensure residents received proper care and treatment, their health and safety were protected and their rights were respected. Findings include: During an onsite visit on 08/11/2025 and with information collected through 08/12/2025, Surveyor substantiated 1 of 2 complaints and identified 6 deficiencies: (1) Reporting When Law Enforcement is Called (2) Allowable Reasons for Discharge (3) Involuntary Discharge Notice Requirements (4) Service Plans Updated Annually or On Change (5) PRN Psychotropic Medications - repeat deficiency and (6) Treatment. In summary: --Administrator A did not ensure Resident 2's individual service plan (ISP) was updated based on assessment and with Guardian E's involvement to identify current interventions for behaviors. In addition, the ISP did not include a detailed description of the circumstances for	N 214		

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	0017959	A. BUILDING: _____ B. WING _____	R-C 08/12/2025

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BETHEL MENASHA II	1650 CENTURY OAKS COURT MENASHA, WI 54952

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N 214	Continued From page 4 administration of Resident 2's PRN (as needed) psychotropic medication. --Administrator A subsequently initiated an involuntary discharge for Resident 2 due to behaviors and problems with Guardian E. Caregivers did not corroborate Administrator A's position that Resident 2's behaviors were unmanageable and difficulty with a guardian is not a reason for discharge as outlined in a code. The written notice of discharge authored by Administrator A, was not accurately dated and did not contain accurate information the timeframe to appeal the discharge to the Department and did not include all required phone numbers. In addition, Administrator A did not provide the notice to Guardian E in a timely manner. --Administrator A did not ensure Resident 3's legal representative was involved in development of Resident 3's ISP. Resident 3 experienced dementia related behaviors to include aggression towards staff and residents, persistent exit seeking and an elopement incident where s/he was found 2.5 miles away from the facility. Administrator A did not update Resident 3's ISP to include the aforementioned behaviors or elopement incident or to identify the services the provider would offer to meet Resident 3's needs. --Administrator A authorized a caregiver to make Resident 4 sit in a "time out" for an hour at the kitchen table after Resident 4 became upset about the passing of his/her parent and had a behavior. The following day 08/11/2025, Surveyor observed Administrator A speak disrespectfully to Resident 4 about the incident in front of 3 other residents. --Administrator A did not ensure reports were submitted to the Department after law enforcement responded to the facility twice during July 2025.	N 214		

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 08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 214	Continued From page 5 Cross Reference: N0164 DHS 83.12(4)(b) Reporting when Law Enforcement is Called N0327 DHS 83.31(4)(b) Allowable Reasons For Involuntary Discharge N0328 DHS 83.31(4)(c) Involuntary Discharge Notice Requirements N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0408 DHS 83.37(1)(i) PRN Psychotropic Medication Y3234 Ch 50.09(1)(e) Treatment	N 214		
N 327	83.31(4)(b) Allowable reasons for involuntary discharge. Discharge or transfer initiated by CBRF. Reasons for involuntary discharge. The CBRF may not involuntarily discharge a resident except for any of the following reasons: 1. Nonpayment of charges, following reasonable opportunity to pay. 2. Care is required that is beyond the CBRF ' s license classification. 3. Care is required that is inconsistent with the CBRF ' s program statement and beyond that which the CBRF is required to provide under the terms of the admission agreement and this chapter. 4. Medical care is required that the CBRF cannot provide. 5. There is imminent risk of serious harm to the health or safety of the resident, other residents or employees, as documented in the resident ' s record. 6. As provided under s. 50.03 (5m), Stats. 7. As otherwise permitted by law.	N 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 327	Continued From page 6 This Rule is not met as evidenced by: Based on interview and record review, the provider initiated an involuntary discharge for Resident 2 for reasons inconsistent with the reasons permitted by the code. Administrator A authored an involuntary discharge notice dated 07/25/2025 for Resident 2 based on increased care needs. However, Resident 2's care needs were within the scope of the license classification. In addition, the provider did not ensure Resident 2 received the services outlined in the provider's program statement to meet his/her care needs prior to initiating discharge. Findings include: The Department received a complaint regarding compliance with involuntary discharge requirements. The provider is licensed to serve up to 8 residents from client groups to include: emotionally disturbed/mentally ill, traumatic brain injury, developmentally disabled and irreversible dementia/Alzheimer's. Surveyor interviewed Administrator A on 08/11/2025 at 9:18 AM. Administrator A said s/he initiated an involuntary discharge for Resident 2 near the end of July 2025 because his/her "cares are more than we can do and [Guardian E] is non-compliant with appointments." Administrator A went on to explain, "[Guardian E] will make appointments and then cancel so then we take [him/her] to appointments then [Resident 2] gets upset...Just last week we took [Resident 2] to (a dermatology) appointment and [Guardian E] canceled 4 days prior and didn't tell anybody about it. The time before that in July same thing	N 327		

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 08/12/2025

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BETHEL MENASHA II	1650 CENTURY OAKS COURT MENASHA, WI 54952

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N 327	Continued From page 7	N 327		

(with a counseling) appointment." Administrator A further explained sometimes Resident 2 has behaviors and s/he needs one to one assistance. Administrator A some behaviors occur because Guardian E gets Resident 2 "riled up" and Guardian E is a big part of the problem.

Surveyor called the office for Resident 2's counselor on 08/11/2025 at 12:20 PM and spoke with Person G in the scheduling department. Person G said there has not been a concern with canceled appointments for Resident 2 and s/he comes in every week as scheduled. Person G said the last cancellation was in June of 2025 and was initiated by their office.

Surveyor interviewed Guardian E on 08/11/2025 at 11:50 AM. Guardian E explained s/he had to cancel an appointment with the dermatologist on 08/08/2025 because Resident 2 needed to undergo a procedure and the medical provider wanted Guardian E present. Guardian E said s/he lives a long distance from the facility and s/he was not able to attend the appointment.

Surveyor interviewed Caregiver F on 08/11/2025 at approximately 9:45 AM. Caregiver F said things were going fine with Resident 2 and said s/he has "no issues" and there are "not really" any significant behaviors. Caregiver F said, "[S/he] corrects [him/herself] very easily...I don't have a real struggle with [him/her]." Caregiver F said Resident 2's moods can be "up and down" and worse when s/he feels "misunderstood." Caregiver F said s/he thinks sometimes caregivers could use a better approach but "I don't have a real struggle with [him/her]."

Surveyor interviewed Caregiver C on 08/11/2025 at approximately 2:20 PM. Caregiver C said, "I

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 08/12/2025

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 327	Continued From page 8	N 327		

haven't had any issues with [Resident 2] for a while." Caregiver C recalled an incident in mid-July and added, "Otherwise, [s/he] has been fine with me."

Neither caregiver described the need for one to one supervision during times when Resident 2 has behaviors.

Surveyor reviewed the written notice of discharge and the provider's program statement provided by Administrator A on 08/11/2025 at approximately 1:30 PM.

--The discharge notice dated 07/25/2025 read in part, "The reason for this 30 day notice from Bethel Assisted Living is as for [sic] these reasons: [Resident 2] was given notice Assisted Living. [sic] Resident cannot be maintained at the Level [sic] of care that [s/he] is at due to [his/her] progressing Dementia [sic], Mental [sic] health status."
--The program statement noted residents with irreversible dementia/Alzheimer's will "have their needs me emotionally, spiritually, socially and medically with a strong team of professionals" and provider staff will "work closely with these residents and their families...to ensure that their quality of life is maintained as much as possible. Will look at you as a whole person and work as a team to develop your plan of care."

Surveyor reviewed Resident 2's electronic facility records on 08/11/2025 at approximately 8:39 AM. Surveyor noted Resident 2's individual service plan (ISP) was most recently reviewed at a care team meeting on 07/14/2025. However, the "active cares" portion of the record which populates the ISP did not contain recent updates in areas related to behavior management. For

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 08/12/2025

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BETHEL MENASHA II	1650 CENTURY OAKS COURT MENASHA, WI 54952

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N 327	Continued From page 9 example, the category titled "Aggressive/Combative" was last updated 10/18/2023, "Behavioral epsodes" [sic] was last updated 02/26/2024 and "Attitude - Supevise/Intervene" [sic] was last updated 06/10/2024. During an interview with Administrator A on 08/11/2025 at approximately 9:10 AM, s/he confirmed Surveyor's review of the record. During a follow up interview with Administrator A at approximately 2:00 PM, Surveyor reviewed the concerns the involuntary discharge notice was issued for reasons that were not consistent with the code requirements. Administrator A did not dispute the concerns or offer additional information. Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0328 DHS 83.31(4)(c) Involuntary Discharge Notice Requirements N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 327		
N 328	83.31(4)(c) Involuntary discharge notice requirements. Discharge or transfer initiated by CBRF. Notice requirements. Every notice of involuntary discharge shall be in writing to the resident or resident ' s legal representative and shall include all of the following: 1. A statement setting forth the reason and justification for discharge listed under par. (b). 2. A statement that the resident or the resident ' s legal representative may ask the department to review the involuntary discharge by sending a written request within 10 days of	N 328		

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 08/12/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 328	Continued From page 10 receipt of the discharge statement to the department ' s regional office with a copy to the CBRF. The notice shall state that the request must provide an explanation why the discharge should not take place. 3. The name, address and telephone number of the department ' s regional office director. 4. The name, address and telephone number of the regional office of the board on aging and long term care ' s ombudsman program. For residents with developmental disability or mental illness, the notice shall include the name, address and telephone number of the protection and advocacy agency designated under s. 51.62(2)(a), Stats. This Rule is not met as evidenced by: Based on interview and record review, the provider initiated an involuntary discharge for Resident 2 for reasons inconsistent with the reasons permitted by the code. Administrator A authored an involuntary discharge notice dated 07/25/2025 for Resident 2 based on increased care needs. However, Resident 2's care needs were within the scope of the license classification. In addition, the provider did not ensure Resident 2 received the services outlined in the provider's program statement to meet his/her care needs prior to initiating discharge. Findings include: The Department received a complaint regarding compliance with involuntary discharge requirements. The provider is licensed to serve up to 8 residents from client groups to include: emotionally	N 328		

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 08/12/2025

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 328	Continued From page 11	N 328		

disturbed/mentally ill, traumatic brain injury, developmentally disabled and irreversible dementia/Alzheimer's.

Surveyor interviewed Administrator A on 08/11/2025 at 9:18 AM. Administrator A said s/he initiated an involuntary discharge for Resident 2 near the end of July 2025 because his/her "cares are more than we can do and [Guardian E] is non-compliant with appointments." Administrator A went on to explain, "[Guardian E] will make appointments and then cancel so then we take [him/her] to appointments then [Resident 2] gets upset...Just last week we took [Resident 2] to (a dermatology) appointment and [Guardian E] canceled 4 days prior and didn't tell anybody about it. The time before that in July same thing (with a counseling) appointment." Administrator A further explained sometimes Resident 2 has behaviors and s/he needs one to one assistance. Administrator A some behaviors occur because Guardian E gets Resident 2 "riled up" and Guardian E is a big part of the problem.

Surveyor called the office for Resident 2's counselor on 08/11/2025 at 12:20 PM and spoke with Person G in the scheduling department. Person G said there has not been a concern with canceled appointments for Resident 2 and s/he comes in every week as scheduled. Person G said the last cancellation was in June of 2025 and was initiated by their office.

Surveyor interviewed Guardian E on 08/11/2025 at 11:50 AM. Guardian E explained s/he had to cancel an appointment with the dermatologist on 08/08/2025 because Resident 2 needed to undergo a procedure and the medical provider wanted Guardian E present. Guardian E said s/he lives a long distance from the facility and s/he

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 08/12/2025

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 328	Continued From page 12	N 328		

was not able to attend the appointment.

Surveyor interviewed Caregiver F on 08/11/2025 at approximately 9:45 AM. Caregiver F said things were going fine with Resident 2 and said s/he has "no issues" and there are "not really" any significant behaviors. Caregiver F said, "[S/he] corrects [him/herself] very easily...I don't have a real struggle with [him/her]." Caregiver F said Resident 2's moods can be "up and down" and worse when s/he feels "misunderstood." Caregiver F said s/he thinks sometimes caregivers could use a better approach but "I don't have a real struggle with [him/her]."

Surveyor interviewed Caregiver C on 08/11/2025 at approximately 2:20 PM. Caregiver C said Resident 2 has some behaviors, but overall s/he does not struggle managing them.

Neither caregiver described the need for one to one supervision during times when Resident 2 has behaviors.

Surveyor reviewed the written notice of discharge and the provider's program statement provided by Administrator A on 08/11/2025 at approximately 1:30 PM.

--The discharge notice dated 07/25/2025 read in part, "The reason for this 30 day notice from Bethel Assisted Living is as for [sic] these reasons: [Resident 2] was given notice Assisted Living. [sic] Resident cannot be maintained at the Level [sic] of care that [s/he] is at due to [his/her] progressing Dementia [sic], Mental [sic] health status."
--The program statement noted residents with irreversible dementia/Alzheimer's will "have their needs me emotionally, spiritually, socially and

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 08/12/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 328	Continued From page 13	N 328		

medically with a strong team of professionals" and provider staff will "work closely with these residents and their families...to ensure that their quality of life is maintained as much as possible. Will look at you as a whole person and work as a team to develop your plan of care."

Surveyor reviewed Resident 2's electronic facility records on 08/11/2025 at approximately 8:39 AM. Surveyor noted Resident 2's individual service plan (ISP) was most recently reviewed at a care team meeting on 07/14/2025. However, the "active cares" portion of the record which populates the ISP did not contain recent updates in areas related to behavior management. For example, the category titled "Aggressive/Combative" was last updated 10/18/2023, "Behavioral epsodes" [sic] was last updated 02/26/2024 and "Attitude - Supevise/Intervene" [sic] was last updated 06/10/2024.

During an interview with Administrator A on 08/11/2025 at approximately 9:10 AM, s/he confirmed Surveyor's review of the record. During a follow up interview with Administrator A at approximately 2:00 PM, Surveyor reviewed the concerns the involuntary discharge notice was issued for reasons that were not consistent with the code requirements. Administrator A did not offer additional information.

Cross Reference:
N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations
N0328 DHS 83.31(4)(c) Involuntary Discharge Notice Requirements
N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes

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 08/12/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 389	Continued From page 14	N 389		
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 with the individual service plan. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not update Resident 2 or Resident 3's individual service plans (ISPs) based on assessment and with involvement of their legal representatives when their condition or needs changed. The provider did not ensure Resident 2's legal guardian was involved in his/her ISP meeting on 07/14/2025 and did not update Resident 2's ISP based on assessment to identify current interventions for behavior management. The provider did not ensure Resident 3's activated power of attorney for health care was involved in the development of his/her comprehensive ISP. In addition, the provider did not ensure Resident 3's ISP was updated based on assessment to identify interventions to	N 389		

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 08/12/2025

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BETHEL MENASHA II	1650 CENTURY OAKS COURT MENASHA, WI 54952

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N 389	Continued From page 15 manage his/her dementia related behaviors to include aggression towards staff and residents, incontinence and elopement risk. Findings include: The Department received a complaint alleging the provider was not involving legal representatives in ISP development. RESIDENT 2: On 08/11/2025 at 10:45 AM, Surveyor reviewed portions of Resident 2's facility records. Resident 2 was admitted on 10/17/2023. The most recent ISP was signed and dated 07/14/2025 and included signatures from Administrator A, MCO (managed care organization) Care Manager I, an MCO registered nurse (illegible signature) and Supported Employment Staff I. The section titled "Resident or Guardian" included Resident 2's signature with a note "Verbal Consent by [Guardian E]." Surveyor interviewed Administrator A at 1:52 PM. Administrator A said on 07/14/2025, Guardian E participated in the ISP meeting by phone for a "couple of minutes" and gave consent for Resident 2 to sign the ISP. Surveyor asked how long the ISP meeting lasted and Administrator E said, "Ten to fifteen minutes because Resident 2 had an episode (behavior.)" Surveyor interviewed Care Manager I on 08/11/2025 at 2:40 PM. Care Manager I said Guardian E did not participate in the ISP meeting either in person or by phone. Care Manager I recalled the meeting lasted about an hour, after the meeting Resident 2 gave Care Manager I a	N 389		

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 08/12/2025

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 389	Continued From page 16	N 389		

tour of his/her room and Resident 2 did not display any behaviors. Surveyor asked if Guardian E tried to call Resident 2 during the meeting and s/he replied, "I believe so but I wasn't looking at [Resident 2]'s phone." Care Manager I said Guardian E wanted to be involved in the meeting but there was miscommunication and ultimately Guardian E did not participate.

Surveyor interviewed Guardian E on 08/11/2025 at 11:50 AM. S/he said Care Manager I reminded him/her of the ISP the morning of 07/14/2025, but when s/he called Resident 2 during the meeting in an effort to join by phone, Administrator A instructed Resident 2 to hang up. Guardian E stated s/he did not give consent for Resident 2 to sign the ISP and s/he was frustrated s/he was excluded from the meeting, especially because s/he has been unhappy with the care Resident has been receiving.

Surveyor interviewed Resident 2 on 08/11/2025 at 3:54 PM. S/he also recalled the 07/14/2025 ISP meeting. Resident 2 said Guardian E called him/her twice during the meeting and Administrator A told Resident 2 to hang up. Resident 2 said, "I didn't like the way s/he treated [Guardian E]. It was disrespectful."

Surveyor interviewed Administrator A about Resident 2's needs on 08/11/2024 at 09:18 AM and 1:52 PM. Administrator A said Resident 2's mental condition has changed with a worsening of his/her dementia and increased behaviors.. Administrator A also expressed frustration with Guardian E. Administrator A said the behaviors and problems with the guardian have increased to the point Administrator A issued an involuntary discharge notice during the end of July 2025.

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 08/12/2025

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 389	Continued From page 17 Surveyor reviewed portions of Resident 2's ISP and associated "active cares" with Administrator A. Surveyor noted the active cares for behaviors had not been updated since June 2024, or longer. Administrator A confirmed Surveyors review of the record. Surveyor conducted an interview with Caregiver C and Caregiver F at 2:23 PM. Both caregivers said Resident 2 has some behaviors, but the behavior management interventions in the ISP are outdated and no longer being utilized. For example, Caregiver F said the ISP intervention for staff to check in each shift with Resident 2 to discuss his/her journal entries, is an intervention that has not been used for a long time. RESIDENT 3: OBSERVATIONS AND INTERVIEWS ON 08/11/2025: 8:05 AM: Surveyor entered the facility and was greeted by Caregiver L (the only staff in the building) and Resident 3. Surveyor observed Resident 3 was initially pleasant but confused. S/he attempted to engage in conversation with Surveyor but his/her speech pattern was disorganized and s/he used nonsensical strings of words. 8:40 AM - 8:55 AM: Resident 3 remained in the common area and became agitated. S/he spoke in an upset tone, used swear words, grabbed an item from Resident 4 (which upset Resident 4) and moved furniture around. Resident 3 was also actively exit seeking. Caregiver L was not able to effectively redirect him/her. Resident 3 raised his/her hands several times as if s/he were going to hit Caregiver L. Surveyor asked Caregiver L if	N 389		

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 08/12/2025

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 389	Continued From page 18 there were any interventions that work for Resident 3, and Caregiver L said "No." Surveyor asked if offering a snack or activity might be a good distraction and Caregiver L said, "No." At approximately 8:50 AM, Surveyor engaged in conversation with Resident 3 about the show on the TV and then complimented Resident 3 on his/her clothing choice and appearance. Resident 3 smiled, spoke in pleasant tone and the behavior ended. At 8:55 AM, Surveyor observed Resident 3 walk down the hall towards his/her room. As s/he walked away Surveyor observed Resident 3's brief appeared bulky through his/her pants. 9:45 AM - Surveyor interviewed Caregiver F (the only staff in the building). Caregiver F. S/he said, "[Resident 4] just beat the crap out of me putting [his/her] clothes on. I don't know how to handle that. I don't think we can support [him/her] here." S/he added, "Recently [s/he] has been incontinent more which makes [him/her] agitated. Earlier, [s/he] was wet when [s/he] was acting out with [Caregiver L]. [S/he] was agitated couldn't tell [Caregiver L] what [s/he] needed. To me, that seems when the fights happen. [S/he] knows [s/he] has a need and [s/he] can't express it." Caregiver F said sometimes doing a face time call with Resident 3's family can be a helpful intervention. Caregiver F said Resident 3 is an elopement risk and s/he "gets out all the time." Caregiver F said Resident 2 gets out the side doors which are alarmed and staff respond within "two seconds." However, Caregiver F said a few weeks ago Resident 3 eloped was found a long distance from the facility. Surveyor and Caregiver F reviewed Resident 3's observation notes and incident reports and did not find documentation of the incident. Caregiver F said s/he believes on the day of the elopement, one of the doors was not shut tight so it did not alarm.	N 389		

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 08/12/2025

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 389	Continued From page 19 10:00 - 11:40 AM: Resident 3 continued to wander, set off the door alarms and needed nearly constant supervision and redirection from Caregiver F. Surveyor left the facility at 11:40 AM. 12:00 PM: Surveyor returned to the facility. Caregiver F appeared flustered and immediately said, "Things have got worse, not better since you left." Caregiver F said s/he ruined a portion of the lunch s/he was trying to cook because Resident 3 "set off the door alarms so many times." 1:25 PM: Surveyor conducted an interview with Administrator A in the sister facility across the parking lot. Administrator A confirmed Resident 3 eloped from the facility on 07/31/2025. The only documentation of the incident was a self-report which Administrator A said s/he faxed to the Department. Surveyor noted a self-report was not received and asked for a fax confirmation. Administrator A said his/her fax machine doesn't provide that. Administrator A printed the self-report from his/her computer, then filled in the date/time portion of the form by handwriting 7/31/2025 at 6:15 AM. The report documented Resident 3 was restless all night, was last seen at 5:10 AM, discovered missing at 5:30 AM and the police were called "around 6:00 AM." A citizen found Resident 3 pacing outside a gas station on Oneida St., brought Resident 3 in the station, fed him/her and called police. NOTE: On 08/11/2025 at 3:42 PM, Surveyor obtained the police report. Staff called the police at 6:18 AM. While police were onsite, they learned a citizen located Resident 3 at a gas station on Oneida St. 2.5 miles away. 1:42 PM: During Surveyor's interview with Administrator A, Caregiver F called and was	N 389		

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 08/12/2025

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N 389	Continued From page 20	N 389		

talking in a loud, frantic tone. Surveyor heard Caregiver F tell Administrator A, "I cannot get [Resident 3] in the house. [S/he] just beat the [expletive] out of me! I'm very hurt, I'm very frustrated. [S/he] is in the parking lot. [S/he] is going to hurt [him/herself] or someone else... [S/he] is unsafe!" Administrator A asked, "Did you call [his/her] [family]?" Caregiver F responded, "How am I supposed to do that when [s/he] is running out the door!" Administrator A asked Caregiver F several questions about the interventions s/he had tried and Caregiver F continued to express frustration with his/her inability to manage the situation. Caregiver F then exclaimed, "[S/he] is about to walk in the road!" Surveyor interjected and told Administrator A it sounded like Caregiver F needed his/her help.

1:44 PM: Surveyor and Administrator A went outside. Surveyor observed Resident 3 had exited the parking lot and walked approximately 100 feet down the road to the intersecting road, which was under construction. Resident 3 was in the immediate area of a trench in the grass that had been dug from the road, to and around a fire hydrant. The trench was approximately 3 feet wide by 4 feet long. The trench was approximately 1 foot deep in some areas, filled with gravel in some areas and presented a fall hazard. Caregiver F and a staff member from another building were standing by Resident 3. Caregiver F told Surveyor s/he had to leave the other 6 residents unattended for approximately 7 minutes while s/he had been outside with Resident 3.

Administrator A was able to convince Resident 3 to join Surveyor and Administrator A in the sister building for a snack and drink. Resident 3 then

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 08/12/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 389	Continued From page 21	N 389		

sat calmly with Administrator A and Surveyor and enjoyed his/her snack and drink for approximately 10 minutes.

4:05 PM: Surveyor interviewed Resident 2. S/he complained about Resident 3 being aggressive. Resident 2 said, "I know it's not [his/her] fault, [s/he] can't help it. But still, I don't want to be [his/her] punching bag."

RECORD REVIEW ON 08/11/2025 AT APPROXIMATELY 11:00 AM:

Surveyor reviewed Resident 3's record on 08/11/2025 at approximately 11:00 AM. Resident 3 was admitted on 04/05/2025, had an activated power of attorney for health care and diagnoses to include early onset Alzheimer's disease. The record contained 2 assessments dated 04/05/2025 and 04/07/2025. Resident 1's ISP was not signed or dated. The ISP read in part, "To receive full supervision and redirection from staff to avoid and prevent wandering episodes...will pace and walk around....has not eloped but keep [him/her] on 30 min (checks) just in case." The ISP was silent to exit seeking, history of elopement, incontinence, agitation or aggression and did not identify interventions to meet Resident 3's needs in those areas.

Observation notes dating back to 08/01/2025 documented 7 incidents of physical aggression towards staff, 1 incident of hitting a resident and at least 7 entries about active exit seeking.

On 08/04/2025, Caregiver C documented Resident 3 tried to take another resident's belongings and then "became very mad...kicking, throwing things, swearing..." Caregiver C sent all the other residents to their rooms until s/he could

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 08/12/2025

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 389	Continued From page 22 "get [Resident 3] under control" and wrote, "I cannot spend one on one with [him/her] with 7 other residents in the (building.)" During the aforementioned interview with Administrator A, s/he confirmed the ISP was the comprehensive ISP completed 2 days after admission in April and did not include involvement of Resident 3's family. S/he said it was the most current one on file, was based on the preadmission assessment and had not been updated based on reassessment since 04/07/2025. Surveyor expressed concerns based on the observations and interviews throughout the day, that staff were ill equipped to manage Resident 3's dementia related behaviors and s/he presented a high risk for elopement. Administrator A acknowledged Surveyor's concerns and agreed the ISP needed to be updated. Cross Reference: N0164 DHS 83.12(4)(b) Reporting when Law Enforcement is Called N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0327 DHS 83.31(4)(b) Allowable Reasons For Involuntary Discharge N0408 DHS 83.37(1)(i) PRN Psychotropic Medication	N 389		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the	N 408		

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 08/12/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 408	Continued From page 23 behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. 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) included the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN Haldol. This is a repeat deficiency. See Statement of Deficiency #S8KF11, dated 04/16/2024. Findings include: On 08/11/2025 at 9:45 AM, Surveyor reviewed portions of Resident 2's record. The current ISP was signed and dated 07/14/2025. The ISP section titled "AGGRESSIVE/COMBATIVE" read, "To receive complete assistance and aiding in alleviating aggressive/combative situations...will get verbally aggressive at times when [s/he] isn't being heard or someone isn't listening to [him/her]...Resident	N 408		

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 08/12/2025

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 408	Continued From page 24	N 408		

has PRN Haldol for extreme anxiety. [S/he] has not used it."

The July 2025 medication administration record (MAR) listed prescribed haloperidol (generic Haldol), 1 MG tablet to be taken as needed once daily for "AGITATION/MOOD." The medication was administered on 07/03 at 10:26 PM, 07/17 at 7:31 PM, 07/19 at 8:09 PM and 07/24 at 8:44 PM. The MAR did not include information to indicate if the medication was effective.

Observation notes during July 2025 documented the following:

--07/03 at 9:30 PM - Resident 2 was upset about cleaning his/her room had having diarrhea. Caregiver C wrote, "This all came out of no where." [sic] and "Had to give a PRN...to get [him/her] to calm down."

--07/17 at 7:15 PM - Resident 2 was "aggressive towards staff and defiant [s/he]'s refusing meds, food and just seems mad at the world" Resident 2 also called police to report concerns about staff and management and did not want to come inside the facility. Caregiver C wrote, "PRN was issued per management. This will keep [him/her] calm...hopefully we do not see the Police [sic] again tonight."

--07/19 at 8:30 PM - Resident 2 said s/he was mad because another resident was wearing his/her clothes. Caregiver C wrote s/he did not recognize the clothes as belonging to Resident 2 and added, "[S/he] got mad, and started yelling. I sent [him/her] to[his/her] room...[S/he] took [his/her] meds and a PRN to calm [him/her] down."

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 08/12/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 408	Continued From page 25 --07/24 at 8:30 PM - Resident 2 was upset because s/he hadn't had a bowel movement since 07/21. Caregiver C noted Resident 2 didn't mention this over the past several days. Caregiver C wrote, "Informed management, and a PRN was given." Surveyor interviewed Administrator A on 08/11/2025 at 1:25 PM. S/he confirmed the ISP dated 07/14/2025 was the most current ISP. Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0327 DHS 83.31(4)(b) Allowable Reasons For Involuntary Discharge N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 408		
Y3234	50.09(1)(e) Treatment (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact.	Y3234		

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 08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Y3234	Continued From page 26	Y3234		

This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure Resident 4 was treated with courtesy, respect and full recognition of the resident's dignity and individuality.

On 08/10/2025, Resident 4 was made to sit in at the kitchen table for approximately 1 hour and on 08/11/2025 Administrator A spoke disrespectfully to Resident 4 about the incident.

Findings include:

Surveyor interviewed Resident 4 on 08/11/2025 at 8:26 AM. Resident 4 volunteered the previous night Administrator A "yelled" at him/her because s/he got mad and was pounding on the wall. S/he said, "I have [sic] to sit at the kitchen table. I didn't follow the rules." Resident 4 could not articulate which rule s/he didn't follow but explained why s/he had been upset. Resident 4 said his/her parent died and sometimes when s/he thinks about it, s/he feels mad. Resident 4 reiterated s/he was made to sit at the dining room table for 1 hour, until 10:00 PM, and then s/he had to go to bed. Surveyor asked how s/he felt about that and Resident 4 replied, "Terrible."

Surveyor interviewed Caregiver E on 08/11/2025 at 9:45 AM and s/he confirmed sometimes staff will place Resident 4 at the kitchen table for 1 hour when s/he has behaviors.

Surveyor reviewed Resident 4's record at 8:37 AM. Resident 4 was admitted on 01/07/2022 and had a legal guardian. The face sheet and current

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 08/12/2025

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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Y3234	Continued From page 27	Y3234		

individual service plan (ISP) were silent to his/her diagnoses. (Surveyor noted during the aforementioned interview Resident 4 appeared to have a developmental disability.) The ISP noted s/he needed assistance with redirection during behaviors. The ISP did not identify needs related to feeling upset about the loss of his/her parent or support the provider would offer during those times. The ISP did not identify an intervention of having him/her sit at the kitchen table in response to any behaviors.

An observation note dated 08/10/2025 at 10:15 AM read, "...began pounding the walls and throwing stuff around in [his/her] room. [Administrator A] was notified [Resident 4] was put on time out and sat in [sic] dining room table till [sic] about 9;45 pm [sic] and was told to go to bed and [s/he]'s to leave [his/her] room door open."

On 08/11/2025 at 9:00 AM, Resident 4 was in the common area with 3 other residents and Surveyor. Surveyor observed Administrator A enter the building and say to Resident 4, "Are you behaving now? Did you apologize for misbehaving last night?"

Surveyor interviewed Administrator A on 08/11/2025 at 10:23 AM, and asked about the comments s/he made earlier to Resident 4. Administrator A said, "[S/he] had a rough night. [S/he] had one of [his/her] little episodes. [S/he] stomps [his/her] feet and pounds on the wall. It usually lasts for a few minutes. They called me on phone. (S/he) wanted to talk to me. [S/he] sat in living room settled down and went back to bed." Surveyor asked what Resident 4 was upset about and Administrator A first said, "[S/he] couldn't tell me" then added, "Nobody could figure it out.

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Y3234	Continued From page 28 Once in a while [s/he] has these episodes when [s/he] starts remembering [his/her] [parent]." Administrator A said if staff talk with Resident 4, s/he will "settle down and [s/he] is fine." Surveyor read the 08/10/2025 observation note to Administrator A which referred to a "time out" directed by Administrator A. Administrator A nodded his/her head in agreement and said, "[Resident 4] calls them time outs." During a follow up interview at 1:52 PM with Administrator A, Surveyor identified concerns about disrespectful and undignified treatment based on Administrator A's comments to Resident 4 about misbehaving/apologizing and hour long time outs in at the table. Administrator A did not offer additional information. N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	Y3234		