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 02/03/2026

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 000}	Initial Comments On 01/26/2026, Surveyors conducted an onsite visit to investigate 3 complaints and to complete a verification visit for 7 deficiencies identified during the previous survey. Additional information was collected through 02/03/2026. Three (3) of 3 complaints were substantiated. Two (2) of 7 previous deficiencies were uncorrected. A total of 20 new deficiencies were identified. Census: 7 Under statutory provisions of WI Stat. Ch. 50 a $200 revisit fee is being assessed.	{N 000}		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.	N 158		

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
	0017959	A. BUILDING: _____ B. WING _____	R-C 02/03/2026

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 158	Continued From page 1	N 158		

This Rule is not met as evidenced by:
Based on interview and record review, Administrator A did not conduct or document an investigation after receiving an allegation of neglect.

On 12/31/2025, Caregiver O made an allegation to Administrator A that Driver P neglected Resident 2 by leaving him/her alone in the company van during cold weather. Administrator A did not conduct an investigation into the allegations.

Findings include:

The Department received a complaint alleging a resident was left unsupervised in the company van during cold weather for an extended period of time.

On 01/12/2026, Administrator A submitted a self-report to the Bureau of Assisted Living's regional office to report that Resident 2 was seen at the emergency room after ingesting hand sanitizer. Administrator A further described the 12/31/2025 incident as follows:

Driver P picked Resident 2 up from work and Resident 2 was "acting different." During the ride home Resident 2 was on the phone with Guardian E and upon arrival home Resident 2 "refused to get out of the van." The report went on to explain, at 4:30 PM, around the time Resident 2 was expected home from work, a caregiver observed the van arrive in the parking lot. However, Resident 2 did not exit the van and after 10 minutes the van drove away. At 5:30 PM, Guardian E called the facility to request increased

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 02/03/2026

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 158	Continued From page 2	N 158		

monitoring of Resident 2 because s/he was not sounding like him/herself on the phone. At that time, the caregiver realized Resident 2 did not return home from work as expected. Guardian E informed the caregiver Resident 2 may still be in the van. The caregiver searched and found Resident 2 in the van where s/he appeared to be intoxicated. Resident 2 had difficulty with balance and walking and it took 2 staff to walk him/her inside the facility. Later in the evening, Caregiver O learned Resident 2 was experiencing a change in condition due to consuming hand sanitizer while at work and s/he was sent to the emergency room and treated for alcohol poisoning.

Administrator A's report did not include evidence of an investigation into the circumstances of Resident 2 being left in the van and the report was not submitted to the Office of Caregiver Quality.

On 01/28/2026 at 7:30 AM, Surveyor interviewed Caregiver O who said s/he was the caregiver working on 12/31/2025. Caregiver O recalled after observing the van sit outside from approximately 4:30 PM until 4:40 PM, s/he watched Driver P pull away, park the van across the street in the building 3 parking lot and then leave in his/her own vehicle. Around 5:30 PM, Guardian E called to ask Caregiver O to keep a close eye on Resident 2 and that is when Caregiver O realized Resident 2 never returned from his/her supported work placement. After Guardian E's call, s/he searched for Resident 2 and called Administrator A who said s/he would reach out to Driver P. Subsequently, both Administrator A and Guardian E told Caregiver O to look in the van. When Caregiver O found Resident 2 s/he said s/he was "freezing" 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 02/03/2026

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 158	Continued From page 3	N 158		

appeared intoxicated. Caregiver O said Resident 2 had poor balance and needed the assistance of 2 caregivers to walk back to the facility. Caregiver O said after the incident, Administrator A did not interview him/her or conduct any other follow up about the incident.

Caregiver O stated s/he was very concerned that Driver P left Resident 2 in the van unsupervised and messaged Administrator A. Caregiver O shared a copy of the messages dated 12/31/2025 which read:
--Caregiver O, "...why would [Driver P] leave [him/her] in the van [sic] at least ask for help. Or something. That doesn't just sit well with me... [S/he] was freezing."
--Administrator A replied, "[S/he] refused to get out of the van. [Driver P] tried but [s/he] refused so [Driver P] just left the door open and said when your [sic] ready...[Resident 2] shut down and [Driver P] refused to fight with [him/her]."
--Caregiver O, "[Driver P] could have got help like I did. That's neglect...that's crazy."
--Administrator A replied, "Oh I agree I yelled at [Driver P] about that"

SURVEYOR NOTE: On 12/31/2025 between 4:45 PM and 5:45 PM, the temperature was 18°F and winds were 13 mph with gusts up to 20 mph. Source: https://www.wunderground.com/history/daily/us/wi/appleton/KATW/date/2025-12-31, retrieval date 02/02/2026.

On 02/02/2026 at 10:00 AM, Surveyors conducted an interview with Administrator A. Administrator A said s/he had responsibility to conduct misconduct investigations and provided Surveyors with a copy of the policy. Surveyor asked if s/he conducted any abuse or neglect

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 02/03/2026

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 158	Continued From page 4	N 158		

investigations since November 2025 and Administrator A said s/he had not. Surveyor reviewed the incident involving Resident 2 on 12/31/2025 and the message sent alleging neglect. Administrator A did not offer additional information.

On 02/02/2026 at 1:00 PM, Surveyor reviewed the provider's policy titled "Caregiver Misconduct Reporting Requirements." The policy indicated the requirement for immediate steps to protect clients from possible subsequent incidents of misconduct. It detailed the need to conduct a thorough internal investigation "of all allegations or incidents" to include alleged victim and witness interviews and collecting evidence and for all investigative steps and findings to be documented. An associated policy titled "Abuse, Neglect, and Misappropriating" read, "Neglect - Definition: A careless or negligent act that fails to follow procedure or care plan AND causes or could cause pain, injury, or death..."

Surveyor reviewed Resident 2's face sheet and individual service plan (ISP) on 01/26/2026 at 11:00 AM. Resident 2 had diagnoses to include anxiety disorder, bipolar disorder and frontal lobe and executive function deficit. The ISP identified Resident 2 as being at risk for self-harm and elopement and requiring "constant supervision and assistance."

Cross Reference:
N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws
N0214 DHS 83.15(3)(b) Administrator Shall Supervise Daily Operation
N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes
N0435 DHS 83.38(1)(k) Transportation

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 02/03/2026

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 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review and interview, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF. --Licensee C did not ensure all deficiencies from the previous survey were corrected or that special orders were complied with. --Licensee C did not ensure the water heater was promptly repaired resulting in residents going without hot water for 10 days. --A total of 20 deficient practices were identified as a result of the current survey and 7 of 20 deficiencies were repeat deficiencies. Findings include: Prior to conducting the onsite visit on 01/26/2026, Surveyor reviewed the facility's compliance history. On 09/03/2025, the provider was issued Statement of Deficiency (SOD) #R1F013 for the previous survey ending on 08/12/2025. The SOD identified 7 deficiencies and included a Notice and Order letter which read in part, --"Pursuant to Wis. Stat. § 50.03(5g)(b)3., effective immediately, the licensee shall comply with the requirements specified by Wis. Stat. ch. 50 and Wis. Admin. Code ch. DHS 83 that establish the standards for the operation of the Community Based Residential Facility in order to	N 196		

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 02/03/2026

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 196	Continued From page 6 protect and promote the health, safety and welfare of the residents. AS SOON AS PRACTICABLE AND WITHOUT DELAY, within 45 days of receipt of this notice, the licensee shall achieve and maintain substantial compliance with all requirements." --SPECIAL ORDER: "Pursuant to Wis. Stat. § 50.03(5g)(b)6., WITHIN 7 DAYS of receipt of this notice, the licensee shall provide the legal representative and case manager (if any) for each resident with a copy of Statement of Deficiency R1F013 and a copy of this Notice and Order letter. The licensee shall retain documentation, acceptable to the department, to verify compliance. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from each legal representative and case manager. Required evidence will be made available to the department representatives upon request." --SPECIAL ORDER: "WITHIN 45 DAYS, the licensee will obtain resident rights training for all current resident care staff..." --"According to Wis. Admin. Code DHS §§ 83.13(3)(a) and 83.14(2)(h), each facility shall immediately upon receipt post next to its CBRF license, and in a public area that is visually and physically available, any citation/statement of deficiency, notice of revocation, notice of non-renewal, and any other notice of enforcement action. Citations and statements of deficiency shall remain posted for ninety (90) days following receipt. Notices of revocation, non-renewal, and other notices of enforcement action shall remain posted until a final determination is made. Therefore, the license shall immediately post this Notice and Order letter and it shall remain posted	N 196		

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 02/03/2026

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 196	Continued From page 7 until a final determination is made." On 01/26/2026, Surveyors conducted a verification visit to confirm correction of the previous deficiencies and compliance with the orders. Additional information was collected through 02/03/2026. NOTIFICATION TO CARE MANAGERS AND LEGAL REPRESENTATIVES: On 01/26/2026 at 8:42 AM, Surveyor interviewed Administrator A and requested documentation to verify residents' legal representative and case managers were given a copy of SOD #R1F013 and the Notice and Order letter. Administrator A initially indicated s/he did not proactively notify the care managers via written copy of the SOD and said, "we did respond back to their questions." Surveyor explained the Department's process of a general monthly notification to managed care organizations (MCOs) of SODs issued; however that does not absolve the requirement in the enforcement letter for the provider to proactively provide the SOD/letter within 7 days. Administrator A replied, "I don't believe that. I did talk to them and asked them if they wanted a copy, they said no. I discussed it with them the day after it was issued...I figured it was easier to talk to them in person." Licensee C was not present during either of the onsite visits conducted by Surveyors on 01/26/2026 and 02/02/2026. During a previous interview on 01/13/2026 at 9:04 AM regarding identical orders in sister facilities, Licensee C stated they had the impression the Department sent the SODs, and if Administrator A did not proactively send the information that would be why.	N 196		

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 02/03/2026

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 196	Continued From page 8 On 01/28/2026 at 3:04 PM, Surveyor interviewed Resident 3's legal representative (power of attorney - POA Q). S/he said Administrator A did not provide information about a SOD issued in September, either verbally or in writing. POA Q went on to describe concerns with an elopement and service planning. Surveyor noted both were examples specific to Resident 3 in SOD #R1F013 and POA Q was unaware. On 01/29/2026 at 9:30 AM, Surveyor interviewed MCO Quality Manager (QM) V. QM V said they first were informed of SOD #R1F013 on 10/13/2025 via the Department's monthly report. QM V said Administrator A did not provide information about the SOD verbally or in writing and their agency never declined to receive a copy of the SOD. Based on an interview with Administrator A on 02/02/2026 at 10:00 AM: --7 of 7 residents had legal representatives --7 of 7 residents had care managers POSTING: On 01/26/2026 at 8:00 AM, Surveyor walked through the facility and did not observe SOD #R1F013 posted. During an interview with Administrator A at 8:42 AM, s/he said, "It was by the front door...residents do take things down." Administrator A then described a plan to keep SODs in a folder in the common area moving forward. Surveyors were in the facility from 8:00 AM until 6:20 PM on 01/26/2026 and did not observe any residents taking down or lingering near any of the other postings that were in the facility. RESIDENT RIGHTS TRAINING:	N 196		

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 02/03/2026

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 196	Continued From page 9 On 01/26/2026 at approximately 10:40 AM, Administrator A provided Surveyors with a current staff roster. Administrator A also provided a training sign in sheet dated 10/14/2025 as evidence of compliance with the order for resident rights training. Surveyor compared the roster with the sign in sheet and noted at least 3 caregivers hired before 10/14/2025, did not attend the training. On 02/02/2026 at 10:00 AM, Surveyors conducted an interview with Administrator A about the findings that not all staff received the required training. Administrator A did not provide additional information. WATER HEATER: The Department received a complaint alleging the residents did not have access to hot water for days because the provider did not promptly repair the water heater. On 01/28/2026 at 7:30 AM, Surveyor interviewd Caregiver O. S/he said, "I called [Administrator A] a few times, residents complained and I can't do dishes. That was first day. The second day I got yelled at by [Licensee C] because dirty dishes were left." Caregiver O said s/he told Licensee C s/he would door dash paper plates, but Licensee C "got defensive and angry and said, 'wash the [expletive] dishes.' We were washing dishes in cold water and residents went to shower in other buildings after a few days. I repeated to [Administrator A] this was an issue..." On 01/26/2026 at 9:04 AM, Surveyor interviewed Resident 4 and asked if there had been problems with the hot water. S/he replied, "With my shower? Yeah...I went to the other buildings."	N 196		

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 02/03/2026

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 196	Continued From page 10 Surveyor asked how long the facility was without hot water and Resident 4 said s/he didn't know. On 01/26/2026 at 4:23 PM, Surveyor interviewed Resident 2. Resident 2 said in December they went for days without hot water and s/he had to take a "spit bath in the sink." S/he explained this as warming up a big cup of hot water in the microwave and taking it to the bathroom to wash up. Resident 2 said at some point s/he was offered to take a bath in one of the sister facilities on the same campus but shortly thereafter the water heater was fixed. Resident 2 said even if it had gone on longer s/he would have declined bathing in another facility. S/he explained, "I would feel uncomfortable and awkward" and that s/he was worried about how the residents in those buildings would react to having all the building 2 residents there to bathe or shower. On 01/28/2026 at 1:30 PM, Surveyor sent an email to Administrator A and requested details about lack of hot water during December. The requests and Administrator A's reply are as follows: -"When was the concern first identified?" Administrator A reply, "12/11/25, 12/18/25 [Licensee C] fixed it" -"How and when was the situation resolved." Administrator A reply, "Same day" -"What plans were implemented to ensure dishes were sanitized and residents had hot water for bathing?" Administrator A reply, "If needed they were taken to another bld [sic]" -"Dates of repairs and/or replacement including receipts (for parts if serviced by the facility or from the plumber if serviced by a company.)" Administrator A reply, "Same day by [Licensee C]" -"Any other information you would like to provide about this." Administrator A reply, "Not a [sic] this	N 196		

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 02/03/2026

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 196	Continued From page 11 time" On 01/28/2026 at 6:04 PM, Surveyor sent an email to Licensee C, "...One of the complaint topics we are investigating is regarding a time period in December when the facility was out of hot water. I've learned you took the lead on addressing that so I thought it would be best to ask you directly. Please provide the following information..." Surveyor sent the same request for details that had been emailed to Administrator A. Licensee C did not respond to the email. Surveyor reviewed case notes from the MCO which detailed their communication with Administrator A about the lack of hot water. Surveyor also interviewed Caregiver O on 01/28/2026 at 7:30 AM and reviewed copies of text messages sent by Caregiver O. Surveyor determined the following timeline: 12/08 - first indication there was no hot water as evidenced by Caregiver O's interview and text to Administrator A. Administrator A replied to the text that s/he would let Licensee C know. 12/11 - Administrator A responded to an MCO inquiry and reported they had been without hot water for 2-3 days and were waiting for water heater parts to arrive. 12/15 - Administrator A responded to an MCO inquiry and indicated "water heater was resolved on 12/11 but went out again today so they ordered a replacement heater. The MCO requested an estimated date of the replacement "which was not provided..." 12/18 - MCO requested an update from Administrator A. No response was noted. 12/31 - MCO requested an update from Administrator A. [Administrator A] indicated, "It was fixed the next day"	N 196		

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 02/03/2026

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 196	Continued From page 12 On 01/29/2026 at 6:39 AM, Surveyors sent an email to Administrator A and Licensee C requesting an in person meeting for an exit conference on 02/02/2026. The email read in part, "[Licensee C], if you are able to join the exit conference we think that would be beneficial. Please let us know if you will be able to attend either in person or by phone." Licensee C did not respond to the email. On 02/02/2026 at 10:00 AM, Surveyors interviewed Administrator A. Administrator A confirmed the Department has the correct email for Licensee C, however Licensee C was not available because s/he was out of town. Administrator A said Licensee C would not be joining by phone either. During the interview, Administrator A said all s/he knew was that the water heater stopped working and subsequently it was repaired (not replaced.) S/he did not provide additional details about the length of time it took for repair or any barriers they may have faced accomplishing the repair. Surveyor reviewed concerns residents did not have access to hot water for at least 10 days (12/08/2025 - 12/18/2025), at a minimum impacting resident's ability to bathe at the facility. Surveyor also noted despite 2 written requests, there was no evidence the provider promptly addressed the concern. Surveyor informed Administrator A documentation of their efforts to promptly repair the water heater could be submitted through the end of the day. Additional documentation was not provided. ONGOING COMPLIANCE CONCERNS: As a result of the verification visit beginning on 01/26/2026, Surveyors determined 2 of 7 of the	N 196		

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 02/03/2026

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 196	Continued From page 13 previous deficiencies were uncorrected: --DHS 83.15(3)(b) Administrator Shall Supervise Daily Operation --DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes In addition, 18 new deficiencies were identified. As a result of the survey, a total of 20 new deficiencies (including this one) were identified. Seven (7) of 20 deficiencies were repeat deficiencies. This is the fourth consecutive survey with deficiencies. Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0214 DHS 83.15(3)(b) Administrator Shall Supervise Daily Operation N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule N0409 DHS 83.37(1)(j) Proof-Of-Use Record N0415 DHS 83.37(2)(c)Documentation Of Medication Administration N0427 DHS 83.38(1)(c) Leisure Time Activities N0431 DHS 83.38(1)(g) Health Monitoring N0432 DHS 83.38 (1)(h) Medication Administration N0435 DHS 83.38(1)(k) Transportation N0448 DHS 83.41(2)(a) Nutrition: Diet N0450 DHS 83.41(2)(c) Nutrition: Menus	N 196		

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 02/03/2026

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 196	Continued From page 14 N0452 DHS 83.41(3)(b) Food Safety N0481 DHS 83.43(1) Environment Safe, Clean, And Comfortable N0492 DHS 83.45(1)(a) Exterior Areas N0499 DHS 83.45(3) Toxic Substances N0617 DHS 83.55(6)(b) Bath And Toilet Areas: Water Temperature Y3244 Ch 50.09(1)(L) Care	N 196		
{N 214}	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily 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, record review and interview 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. This is a repeat deficiency. See Statement of Deficiency R1F013, dated 08/12/2025. Findings include:	{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 02/03/2026

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 214}	Continued From page 15 The Department received complaints alleging concerns with administrator oversight. During onsite visits 01/26/2026 and 02/02/2026, and with information collected through 02/03/2026, Surveyors investigated 3 complaints and completed a verification visit to review for correction of the 7 previously identified deficiencies. Surveyors made observations and conducted interviews with residents, facility staff, managed care organization (MCO) representatives and legal representatives. Surveyors reviewed facility records, MCO records, law enforcement records and hospital records. Based on the evidence collected, 3 of 3 complaints were substantiated and 2 of 7 previous deficiencies were uncorrected from the previous survey. A total of 20 new deficiencies were identified and 7 of 20 were repeat deficiencies. In summary: --Administrator A did not ensure residents' rights to receive medication were protected. In addition, s/he did not ensure medication administration was accurately documented or provided in a manner appropriate to meet the needs of the residents. This impacted Residents 2, 3, 4 and 5. --Administrator A did not ensure Resident 2 and 3's individual services plans were updated to identify residents' needs and associated interventions. --Administrator A did not ensure menus were available and accurate, that food was stored and served safely, the food supply was adequate to meet residents' dietary needs or that meals were palatable. --Administrator A did not ensure health monitoring	{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 02/03/2026

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 214}	Continued From page 16 for Resident 2, 4 and 5. Resident 6 did not receive adequate care after a significant change in condition; s/he was subsequently hospitalized and passed away. --Administrator A did not consistently arrange or coordinate transportation for Resident 2 resulting in missed work and medical appointments. --Administrator A did not ensure the environment was safe, comfortable and well maintained. Furniture was in poor repair, water temperatures exceeded 115°F, toxic chemicals were not secured and snow removal was not completed resulting in hazardous conditions. --Administrator A did not ensure activities were provided, accurate staffing records were maintained or that an investigation was conducted after receiving an allegation of neglect. During an interview with Administrator A on 02/02/2026 at 10:00 AM, Surveyors reviewed the deficient practices identified above. Administrator A acknowledged s/he has responsibility for oversight of day to day operations at this facility and 8 others also licensed by Licensee C. Administrator A did not dispute the findings and did not offer additional insight or information. Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule N0409 DHS 83.37(1)(j) Proof-Of-Use Record N0415 DHS 83.37(2)(c)Documentation Of	{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 02/03/2026

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 214}	Continued From page 17 Medication Administration N0427 DHS 83.38(1)(c) Leisure Time Activities N0431 DHS 83.38(1)(g) Health Monitoring N0432 DHS 83.38 (1)(h) Medication Administration N0435 DHS 83.38(1)(k) Transportation N0448 DHS 83.41(2)(a) Nutrition: Diet N0450 DHS 83.41(2)(c) Nutrition: Menus N0452 DHS 83.41(3)(b) Food Safety N0481 DHS 83.43(1) Environment Safe, Clean, And Comfortable N0492 DHS 83.45(1)(a) Exterior Areas N0499 DHS 83.45(3) Toxic Substances N0617 DHS 83.55(6)(b) Bath And Toilet Areas: Water Temperature Y3244 Ch 50.09(1)(L) Care	{N 214}		
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 observation, record review and interview, the provider did not allow each resident to receive all prescribed medications in the dosage and at the intervals prescribed by a practitioner for 4 of 4 residents reviewed. Resident 2 did not receive her/his Anoro Ellipta inhaler (medication to treat COPD-chronic obstructive pulmonary disease) for six (6) consecutive days from 01/01/2026 through	N 352		

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 02/03/2026

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 352	Continued From page 18 01/06/2026. Additionally, Resident 2 did not receive her/his docusate sodium tablet (a stool softener) as ordered twenty-two times in January 2026, because the medication was either not available or documented as not given. Resident 3 did not receive his/her prescribed atorvastatin tablet (a medication used to treat high cholesterol) during the 8 PM medication pass on 01/11/2026 as the medication remained in the blister pack card, even though the medication pass was charted as given. In addition, Resident 3 did not receive her/his prescribed valproic acid (medication used to treat seizure disorders) as ordered twenty-two times in December 2025, because the medication was either not available or documented as not given. Resident 4 did not receive her/his prescribed Lisdexamfetamine tablet (medication used to treat ADHD-attention deficit hyperactivity disorder) for ten (10) consecutive days from 01/12/2026 through 01/21/2026. Resident 5 did not receive his/her prescribed Jardiance tablet (medication used to reduce the risk of cardiovascular problems) on 01/01/2026 because the medication was "On Order." Additionally, Resident 5 did not receive his/her Metoprolol (medication used to treat angina (chest pain) and hypertension) on 12/04/2025 because the medication was "Not in." This is a repeat deficiency and is being cited for the third time. See Statement of Deficiency (SOD) R1F011, dated 10/28/2024 and SOD R1F012 dated, 04/28/2025. Findings include:	N 352		

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 02/03/2026

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 352	Continued From page 19 On 10/31/2025 and 12/10/2025, the Department received concerns regarding medication administration. On 01/26/2026 at 8:30 AM, Surveyor and Caregiver M observed the facility had one medication cart. Resident 2 On 01/26/2026, Surveyor reviewed Resident 2's record which indicated, the resident was admitted to the facility on 10/17/2023 with diagnosis to include COPD and history of constipation. Additionally, the facility managed and administered all of Resident 2's medication. Resident 2 had physician's orders for, "Anoro Ellipta 62.5-25 mcg inhaler take one puff by mouth once daily and docusate sodium 100 mg capsule by mouth twice daily." Resident 2's current MCP (Member Center Plan) dated 01/13/2026 indicated, "Respiratory: I am a current smoker and I have COPD. I use inhalers and I follow up with Fox Valley Pulmonary group regularly. I am not ready to quit smoking. I have a chronic smoker's cough and have medication to help with this. I recently had pneumonia and was prescribed antibiotics. This is resolved..." On 01/26/2026, Surveyor reviewed Resident 2's January 2026 eMAR (electronic Medication Administration Record) which revealed Resident 2 did not receive his/her Anoro Ellipta inhaler from 01/01/2026 through 01/06/2026, for six (6) consecutive days because the medication was "Not in/Not here or No Pass." Additionally, Resident 2's January 2026 eMAR revealed Resident 2 did not receive her/his docusate sodium 100 mg capsule twenty-two times from	N 352		

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 02/03/2026

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 352	Continued From page 20 01/01/2026 through 01/22/2026, because the medication was "On order, not in, out or no pass." On 01/26/2026 at approximately 10 AM, Surveyor observed the medication cart with Caregiver M. Surveyor observed Resident 2's morning and bedtime docusate sodium blister pack cards were dispensed by the pharmacy on 01/23/2026. Caregiver M stated, "[Resident 2] has been out of the docusate sodium for a while, we just got both cards in." Caregiver M went on to say, "On 01/06/2026, I clicked the re-order button in the computer for [Resident 2's] inhaler and docusate sodium, but it would say "waiting to be submitted" meaning [Administrator A] had to approve the reorder and submit for the medications. The same day (01/06/2026) I texted [Administrator A] to let [her/him] know [Resident 2] was out of [her/his] docusate sodium and Anoro Ellipta inhaler and the re-order button was clicked... Staff should be letting [Administrator A] know if the re-order hasn't been submitted by [Administrator A]...I've also noticed some staff just don't re-order medications." On 01/28/2026 at 12:40 PM, Surveyor interviewed Caregiver N regarding Resident 2's Anoro Ellipta inhaler. Caregiver N stated, "[Resident 2's] Anoro Ellipta inhaler was out the beginning of January 2026...I couldn't find the inhaler anywhere in the cart to administer. [Resident 2] has COPD and wanted [her/his] Anoro Ellipta inhaler." Surveyor then asked about Resident 2's docusate sodium capsule. Caregiver N stated, "[Resident 2] didn't receive [her/his] docusate sodium medication from me in January 2026 because the medication wasn't in the cart to give [her/him]. I would click on the re-order button in the computer several times, but [Administrator A] has to approve any refill...	N 352		

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 02/03/2026

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 352	Continued From page 21 [Resident 2] never refused either medication, the medications just weren't available to give." On 02/02/2026 at approximately 11:00 AM, Surveyors shared Resident 2's Anoro Ellipta inhaler and docusate sodium medication was not administered on the above dates due to the above documented reason(s). Administrator A acknowledged Resident 2's January 2026 eMAR documentation. Administrator A indicated, "[Registered Nurse T] and [Administrator A] will now be doing daily eMAR and medication cart audits to ensure medications are given correctly." Resident 3 On 01/26/2026, Surveyor reviewed Resident 3's record which indicated, the resident was admitted to the facility on 04/05/2025 with diagnosis to include seizure disorder, elevated troponion and systolic dysfunction. Additionally, the facility managed and administered all of Resident 3's medication. Resident 3 had physician's orders for, "Atorvastatin 40 mg tablet once daily at bedtime and valproic acid 250 mg/5 ml solution, take 5 ml three times daily." On 01/26/2026 at approximately 10:45 AM, Surveyor observed the medication cart with Caregiver M. Surveyor observed Resident 3's eight (8) PM atorvastatin blister pack card and noticed an extra dose remained in the card for 01/11/2026. Caregiver M acknowledged the observation and verified Resident 3's eight (8) PM atorvastatin medication was not given on 01/11/2026. Caregiver M verified the medication was documented as being administered in Resident 3's eMAR, but the medication remained in the blister pack. Caregiver M explained the facility receives monthly medication blister packs	N 352		

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 02/03/2026

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 352	Continued From page 22	N 352		

with numbered compartments (1-31) to organize pills by the day of the month. Caregiver M indicated the medications were dispensed by correlating the date of the month with the matching number on the blister pack card. Once the medication is punched out and administered, staff initial the eMAR, within ECP. Caregiver M indicated, "Some staff don't always follow the process and the blister cards are never accurate."

On 01/26/2026, Surveyor reviewed Resident 3's December 2025 eMAR which revealed Resident 3 did not receive his/her valproic acid medication twenty-two times from 12/08/2025 through 12/28/2025 because the medication was "Not in, on order or no pass."

On 01/26/2026 at 11 AM, Surveyor interviewed Caregiver M regarding Resident 3's December 2025 valproic acid 250 mg/5 ml solution. Caregiver M stated, "[Resident 3's] valproic acid solution was out for a few days in December 2025...Sometime around 12/29/2025, [Administrator A] sent out a text to all staff telling them to make sure they check the bottom of the med cart for [Resident 3's] valproic acid because [s/he] noticed some staff weren't giving it...There were a few staff that were completely messing up all the meds and not passing the meds correctly...I think [Administrator A] needs to re-train some of the med passers or just have one main med passer."

On 01/27/2026 at 4:10 PM, Surveyor interviewed Caregiver O regarding Resident 3's December 2025 valproic acid solution medication. Caregiver O stated, "I didn't given [Resident 3] [her/his] valproic acid for multiple days in December 2025 because it wasn't in the med cart. [Administrator A] said I signed a pharmacy slip for the

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 02/03/2026

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 352	Continued From page 23	N 352		

medication, but it must of went to one of the sister facilities because it wasn't available for me to give."

On 01/28/2026 at 12:40 PM, Surveyor interviewed Caregiver N regarding Resident 3's valproic acid solution medication. Caregiver N stated, "[Resident 3] needs the medication for seizures...[Resident 3] didn't receive it for over a week and a half in December 2025 because it wasn't in the med cart. [Administrator A] told me [Resident 3's] valproic acid solution had to be in the cart because [Caregiver O] signed for it, but I never saw the valproic acid in the med cart...It could've been locked up in the safe in the med room, but staff don't have access to the safe."

On 01/28/2026 at 3:04 PM, Surveyor interviewed Resident 3's APOA (Activated Power of Attorney) regarding Resident 3's medication. APOA-Q stated, "...I just learned from [Administrator A] on 01/26/2026 there were issues in December 2025 with [Resident 3's] valproic acid refills. I wish I had known, I would have helped. The medication is to prevent seizures..."

On 01/26/2026 at approximately 4:15 PM, Surveyor shared Resident 3's atorvastatin and valproic acid solution medication was not administered on the above dates due to the above observation and documented reason(s). Administrator A acknowledged Resident 3's December 2025 and January 2026 eMAR documentation. Administrator A indicated s/he plans to have Registered Nurse T look into the medications and stated, "There were certain days [Resident 3's] valproic acid solution wasn't given because staff didn't know it was in the med cart...Staff were looking for a tablet instead of the liquid."

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 02/03/2026

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 352	Continued From page 24 Resident 4 On 01/26/2026, Surveyor reviewed Resident 4's record which indicated, the resident was admitted to the facility on 01/07/2022 with diagnosis to include ADHD. Additionally, the facility managed and administered all of Resident 4's medication. Resident 4 had physician's orders written on 12/11/2025 for, "Lisdexamfetamine 30 mg capsule by mouth once daily." Surveyor reviewed the facility's proof-of-use record for Resident 4's Lisdexamfetamine medication. On 12/11/2025, the pharmacy delivered 30 capsules of Lisdexamfetamine medication for Resident 4, and the first dose was administered to the resident on 12/12/2025. According to Resident 4's December 2025 and January 2026 eMARs the resident received the medication daily from 12/12/2025 through 1/11/2026, except for 12/15/2025 as the medication was placed on hold. The last capsule of the 30 capsule supply would be administered on 01/11/2026. The pharmacy did not deliver any additional capsules of Resident 4's Lisdexamfetamine medication until 01/21/2026. On 01/22/2026, Resident 4 received the first dose of the additional 30 capsules. Resident 4 did not receive her/his prescribed Lisdexamfetamine capsule for ten (10) consecutive days from 01/12/2026 through 01/21/2026 as the medication was not available. On 01/26/2026, Surveyor reviewed Resident 4's January 2026 eMAR which revealed the following: ~01/12/2026- staff initialed the medication was given despite not having the medication	N 352		

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 02/03/2026

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 352	Continued From page 25 ~01/13/2026- left blank- staff did not initial ~01/14/2026- staff initialed the medication was given despite not having the medication ~01/15/2026- left blank-staff did not initial ~01/16/2026- staff documented "No pass Reason: Other Problems" ~01/17/2026- staff documented "No pass Reason: Other Problems- On order" ~01/18/2026- staff documented "No pass Reason: Other Problems- Out" ~01/19/2026- staff documented "No pass Reason: Other Problems- Not here" ~01/20/2026- staff documented "No pass Reason: Other Problems- Order finished" ~01/21/2026- staff documented "No pass Reason: Other Problems- Out" On 02/02/2026 at approximately 11 AM, Surveyors interviewed Administrator A regarding Resident 4's Lisdexamfetamine medication. Administrator A confirmed the pharmacy delivered 30 capsules of Resident 4's Lisdexamfetamine medication on 12/11/2025 and no additional capsules were delivered to the facility until 01/21/2026. Administrator A verified the Lisdexamfetamine medication was not given on 1/12/2026 and 01/14/2026 and stated, "Those dates were charting errors." Administrator A further confirmed Resident 4 did not receive his/her Lisdexamfetamine from 01/12/2026 through 01/21/2026, for ten (10) consecutive days because the medication was not available for staff to administer. Administrator A did not offer any additional insight about the reason Resident 4 did not receive the medication when asked by Surveyors. Administrator A indicated the physician, placing agency and guardian/POA was updated about the error on 01/28/2026 and a new policy and re-education was going to be completed regarding medication pass.	N 352		

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 02/03/2026

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 352	Continued From page 26 Resident 5 On 01/26/2026, Surveyor reviewed Resident 5's record which indicated, the resident was admitted to the facility on 01/23/2025 with diagnosis to include hypertensive heart disease, atrial fibrillation, and heart failure. Additionally, the facility managed and administered all of Resident 5's medication. Resident 5 had physician's orders for, "Jardiance 10 mg tablet by mouth once daily and Metoprolol tartrate 25 mg tablet by mouth twice daily." On 01/26/2026, Surveyor reviewed Resident 5's December 2025 eMAR which revealed Resident 5 did not receive his/her Jardiance 10 mg tablet on 12/01/2025 because the medication was "On order." Additionally, the eMAR revealed Caregiver O did not administer Resident 5's Metoprolol 25 mg tablet at 4 PM on 12/04/2025 because the medication was "Not in." On 01/27/2026 at 4:10 PM, Surveyor interviewed Caregiver O regarding Resident 5's Metoprolol 25 mg tablet at 4 PM on 12/04/2025. Caregiver O stated, "I wasn't able to give [Resident 5] the Metoprolol medication because it wasn't available...I didn't have it to give." On 02/02/2026 at approximately 11:20 AM, Surveyors shared with Administrator A Resident 5's Jardiance and Metoprolol medication was not administered on the above dates due to the above documented reason(s). Administrator A acknowledged Resident 5's December 2025 eMAR documentation. Administrator A indicated, "[Registered Nurse T] and [Administrator A] will now be doing daily eMAR and medication cart audits to ensure medications are given correctly."	N 352		

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 02/03/2026

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 352	Continued From page 27 Cross Reference N0409 DHS 83.37(1)(j) Proof-Of-Use Record N0415 DHS 83.37(2)(c) Documentation of Medication Administration N0432 DHS 83.38(1)(h) Medication Administration	N 352		
{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 record review and interview, the provider did not ensure all residents' individual service plans (ISPs) were updated to identify changes in needs and with specific individualized interventions to meet those needs. Resident 2's ISP was not updated to identify his/her needs and individualized interventions related to urinary incontinence, bowel management, behavior management, dietary needs or risks associated with an occurrence of	{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 02/03/2026

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 28 ingesting hand sanitizer. Resident 3's ISP was not updated to identify his/her risk of elopement, history of aggression or individualized strategies to ensure his/her toileting and bathing needs were met. This is a repeat deficiency. See Statement of Deficiency R1F013, dated 08/12/2025. Findings include: The Department received a complaint alleging concerns with incontinence care and delivery of hygiene supplies. RESIDENT 2 On 01/26/2026 beginning at 11:00 AM, Surveyor reviewed Resident 2's face sheet, current ISP, medication administration records, observation notes, task administration records and incident reports. On 01/27/2026 and 01/28/2026, Surveyor reviewed the member centered plan (MCP) developed by the managed care organization (MCO). Surveyor also conducted staff, resident, guardian and MCO interviews. INCONTINENCE: The MCO's MCP dated 07/14/2025 read, "I am incontinent...I have a mattress protector, chucks (under pads to protect beds and furniture) and overnight briefs for incontinence at night...I wear incontinence products ... using 5-6 pull ups per day as well as booster pads....At times I have behaviors that will lead me to voiding in my pants, this is not new...I do require staff to provide oversight on cleaning up my briefs..." MCO case notes: --11/05/2025: Resident 2 agreed to try booster	{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 02/03/2026

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 29	{N 389}		

pads in response to his/her request for more absorbent incontinence products.
--11/12/2025: Guardian E asked if the booster pads had arrived and MCO indicated they would follow with provider
--12/08/2025: Administrator A informed the MCO the "booster pads were received and working well."
--12/10/2025: Resident 2 called MCO to report s/he has not received the booster pads. MCO followed up with Administrator A who stated "[s/he] misspoke ...the booster pads have not been received yet."
--12/16/2025: MCO confirmed the pads were delivered on 11/12 at 7:22 pm. MCO emailed Administrator A asking to locate the pads.
--12/17/2025: Administrator A reported back, "booster pads were received by staff and [Resident 2] was not told."

On 01/26/2026 at 9:52 AM, Surveyor interviewed Caregiver S who said s/he was not sure if Resident 2 used incontinent products because Resident 2 was independent with all toileting needs.

On 01/28/2026 at 7:30 AM, Surveyor interviewed Caregiver O who said s/he was unaware Resident 2 utilized booster pads

The ISP category titled, "Toileting" was last updated on 09/30/2024 and read, "remind resident every 2 hrs to use the bathroom as [s/he] is urinating in [his/her] garbage can." The ISP described behaviors where Resident 2 would intentionally "urinate on [him/herself]...if [s/he] doesn't get [his/her] way or all the attention." The ISP was silent to the need for incontinence briefs, booster pads or urinary incontinence in situations other than intentional behaviors.

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 02/03/2026

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 30 BOWEL MANAGEMENT AND ASSOCIATED DIETARY NEEDS: Resident 2's January 2026 medication administration records documented 3 medications prescribed daily for chronic constipation and 2 prescribed as needed for constipation or hard stools. The MCO's MCP dated 07/14/2025 read, "...bowels will be managed appropriately as evidenced by no episodes of significant constipation requiring additional medical management...take bowel medications as ordered and follow dietary and fluid intake recommendations as recommended by my PCP." MCO case notes documented an emergency department (ED) visit for Resident 2 on 12/06/2025 where s/he received treatment for an episode of painful constipation. On 01/29/2026 at 9:30 AM, Surveyor interviewed MCO Registered Nurse (RN) U. S/he confirmed Resident 2 is prone to constipation and was treated in the ED on 12/06/2025. RN U described the dietary standards of practice for preventing constipation as; encouraging as many fruits and vegetables as possible and encourage hydration. RN U said, "Those would be my main concerns with [him/her]... [s/he] does not eat as many fiber foods as [s/he] needs." Surveyor reviewed the provider's current ISP and it was silent to chronic constipation or the need for bowel management or monitoring. The dietary category of the ISP was last updated on 04/23/2025 and documented Resident 2's preference for sugary snacks and junk food. The ISP did not identify any special dietary needs or	{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 02/03/2026

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 31	{N 389}		

interventions to encourage acceptance of a healthy diet

SELF-HARM:
Administrator A submitted a self-report to the Department on 01/12/2026 documenting an incident on 12/31/2025 when Resident 2 ingested hand sanitizer. This caused significant impairment and ultimately required ED evaluation for alcohol poisoning. The "Action Taken" section read, "[S/he] is already on 30 min checks."

On 01/26/2026 at 6:08 PM, Administrator A provided Surveyor with the after visit summary from the ED visit and the diagnosis was "isopropyl alcohol poisoning."

Surveyor interviewed Caregiver O on 01/28/2026 at 7:30 AM. S/he recalled messaging with Administrator A on 12/31/2025 and shared copies of the messages with Surveyor. Caregiver O informed Administrator A that Resident 2 admitted drinking hand sanitizer to become intoxicated and enjoy New Year's Eve, but also said s/he has attempted suicide in the past. Administrator A replied, "Omg [sic] that is very dangerous!" and "This sounds...like a suicide attempt." Administrator A instructed Caregiver O to call 911.

During the aforementioned interview with Caregiver S, s/he described Resident 2's needs and said s/he was not at risk for hurting him/herself and did not indicate awareness of the 12/31/2025 incident. Caregiver S said Resident 2 gets checked on every 2 hours like the other residents.

On 01/26/2026 at 1:35 PM, Surveyor interviewed Caregiver M who said s/he was aware of the incident but was unaware of any changes to the

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 02/03/2026

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 32 ISP. Caregiver M said s/he was unsure if Resident 2 was on standard 2 hour checks or if s/he needed 30 minute checks. The ISP category titled "30 min checks due to threat to harm [him/herself]" was updated 01/13/2026 but was silent to the event of drinking hand sanitizer. Surveyor reviewed a record titled "Task Administration Record" for January 2026. The record prompted for "30 min [sic] checks due to threat to harm [him/herself]." Between 01/14/2026 and 01/24/2026, checks were charted very infrequently and after 01/23/2026, no checks were documented. The ISP category titled "Self Abusive" last updated 10/18/2023 read, "To receive complete supervision and constant monitoring and cuing to avoid/prevent self abusive behavior. Doesn't like to be told what to do." ISP category titled "Suicidal Behavior" last updated on 09/30/2024 read, "Receiving supervision and assistance in all areas of preventing and redirecting suicidal thoughts and behaviors. [S/he] will threaten harm if [s/he] doesn't get [his/her] way." The ISP was not updated based on assessment to determine the root cause of the hand sanitizer incident or to identify interventions to prevent future occurrences. BEHAVIORS: The ISP category titled "Behavioral Episodes" was last updated 12/29/25. It described Resident 2 as creating stories and alleging people shame him/her to get attention or to "get [his/her] way."	{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 02/03/2026

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 33 The interventions were, "If [s/he] has behaviors that can't be redirected call [Licensee C] to talk to [Resident 2]." The category concluded with, "[S/he] will also call the police and when they get here [s/he] will...make up a story to tell them...police told [him/her]...[s/he] can get in trouble for that. Resident has ...Haldol that can be used for extreme behaviors. Call [Administrator A] first before giving this..." SURVEYOR NOTE: See interview below with Resident 2 regarding Licensee C. Surveyor reviewed incident reports and observation notes dating back to 11/01/2025; none of the aforementioned behaviors were documented. During the aforementioned interview with Caregiver S s/he said, "When I work here, [Resident 2] doesn't have behaviors." During the aforementioned interview with Caregiver M, s/he said the only behavior s/he sees is that Resident 2 will "barricade" him/herself in the exercise room to avoid Resident 3 because Resident 3 can get aggressive. During the aforementioned interview with Caregiver O, the only behavior s/he described was related to the 12/31/2025 situation when s/he ingested hand sanitizer. Surveyor reviewed a self-report submitted by Administrator A documenting an incident on 01/05/2026 when Resident 2 called the police to report [Resident 3] grabbed [his/her] cereal bowl and got aggressive. Administrator A wrote that no physical marks were found on Resident 2 and noted, "[S/he] has a history of calling the police	{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 02/03/2026

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 34 and making false claims." Surveyor submitted a request to the Fox Crossing Police Department for all responses to the facility since 10/01/2025. Surveyor obtained and reviewed 1 police report for the call on 01/05/2026. The officer found no physical injuries; however surveyor noted the aggressiveness Resident 2 described to police may not have resulted in physical injuries. The officer also wrote, "After speaking with [Resident 2], I made contact with...[Administrator A] ...(s/he) said [Resident 3] has dementia and would not slap [Resident 2]...[Administrator A] said [Resident 2] is a bully and makes trouble when [s/he] is not getting [his/her] way...I remade contact with [Resident 2]. I told [Resident 2] to resolve what occurred...[s/he] should stay away from [Resident 3]...also suggested [s/he] contact [his/her] guardian to see if s/he could move..." Surveyor noted Resident 3 has progressed dementia, routinely wanders throughout the facility and at times will display aggression. (See Resident 3 example below.) Surveyor also observed during the onsite visit 01/26/2026, Resident 2 and Resident 3 have rooms in close proximity in the same hallway and instruction to avoid Resident 3 would not be practical. On 01/29/2026 at 9:00 AM, Surveyor interviewed MCO Care Coordinator (CC) W and asked for examples of recent behaviors. CC W recalled the 12/31/2025 hand sanitizer incident and said the provider also reports "relationship issues with other residents." CC W provided 1 example of an incident on 01/05/2026 when Resident 2 called the police about another resident. CC W volunteered his/her observation during the most recent care team meeting and noted Resident 2	{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 02/03/2026

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 35 would try to bring concerns up but Administrator A would minimize them. CC W said neither Administrator A nor Resident 2 and his/her guardian were happy with Resident 2's current living situation and the MCO team is assisting Resident 2 with finding a different placement. Surveyor interviewed Resident 2 on 01/26/2026 at 4:23 PM. S/he described overall dissatisfaction living at the facility. Resident 2 also indicated s/he is afraid of Resident 3 and feels very uncomfortable being around Licensee C. Surveyor interviewed Guardian E on 01/28/2026 at 1:01 PM. S/he expressed extreme frustration with the overall care at the facility and poor communication from Administrator A. Guardian E described concern the provider does not seem to understand Resident 2's disabilities or needs and takes a blaming approach with Resident 2. Guardian E said s/he is actively working with the MCO to find a new home for Resident 2. RESIDENT 3 Prior to conducting the onsite visit, Surveyor reviewed the provider's compliance history. During the previous survey (Statement of Deficiency R1F013, 08/12/2025) a deficiency was issued for not ensuring Resident 3's ISP was updated to identify interventions to manage his/her dementia related behaviors to include aggression towards staff and residents, needs for incontinence care and risk of elopement. During the previous survey, Surveyor observed Resident 3 be intrusive with another resident and a caregiver was frustrated with Resident 3's aggression and persistent exit seeking. In addition, Surveyor reviewed an elopement incident on 07/31/2025 when Resident 3 left the building without staff knowledge 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 02/03/2026

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 36 discovered 2.5 miles away by a citizen who then notified the police. On 01/26/2026, Surveyors were on site from 8:00 AM until 6:20 PM. Throughout the day, Surveyors observed Resident 3 consistently wandering through the facility and lingering near exit doors. The doors were alarmed and had delayed egress. Resident 3 set off the alarms at least twice during the day trying to open them. Surveyors attempted to engage in conversation with Resident 3. S/he was confused and unable to effectively communicate. On 01/26/2026 at 11:10 AM, Surveyor reviewed portions of Resident 3's record. S/he was admitted on 04/05/2025 with diagnoses to include Alzheimer's disease with early onset. Surveyor reviewed the current ISP maintained in the electronic record and at 6:08 PM, Administrator A provided Surveyor with Resident 3's most recent signed ISP which was dated 05/01/2025. EXIT SEEKING/ELOPEMENT RISK: The ISP category (in both versions of the ISP) titled "Wandering/Elopement" was dated 04/05/2025 (the day of admission) and was unchanged since the last survey. It read, "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." During an interview with Caregiver M at 8:18 AM, s/he said Resident 3 remains at high risk for elopement. Caregiver M said on any given day his/her main focus to "to make sure [s/he] doesn't leave." Surveyor interviewed Caregiver S at 9:52 AM.	{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 02/03/2026

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 37 Caregiver S did not indicate knowledge that Resident 3 had eloped in the past but said s/he knows to keep an eye on him/her. At 10:39 AM, Surveyor observed Resident 3 approach and linger at the exit door at the end of the north hallway. Caregiver S had just left the building and Caregiver M was in the medication room and not in view of Resident 3. Surveyor observed the door was not shut tight and was not alarming. Surveyor closed the door and informed Caregiver M. Surveyor interviewed Caregiver O on 01/28/2026 at 7:30 AM. S/he said Resident 3 exit seeks and recalled a time when Resident 3 made it outside a few steps. Surveyor asked how Resident 3 exited given the alarms and delayed egress and Caregiver O said, "Sometimes workers won't shut them (the doors) all the way." AGGRESSION: The ISP category titled, "Aggressive/Combative" was dated 04/07/2025 (2 days after admission) was unchanged since the last survey. It read, "To receive complete assistance from staff preventing/alleviating aggressive and/or combative behaviors." The ISP did not identify specific or individualized strategies for preventing or alleviating aggression. Surveyor noted a recent episode of potential aggression on 01/05/2026 when Resident 2 called the police. According to the police report, Resident 2 said Resident 3 grabbed away his/her cereal bowl and then slapped and tried to poke Resident 2 in the eye when Resident 2 grabbed the bowl back. During the aforementioned interview with	{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 02/03/2026

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 38 Caregiver M, Surveyor asked if s/he was working on 01/05/2026 when Resident 2 called the police. Caregiver M said s/he was not but said Resident 3 "can get aggressive" and "When [Resident 3] is frustrated, [s/he] can hit." BATHING: During the aforementioned interview with Caregiver M, s/he said Resident 3's family has "a team come twice a week to make sure [Resident 3] is getting [his/her] showers." Caregiver M said this was set up in case caregivers miss showers. Caregiver M said s/he has noticed Resident 3 is particular about the water temperature and that can impact his/her acceptance of showers. On 01/28/2026 at 3:04 PM, Surveyor interviewed Resident 3's activated power of attorney for healthcare (POA.) POA Q explained that caregivers have struggled to provide consistent showers and as a result in November 2025, they hired an outside agency. POA Q acknowledged it can be difficult because of Resident 3's dementia and sensory issues during showers; however s/he feels like staff are not well trained in working with individuals with dementia and are not familiar with specific approaches that may be effective for Resident 3. S/he said, "They end up pushing too hard, it blows up and they all get frustrated. And then they don't do it." The ISP category titled, "Bathing" was dated 04/05/2025 and read, "Requires full assistance bathing/showering...[s/he] may be resistant to taking a shower. Be creative to be able to get [him/her] into the shower." The ISP did not provide specificity regarding the resistance to showers or identify individualized strategies encourage acceptance of showers.	{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 02/03/2026

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 39 INCONTINENCE: The ISP category titled, "Toilet Check" dated 04/05/2025 and was unchanged since the last survey. It identified a goal to maintain continence and the need for a 2 hour toileting schedule. The ISP did not identify Resident 3's tendency to resist or identify specific strategies staff could use to encourage acceptance of toileting assistance. During the aforementioned interview with Caregiver S s/he said, "Sometimes [Resident 3] refuses to change [his/her] diaper and you keep telling [him/her] you have to change it...you keep telling [him/her], it takes maybe 4 times." During the aforementioned interview with Caregiver O s/he said Resident 3 does not understand how or know when s/he needs to use the toilet. Caregiver O said Resident 3 needs a careful approach or s/he'll decline and s/he has had success using music to reduce refusals. Caregiver O said some staff do not use good interventions and Resident 3 will "walk around with BM (bowel movement) all up [his/her] back or all drenched in urine." During the aforementioned interview with POA Q, s/he said some days Resident 3 accepts help with toileting but other days, s/he "doesn't know how to execute" and staff need to guide him/her and be patient. POA Q said Resident 3 wears incontinence briefs and will get uncomfortable because the brief is full of urine or BM, but during those times s/he can't express the reason s/he is frustrated and becomes uncooperative with staff. POA Q said about half the time when they visit they find Resident 3 incontinent and sometimes the brief is excessively full. POA Q said the most recent time they expressed concern to Administrator A about toileting was 01/26/2026.	{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 02/03/2026

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 40 POA Q went on to explain that overall s/he has been disappointed in Administrator A's care planning and follow through; after s/he complains things improve temporarily but then they revert back. POA Q said Administrator A has not revisited the ISP with them since they originally reviewed it on 05/01/2025. During an interview with Administrator A on 02/02/2026 at 10:00 AM, Surveyor reviewed the concerns with Resident 2 and Resident 3's ISPs in each of the categories. Administrator A did not provide additional information. Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0214 DHS 83.15(3)(b) Administrator Shall Supervise Daily Operation N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0431 DHS 83.38(1)(g) Health Monitoring N0432 DHS 83.38 (1)(h) Medication Administration N0448 DHS 83.41(2)(a) Nutrition: Diet	{N 389}		
N 399	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked. This Rule is not met as evidenced by:	N 399		

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 02/03/2026

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 399	Continued From page 41 Based on record review and interview, the provider did not maintain an accurate and current written schedule including full names and job assignments. Findings include: On 01/26/2026, Surveyors requested administrator A provide staff schedules for all of December 2025 and January 2026, along with a current staff roster including dates of hire. Surveyors received and reviewed the schedules at approximately 10:40 AM and noted the following: --The schedule for December was incomplete and did not include the first 6 days of the month. --Only first names were documented on the schedules. --The schedules included at least 4 first names that did not appear on the staff roster. --The staff rosters included 2 names with hire dates preceding December, that did not appear on the schedules. In addition, the schedules identified 1 caregiver per shift. However during the onsite on 01/26/2026, Surveyor observed Caregiver M leave the facility to pass medications in a sister facility and Caregiver S relieved him/her for approximately 30 minutes. Caregiver S was not listed on any of the schedules or on the staff roster. During an interview with Caregiver M on 01/26/2026 at 1:33 PM, s/he said staff switch buildings often during portions of their shift to administer medications and at times there is an extra "float" caregiver staff between all 4 facilities. Surveyor noted this was not reflected on the schedule.	N 399		

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 02/03/2026

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 399	Continued From page 42 On 01/28/2026, Surveyor sent an email to Administrator A and wrote, "Please provide the first and last name of the staff working all 3 shifts 12/04-12/07/2025 and all 3 shifts the week of 01/18-01/24/2026. Please include the full names of the float caregiver (if any) and the medication passer (if different from the scheduled caregiver.)" On 01/29/2026, Administrator A replied to the email and wrote, "You have a list of this already with staff names and dates. Only one that is not a med passer is [Caregiver X] and [Caregiver Y], you should have all the info i [sic] gave you along with the schedule i [sic] printed out for you as well. It is the same as on the schedule." Surveyor note: Caregiver Y was not listed on the staff roster, Administrator A did not provide the requested schedules for December dates preceding 12/07/2025 and full names were not identified on the schedules. On 02/02/2026 at 10:00 AM, Surveyors interviewed Administrator A and showed him/her the schedule. S/he acknowledged full names were not documented on the schedule and said some of the names are nick names. Surveyor pointed out other incomplete and inconsistent information between the schedules and rosters and asked why they don't align. Administrator A replied, "I'm not exactly sure." Surveyor asked for confirmation that maintaining staff records/hire dates and schedules are Administrator A's responsibility and s/he confirmed they are. Cross Reference: N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 399		

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 02/03/2026

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 399	Continued From page 43 N0214 DHS 83.15(3)(b) Administrator Shall Supervise Daily Operation	N 399		
N 409	83.37(1)(j) Proof-of-use record. Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats, that contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis. This Rule is not met as evidenced by: Based on record review and staff interview, the facility did not ensure the proof-of-use record for Resident 4's scheduled II medication was accurate and audited on a daily basis. Findings include: According to "www.accessdata.fda.gov/drugsatfda_docs/label/2007/021977lbl.pdf" undated, "Vyvanse (lisdexamfetamine dimesylate) is indicated for the treatment of Attention-Deficit/Hyperactivity Disorder (ADHD). Vyvanse is classified as a Schedule II controlled substance...Vyvanse is a federally controlled substance (CII) because it can be abused or lead to dependence." On 01/26/2026, Surveyor interviewed Caregiver M on the facility's controlled substance policy. Caregiver M indicated s/he counts all	N 409		

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 02/03/2026

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 409	Continued From page 44	N 409		

blister-packed medications every shift with the oncoming shift and writes the count of each medication on a piece of paper, which is then sent via text to [Administrator A] who keeps documentation of the counts. Caregiver M stated, "The controlled narc count in ECP (the electronic medication system) doesn't work right and last week [Administrator A] told me we're going to go back to paper and pen narc count sheets."

On 01/26/2026, Surveyor reviewed the facility's medications. Resident 4 was prescribed Lisdexamfetamine 30 mg capsule daily on 12/11/2025.

On 01/29/2026, Surveyor reviewed the facility's proof-of-use record for Resident 4's Lisdexamfetamine medication. On 12/11/2025, the pharmacy delivered 30 capsules of Lisdexamfetamine medication for Resident 4, and the first dose was administered to the resident on 12/12/2025. According to Resident 4's December 2025 and January 2026 eMARs (electronic Medication Administration Records) the resident received the medication daily from 12/12/2025 through 1/12/2026, except for 12/15/2025 as the medication was placed on hold. The proof-of-use record remained accurate until 12/29/2025 when Administrator A added one (1) capsule to the count, when no additional capsule was received from the pharmacy. By [Administrator A] adding a capsule to the proof-of-use record, Resident 4's Lisdexamfetamine medication count was off by one capsule starting on 12/29/2025. The last capsule would have been administered on 01/11/2026 and the count would reflect a "0" balance, but instead the proof-of-use record revealed the last capsule was administered on 1/12/2026, with a "0" balance, when there was no

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 02/03/2026

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 409	Continued From page 45 capsule to administer. Additionally, the proof-of-use record did not have evidence daily audits of the counts were conducted for this medication. On 02/02/2026 at approximately 10:20 AM, Surveyors interviewed Administrator A regarding Resident 4's proof-of-use record for the Lisdexamfetamine medication. Administrator A confirmed the pharmacy delivered 30 capsules of Resident 4's Lisdexamfetamine medication on 12/11/2025 and no additional capsules were delivered to the facility until 01/21/2026. Administrator A confirmed s/he added an additional capsule to the count on 12/29/2025 in error, because s/he thought the 12/15/2025 capsule placed on hold was available for use, when the 12/15/2025 capsule was never deducted from the count on the proof-of-use record. At 10:25 AM, Administrator A reviewed Resident 4's December 2025 and January 2026 proof-of-use record with Surveyor. Administrator A acknowledged the proof-of-use documentation did not contain evidence daily audits were completed. Administrator A stated, "A new policy is being put in place for narc counts. We are going to paper narc counts as ECP is having issues with the narc counts. [Registered Nurse T] and I came up with a ledger book staff will have to fill out so we can do the audits and sign off on daily." Administrator A confirmed the new policy began on 02/02/2026." Cross Reference: N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0415 DHS 83.37(2)(c) Documentation of Medication Administration	N 409		

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 02/03/2026

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 415	Continued From page 46	N 415		
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 interview and record review, the provider did not accurately document administration of medications or ensure staff administrating the medication or treatment documented in the resident record the name, dosage, date and time of medication taken and initial the medication administration record. Resident 3's valproic acid medication was documented as "No pass Reason: Other Problems" nine (9) times in December 2025, with no further explanation as to why the med was not passed or what the "Other Problem" was. Additionally, staff did not initial the eMAR (electronic Medication Administration Record) for the valproic acid six (6) times during the month of December 2025, to identify whether the medication was administered. Resident 2's Anoro Ellipta inhaler was documented as "No pass Reason: Other	N 415		

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 02/03/2026

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 415	Continued From page 47 Problems" three (3) times in January 2026, with no further explanation as to why the med was not passed or what the "Other Problem" was. Staff did not initial the eMAR for the Anoro Ellipta inhaler ten (10) times during the month of January 2026, to identify whether the inhaler was administered. Additionally, Resident 2's docusate sodium medication was documented as "No Pass: Other problems" twelve (12) times in January 2026, with no further explanation as to why the med was not passed or what the "Other Problem" was. Staff did not initial the eMAR for the docusate sodium six (6) times in January 2026, to identify whether the medication was administered. Resident 4's Ensure nutritional supplement was documented as "No pass Reason: Other Problems" nine (9) times in December 2025 and eighteen (18) times in January 2026, with no further explanation as to why the Ensure was not passed or what the "Other Problem" was. Staff did not initial the eMAR for the Ensure nutritional supplement five (5) times in December 2025 and nine (9) times during the month of January 2026, to identify whether the Ensure was administered. Additionally, Caregivers signed the eMAR on 01/12/2026 and 01/14/2026 as administering Resident 4's Lisdexamfetamine 30 mg capsule despite not having the medication at the facility. This is a repeat deficiency and is being cited for the third time. See Statement of Deficiency (SOD) R1F011, dated 10/28/2024 and SOD R1F012 dated, 04/28/2025. Findings include: Resident 3	N 415		

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 02/03/2026

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 415	Continued From page 48 On 01/26/2026, Surveyor reviewed Resident 3's record which indicated, the resident was admitted on 04/05/2025 and the facility managed and administered all of Resident 3's medication. Resident 3 had a physician's order for, "Valproic acid 250 mg/5 ml solution, take 5 ml three times daily at 7 AM, 1 PM and 7 PM." On 01/26/2026, Surveyor reviewed Resident 3's December 2025 eMAR which revealed Resident 3's valproic acid medication was documented as "No pass Reason: Other Problems" nine (9) times in December 2025, with no further explanation as to why the med was not passed or what the "Other Problem" was on the following dates and administration times: ~12/16/2025 at 7 PM ~12/19/2025 at 7 AM and 1 PM ~12/22/2025 at 7 AM and 1 PM ~12/25/2025 at 7 AM ~12/26/2025 at 7 AM, 1 PM and 7 PM Additionally, Resident 3's December 2025 eMAR did not contain staff initials six (6) times between 12/17/2025 and 12/29/2025, to identify whether valproic acid medication was administered on the following dates and administration times: ~12/17/2025 at 7 AM and 7 PM ~12/18/2025 at 7 AM and 1 PM ~12/20/2025 at 1 PM ~12/29/2025 at 1 PM Resident 2 On 01/26/2026, Surveyor reviewed Resident 2's record which indicated, the resident was admitted on 10/17/2023 and the facility managed and administered all of Resident 2's medication. Resident 2 had physician's orders for, "Anoro Ellipta 62.5-25 mcg inhaler take one puff by	N 415		

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 02/03/2026

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 415	Continued From page 49	N 415		

mouth daily at 8 AM and docusate sodium 100 mg capsule by mouth twice daily at 8 AM and 8 PM."

On 01/26/2026, Surveyor reviewed Resident 2's January 2026 eMAR which revealed Resident 2's Anoro Ellipta inhaler was documented as "No pass Reason: Other Problems" three (3) times in January 2026, with no further explanation as to why the med was not passed or what the "Other Problem" was on the following dates: 01/03/2026, 01/04/2026 and 01/05/2026. In addition, Resident 2's docusate sodium medication was documented as "No Pass: Other problems" twelve (12) times in January 2026, with no further explanation as to why the med was not passed or what the "Other Problem" was on the following dates and administration times:

~01/03/2026 at 8 PM
~01/04/2026 at 8 AM and 8 PM
~01/05/2026 at 8 AM and 8 PM
~01/07/2026 at 8 PM
~01/09/2026 at 8 AM
~01/14/2026 at 8 PM
~01/16/2026 at 8 AM and 8 PM
~01/17/2026 at 8 AM and 8 PM

Resident 2's January 2026 eMAR did not contain staff initials ten (10) times between 01/08/2026 through 01/25/2026, to identify whether the Anoro Ellipta inhaler was administered on the following dates: 01/08/2026, 01/10/2026, 01/11/2026, 01/13/2026, 01/15/2026, 01/21/2026, 01/22/2026, 01/23/2026, 01/24/2026 and 01/24/2026. Additionally, Resident 2's January 2026 eMAR did not contain staff initials six (6) times between 01/08/2026 and 01/23/2026, to identify whether the docusate sodium medication was administered on the following dates 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 02/03/2026

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 415	Continued From page 50 administration times: ~01/08/2026 at 8 AM ~01/10/2026 at 8 AM ~01/11/2026 at 8 AM ~01/13/2026 at 8 AM ~01/15/2026 at 8 AM ~01/23/2026 at 8 AM Resident 4 On 01/26/2026, Surveyor reviewed Resident 4's record which indicated, the resident was admitted on 01/07/2022 and the facility managed and administered all of Resident 4's medication. Resident 4 had physician's orders for, "Lisdexamfetamine 30 mg capsule by mouth once daily and Ensure liquid clear nutritional drink three times a day with meals at 8 AM, 12 PM, and 4 PM. On 01/26/2026, Surveyor noted, the pharmacy delivered 30 capsules of Lisdexamfetamine medication for Resident 4 on 12/11/2025, and the first dose was administered to the resident on 12/12/2025. According to Resident 4's December 2025 and January 2026 eMARs the resident received the medication daily from 12/12/2025 through 01/11/2026, except for 12/15/2025 as the medication was placed on hold. The last capsule of the 30 capsule supply was administered on 01/11/2026 and the pharmacy did not dispense any additional capsules of Lisdexamfetamine medication for Resident 4 until 01/21/2026. Caregivers signed the January 2026 eMAR on 01/12/2026 and 01/14/2026 as administering Resident 4's Lisdexamfetamine 30 mg capsule despite not having the medication at the facility. On 01/28/2026, Surveyor asked Administrator A about the Lisdexamfetamine medication being	N 415		

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 02/03/2026

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 415	Continued From page 51	N 415		

charted as given to Resident 4 on 01/12/2026 and 01/14/2026, when the medication was not at the facility. Administrator A stated, "We looked into this and it looks like the 01/12/2026 and 01/14/2026 was not given and looks like charting errors."

On 01/26/2026, Surveyor reviewed Resident 4's December 2025 and January 2026 eMAR which revealed Resident 4's Ensure nutritional supplement was documented as "No pass Reason: Other Problems" nine (9) times in December 2025 and eighteen (18) times in January 2026, with no further explanation as to why the med was not passed or what the "Other Problem" was on the following dates and administration times:

~12/05/2025 at 12 PM
~12/15/2025 at 12 PM and 4 PM
~12/19/2025 at 8 AM
~12/22/2025 at 8 AM and 12 PM
~12/26/2025 at 4 PM
~12/30/2025 at 8 AM and 12 PM
~01/03/2026 at 8 AM, 12 PM, and 4 PM
~01/04/2026 at 8 AM, 12 PM and 4 PM
~01/05/2026 at 8 AM and 12 PM
~01/06/2026 at 4 PM
~01/09/2026 at 12 PM
~01/16/2026 at 8 AM, 12 PM and 4 PM
~01/17/2026 at 8 AM, 12 PM and 4 PM
~01/23/2026 at 8 AM and 12 PM

Resident 4's December 2025 and January 2026 eMAR did not contain staff initials fourteen (14) times between 12/02/2025 through 01/25/2026, to identify whether the Ensure nutritional drink was administered on the following dates and administration times:
~12/02/2025 at 12 PM

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 02/03/2026

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 415	Continued From page 52 ~12/03/2025 at 12 PM ~12/12/2025 at 12 PM ~12/16/2025 at 4 PM ~12/17/2025 at 4 PM ~01/10/2026 at 8 AM and 12 PM ~01/11/2026 at 8 AM ~01/13/2026 at 8 AM and 12 PM ~01/15/2026 at 8 AM ~01/24/2026 at 8 AM and 12 PM ~01/25/2026 at 8 AM On 02/02/2026 at 10 AM, Surveyors conducted an exit conference with Administrator A and discussed the above eMAR documentation of medication/treatment administration for Resident 2, 3 and 4. Administrator A acknowledge the incomplete and inaccurate documentation in the above eMARs for Resident 2, 3 and 4. Cross Reference: N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication	N 415		
N 427	83.38(1)(c) Leisure time activities. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents.	N 427		

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 02/03/2026

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 427	Continued From page 53	N 427		

This Rule is not met as evidenced by:
Based on observation and interview, the CBRF did not provide a daily activity program to meet the interests and capabilities of the residents or encourage and promote resident participation in activities.

Findings include:

On Monday 01/26/2025 at 8:00 AM, Surveyors entered the facility and observed an activity calendar posted in the entry way.

The scheduled activities for the day and every Monday of the month were;
-move for 30 (exercise)
-friends/coffee
-let's make snow
-crafts
-card games
-time for music
-Monday night movie

As of 11:40 AM, Surveyors had not observed any of the scheduled activities, or any other activities take place or be offered to residents.

At 11:45 AM, Surveyor interviewed Resident 5 and asked if the staff offer activities. Resident 5 replied, "Not really."

As of 3:10 PM, Surveyors had not observed any of the scheduled activities, or any other activities take place or be offered to residents.

At 3:12 PM, Surveyor interviewed Caregiver M. Caregiver M said, "for the most part, we do not do

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 02/03/2026

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 427	Continued From page 54	N 427		

activities." S/he said occasionally if there is an extra "float" staff they may have time for coloring or decorating the house but said that doesn't happen often. Caregiver M volunteered, "We are so short staffed right now." Caregiver M said it has been like this since the provider opened 2 new sister facilities (July 2025) and that took away the availability of some staff.

As of 6:20 PM when Surveyor exited the facility, no activities had taken place or been offered to residents.

On 01/28/2026 at 2:37 PM, Surveyor interviewed Caregiver N who said s/he'd worked at the facility for approximately the past month. Surveyor asked if activities are provided and s/he replied, "Nada. They don't exist. Like, they don't even give us stuff to do activities with." Caregiver N said s/he would try to play a movie or music in the background, but there are no organized activities or supplies.

Resident 2:

On 01/27/2026 and 01/28/2026, Surveyor reviewed Resident 2's member center plans dated 07/14/2025 and 01/13/2026 developed by the managed care organization (MCO). They both read, "Strengths: I am a social person that enjoys outings and activities...I am a great dancer and very musically talented...Staff are working collaboratively with [Resident 2] on identifying activities that [s/he] enjoys and being able to manage that with staff and the rest of the home. CBRF will have activities in the home however [Resident 2] may not be interested in certain activities. [Resident 2] is not able to leave and return to the CBRF at will for activities as supervision is required in the home and in the

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 02/03/2026

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 427	Continued From page 55	N 427		

community for safety."

On 01/29/2026 at 9:30 AM, Surveyor interviewed MCO Care Coach (CC) E. S/he said at the most recent care team meeting on 01/13/2026, Administrator A was asked about the provision of activities and s/he reported they are offered when Resident 2 is at work during the day.

On 1/26/2026 at 11:00 AM, Surveyor reviewed Resident 2's current individual service plan (ISP) developed by the provider. A category titled "Attitude" read in part, "...wants to go out in the community to do activities and not participate in the activity's [sic] that we have...[s/he] claims [s/he] is bored."

On 02/03/2026 at 3:17 PM, Surveyor interviewed Resident 2's guardian. Guardian E said activities are not offered in the home and described Resident 2 as feeling trapped there with nothing to do.

Resident 3:

On 01/28/2026, Surveyor interviewed Resident 3's power of attorney (POA Q.) POA Q said s/he does not see activities during visits and "that's been a big struggle" and part of the reason they hired an outside agency to supplement services at the facility. S/he said, "I get [Resident 3]'s attention span is short. But the feedback we've been given is that no one has enough time... [s/he] loves music, [s/he] will dance all day..." POA Q said this information was shared with Administrator A upon admission in April 2025. POA Q recalled when Resident 2 was younger s/he "always had a radio on and danced." POA Q said s/he has expressed concern to Administrator A about the lack of activities and specifically

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 02/03/2026

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 427	Continued From page 56 suggested music but Administrator A said another resident in the building doesn't like the music. On 02/02/2026 at 10:00 AM, Surveyors interviewed Administrator A and reviewed the concerns about activities. Administrator A confirmed Resident 2 and Resident 3 love music but did not offer additional explanation as to why that type of activity, or other activities were not offered. Cross Reference: N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0214 DHS 83.15(3)(b) Administrator Shall Supervise Daily Operation	N 427		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and	N 431		

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 02/03/2026

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 431	Continued From page 57 fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure the health was consistently monitored and appropriate services were provided to meet the needs of residents. Resident 4's weight was not consistently obtained and recorded daily as directed in the ISP (Individual Service Plan) and as ordered by the physician. Resident 5's blood pressure and pulse was not consistently obtained and recorded daily as directed in the ISP and as ordered by the physician. Resident 2's health was not monitored following a reported change in condition on 12/05/2025 when s/he experienced pain associated with constipation. PRN (as needed) medications were not monitored for effectiveness, the guardian was not notified of the change and the after visit summary (AVS) from an emergency department (ED) visit on 12/06/2025 was not obtained to ensure discharge instructions were followed. Findings include: Resident 4 On 01/26/2026, Surveyor reviewed Resident 4's	N 431		

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 02/03/2026

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 431	Continued From page 58	N 431		

record. Resident 4 was admitted to the facility on 01/07/2022 with diagnoses including depression, bulimia and ADHD (attention deficit disorder). On 11/23/2023, Resident 4 was seen by a physician who directed facility staff to obtain Resident 4's weight daily and indicated, "Weight loss-Bulimia...increased depression (family member died), daily weights...Ensure liquid clear nutritional drink three times daily with meals. (Facility to provide)."

On 01/26/2026, Surveyor reviewed Resident 4's most recent ISP (Individual Service Plan) dated 01/26/2026, which indicated, "Eating- [Resident 4] will make [her/himself] throw up for attention or if [s/he] doesn't like something. [S/he] needs to drink ensure three times a day for weight loss. [S/he] should be on a soft diet due to [s/he] is afraid to eat meats...Daily weights to be done. Directions: Resident to be weighed daily and recorded in ECP. Schedule: Daily at 7:00 AM..."

On 01/28/2026, Surveyor reviewed Resident 4's record including observation notes, vital history, care history, TAR (treatment administration record) and eMARs (electronic Medication Administration Record) from 12/01/2025 through 01/26/2026. Surveyor identified concerns with the consistency of documented daily weights. From 12/01/2025 through 01/26/2026, there were only 20 days in which a weight was documented daily, per physician's order, out of a total of fifty-seven days.

On 01/26/2026 at 2:30 PM, Surveyor approached Caregiver M and asked about Resident 4's daily weights. Caregiver M verified Resident 4 was to be weighed daily every morning. Caregiver M also confirmed Resident 4's daily weights were not being documented daily. Surveyor 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 02/03/2026

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 431	Continued From page 59	N 431		

asked Caregiver M if s/he completed a daily morning weight on Resident 4 for 01/26/2026. Caregiver M stated, "I didn't get [Resident 4's] weight this morning, but I will go get it now."

On 02/02/2026 at approximately 11:20 AM, Surveyors discussed the above concern related to Resident 4's weight documentation with Administrator A. Administrator A acknowledged the above documentation did not provide evidence staff obtained Resident 4's weight daily and verified there was no additional documentation to review. Administrator A indicated s/he would expect staff to obtain Resident 4's weights and document the results within the record.

Resident 5

On 01/26/2026, Surveyor reviewed Resident 5's record. Resident 5 was admitted to the facility on 01/23/2025 with diagnoses including hypertensive heart disease and atrial fibrillation. On 08/07/2025, Resident 5 was seen by a physician who directed facility staff to obtain Resident 5's vitals daily. On 09/24/2025, Resident 5 was seen by a physician who wrote, "Vital signs reviewed. BP (blood pressure elevated). Check daily..."

On 01/26/2026, Surveyor reviewed Resident 5's most recent ISP dated 01/26/2026, which indicated, "Check blood pressures and pulse daily for Medical Provider. Directions: Call [Administrator A] if blood pressure is over 150 or under 90. Schedule: Daily at 8:00 AM, Vitals: Blood pressure, Pulse."

On 01/28/2026, Surveyor reviewed Resident 5's record including observation notes, vital history, care history, TAR and eMARs from 12/01/2025

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 02/03/2026

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 431	Continued From page 60	N 431		

through 01/26/2026. Surveyor identified concerns with the consistency of documented blood pressures and pulse readings. From 12/01/2025 through 01/26/2026, there were only 17 days in which a blood pressure was documented daily, per physician's order, out of a total of fifty-seven days. From 12/01/2025 through 01/26/2026, there were only 16 days in which a pulse was documented daily, out of a total of fifty-seven days.

On 02/02/2026 at approximately 11:20 AM, Surveyors discussed the above concern related to Resident 5's blood pressure and pulse documentation with Administrator A. Administrator A acknowledged the above documentation did not provide evidence staff obtained Resident 5's blood pressure and pulse daily and verified there was no additional documentation to review. Administrator A indicated s/he would expect staff to obtain Resident 5's blood pressure and pulse daily and document the results within the record.

Resident 2

The Department received complaints about the provider's response to resident changes in condition.

Surveyor conducted an interview with Caregiver O on 01/28/2026 at 7:30 AM,. S/he recalled arriving to work on 12/05/2025 around 5:00 PM and Resident 2 immediately said, "My stomach hurts...[Administrator A] knows...[s/he] has known since yesterday...I'm backed up. I can't poop...if it gets worse I have to go in but I'm not sure what [Administrator A] will say." Caregiver O said s/he contacted Administrator A who instructed to give Pepto Bismal and later instructed to give

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 02/03/2026

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 431	Continued From page 61	N 431		

Resident 2 a suppository to self-administer if s/he wanted to. Caregiver O also shared copies of a text exchange with Administrator A on 12/05/2025 beginning at 7:22 PM which read:

--Administrator A: "Did [Resident 2] have a bm (bowel movement)"
--Caregiver O: "[Resident 2] did not...I noticed [s/he] took a lot of stuff to help [him/her] with that. And [s/he] said [s/he] may go to the emergency room..."
--Administrator A: "[S/he] does have a suppository [s/he] can insert [him/herself]"
--Caregiver O:"Gotcha, I'll let [him/her] know."

During the interview, Surveyor reviewed Resident 2's December 2025 medication administration record (MAR.) On 12/05/2025, Caregiver Z administered the following 3 medications prescribed PRN for constipation or hard stools:

--Milk of Magnesia at 3:59 PM
--MiraLAX at 4:03 PM
--Docusate Sodium at 4:46 PM

The MAR prompted for "follow up information" after each of the 3 administrations. Caregiver O entered a time of 7:10 PM, but no information about effectiveness was noted. No other PRNs were documented as offered/refused or administered after 4:46 PM or anytime on 12/06/2025.

Surveyor further reviewed the MAR and noted Pepto Bismal was not listed as a prescribed medication or charted as given and there was no charting to show whether or not the suppository was administered.

Caregiver O acknowledged s/he knew the Pepto

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 02/03/2026

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 431	Continued From page 62	N 431		

was not on the MAR but s/he administered from the house supply and s/he did not know whether or not Resident 2 chose to use the suppository. Caregiver O also confirmed s/he did not chart effectiveness of the PRNs given earlier in the shift by Caregiver Z and did not describe any proactive monitoring of Resident 2 during the remainder of his/her shift.

Caregiver O went on to say s/he was unaware Resident 2 was sent to the ED the following day, even though Caregiver O was working when s/he returned in the afternoon. Caregiver O said s/he thought Resident 2 had just arrived home from an outing.

Surveyor interviewed Caregiver M on 01/26/2026 at 11:35 AM. S/he recalled working as a float medication passer on 12/06/2025 and entered building 2 around 10:00 AM. At that time, Resident 2 said his/her "stomach was hurting and [s/he] wanted to be sent out...said [s/he] told staff about it and [s/he] felt like they weren't taking [him/her] serious...I offered prune juice, but [s/he] said no, [s/he] wanted to be sent out." Caregiver M said Resident 2 didn't normally complain of stomach pain and s/he notified Administrator A who agreed s/he could be sent to the ED. Caregiver M said s/he did not notify Resident 2's guardian of the change in condition or decision to seek ED evaluation because s/he believed Resident 2 had already told Guardian E.

Surveyor and Caregiver M reviewed Resident 2's records, and there was no documentation related to the change in condition, monitoring of Resident 2's pain or bowel movements or notification to Guardian E. Caregiver M acknowledged s/he must not have documented the events of 12/06/2025.

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 02/03/2026

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 431	Continued From page 63 On 01/27/2026 and 01/28/2026, Surveyor reviewed emails between the managed care organization (MCO) and Administrator A and MCO notes: Emails: 12/06 at 1:58 PM from Administrator A to the MCO care team and Guardian E: "Resident was sent out to the ER today due to [s/he] complained about constipation . [S/he] stated [s/he] told staff about this but when I inquired about this with staff no one knew anything about this constipation issue even being brought up by [Resident 2] to any staff. We tried milk of mag, stool softeners, prn [MiraLAX], [s/he] said [s/he] was also drinking prune juice and [s/he] stated nothing helped. [S/he] requested to be sent to the ER and a non ambulance [sic] was called...[S/he] did refused [sic] to try to resolve this at home is why we sent [him/her]out." 12/08 at 9:28 AM from MCO Care Coach (CC) AA: "[Administrator A], did staff call [Guardian E] to inform [him/her] of [Resident 2]'s concerns and the intervention they were using?...It would be beneficial for staff to communicate with [Guardian E] of concerns [Resident 2] is expressing on what intervention and plan of care is occurring..." 12/08 at 10:48 AM from Administrator A: "I sent you all a e-mail [sic] on Saturday of what was going on" (Surveyor note: see MCO Care Coordinator W interview below.) Note: 12/08 - MCO accessed Resident 2's electronic medical record from the hospital. [Resident 2] was seen in the ED on 12/6 and was given a fleets enema with total resolution of pain. MCO	N 431		

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 02/03/2026

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 431	Continued From page 64	N 431		

noted [Administrator A] sent follow up emails stating that [Resident 2] is "doing fine since returning home. [S/he] is supposed to continue with home care to prevent constipation."

Surveyor requested a copy of the 12/06/2026 ED AVS from Administrator A via email on 01/28/2026. On 01/29/2026 Administrator A replied, "Never got a copy."

On 02/02/2026 at 10:00 AM, Surveyor interviewed Administrator A. Administrator A said Resident 2's symptoms first started on 12/05 and PRN stool softeners were administered. Administrator A confirmed Resident 2 relies on staff assistance with administration of all medications and s/he should not have been given a suppository to self-administer. Administrator A also said PRNs were tried the morning of 12/06 (Surveyor note: this is not consistent with documentation or interviews.) Surveyor asked about the 12/08/2025 MCO note indicating Administrator A told the MCO Resident 2 "is supposed to continue with home care to prevent constipation" and asked how s/he was aware of the follow up instructions if s/he did not obtain the AVS. Administrator A said the information came from Resident 2.

Surveyor conducted an interview with MCO Care Coordinator (CC) W and MCO Registered Nurse (RN) U on 01/29/2026 at 9:30 AM. RN U said during review of the hospital records they learned there were additional instructions at discharge advising to return if Resident 2 experienced pain, fever or vomiting. In addition, instructions were given to continue with stool softeners to include MiraLAX and Docusate Sodium. When discussing notification to the guardian, CC W said email is not an effective way because everyone

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 02/03/2026

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 431	Continued From page 65 on the care team is aware Guardian E does not have an email address and s/he uses a family member's which s/he only accesses once a week. Cross Reference: N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0214 DHS 83.15(3)(b) Administrator Shall Supervise Daily Operation N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0432 DHS 83.38 (1)(h) Medication Administration N0448 DHS 83.41(2)(a) Nutrition: Diet	N 431		
N 432	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, interviews and record review, the provider did not provide medication services, including procedures to assure the accurate administering of all medications, to meet	N 432		

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 02/03/2026

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 432	Continued From page 66	N 432		

the needs of residents.

In 1 of 1 medication cart of the facility, opened inhalers were discovered in the med cart without a resident name, pharmacy label or date when the inhalers were opened or expired.

Resident 2 needed staff assistance with administration of all medications. Prior to a scheduled colonoscopy on 01/23/2026, the provider did not document administration of the prescribed bowel preparation medication and did not observe Resident 2 to confirm s/he consumed the medication in the dosages and intervals prescribed. The colonoscopy was unable to be completed and was the fifth failed attempt due to inadequate bowel preparation.

This is a repeat deficiency. See Statement of Deficiency (SOD) R1F011, dated 10/28/2024.

Findings include:

EXAMPLE 1:

The prescribing information for Anoro Ellipta inhaler, revised on 10/2022 indicated, "...Discard Anoro Ellipta six (6) weeks after opening...or when the counter reads "0", whichever comes first..."

According to www.drugs.com/medical-answers/you-expired-albuterol-inhaler-3556003/, last updated 01/25/2026, "An albuterol inhaler should be discarded after it passes its expiration date. It should be thrown out even sooner if it has been 13 months since it was removed from its foil packaging."

On 01/26/2026 at approximately 10:20 AM,

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 02/03/2026

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 432	Continued From page 67 Surveyor observed the facility's medication cart with Caregiver M. The top drawer of the medication cart, contained an opened albuterol inhaler and an opened Anoro Ellipta inhaler. Both inhalers were loose in the drawer and contained no resident name or pharmacy label. The inhalers did not contain a date to confirm when the inhalers were opened or expired. Caregiver M verified the inhalers were opened and prescribed for Resident 2. Caregiver M also confirmed the inhalers did not contain the resident's name, a pharmacy label or date when the inhalers were opened or expired. Caregiver M stated, "Both inhalers are for [Resident 2] and both inhalers were in a pharmacy bag/box with a pharmacy label, but somehow the bag/box for the inhalers went missing." On 01/26/2026 at 4:15 PM, Surveyor shared the above observations with Administrator A. Administrator A indicated Resident 2's inhalers should be properly labeled with a pharmacy label and dated when opened. On 01/28/2026 at 10:27 AM, Surveyor sent Administrator A an email asking if the facility had a policy and procedure for medication storage and labeling of inhalers. Administrator A responded on 01/28/2026 at 1:27 PM indicating, "All inhalers should be labeled with name and pharmacy label. We can add on the label the date they were opened. I talked to the pharmacy and they will be sending extra labels if bags get wrecked." EXAMPLE 2: The Department received complaints alleging concerns with administration of medication.	N 432		

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 02/03/2026

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 432	Continued From page 68 On 01/26/2026 at 1:35 PM, Surveyor interviewed Caregiver M. S/he said today s/he received a call from Doctor BB's office informing the facility that after Resident 2's fifth failed colonoscopy, they were not willing to reschedule the procedure again. Caregiver M said s/he would relay the message to Administrator A. On 01/26/2026 at 4:23 PM, Surveyor interviewed Resident 2 who said his/her colonoscopy last week did not go well. Resident 2 recalled on 1/22/2026 s/he drank "medicine that makes you poop." Resident 2 said Caregiver N gave him/her the medicine early in the morning and throughout the day, but s/he couldn't finish it all. S/he acknowledged it tasted bad. Resident 2 pointed to a cup on his/her shelf that contained approximately 6 oz of brown liquid and said that was some of the remaining medicine. Resident 2 said, " they couldn't do the colonoscopy because I still had feces and they couldn't get a clear view. I have to reschedule again." Surveyor reviewed Resident 2's record beginning on 01/26/2026 at 11:00 AM. The January 2026 medication administration record and did not include any new medications prescribed or administered on 01/22/2026. An entry in the observation notes dated 01/19/2026 read, "...Bowel prep on the 22nd...Mix the Golytely electrolyte solution/with warm tap water to fill the line and refrigerated in the morning...Begin at 2PM on the 22nd by drinking 1 - 8 oz glass Golytely about every 20 min [sic] until gone..." On 01/28/2026 at 2:37 PM, Surveyor interviewed Caregiver N. Caregiver N recalled at the start of his/her shift on 01/22/2026, s/he mixed the bowel prep with iced tea and began administering it at 7:00 AM. Caregiver N said s/he kept giving	N 432		

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 02/03/2026

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 432	Continued From page 69	N 432		

Resident 2 more of the mixture throughout the day until 3:00 PM, but s/he did not observe Resident 2 to make sure s/he was consuming it all. Surveyor reviewed the instructions in the notes indicating the medication should not have started until 2:00 PM, and Caregiver N said s/he must have misunderstood. Caregiver N confirmed the Golytely was not listed on the MAR and s/he did not document its administration.

Surveyor interviewed Registered Nurse (RN) R from Doctor BB's office on 01/27/2026 at 3:50 PM. S/he confirmed there have been 5 failed attempts at colonoscopies, each due to inadequate bowel preparation (prep) and added, "We don't know if the home has been compliant with giving [him/her] the prep." RN R confirmed Golytely is a prescription medication and instructions were to administer beginning at 2:00 PM on 1/22/2026 and administer 8 oz every 10 minutes until gone. RN R said upon arrival Resident 2's arrival for the procedure, it was evident the bowels were not adequately prepared so the procedure could not even be attempted. RN R said the record contained a note dated 01/26/2026 that read, "5 attempts at colonoscopy all incomplete due to inadequate prep. No longer will proceed. Bethel Home notified."

Surveyor interviewed Administrator A on 02/02/2026 at 10:00 AM. Administrator A confirmed Resident 2 requires full staff assistance with medication administration which includes observation to ensure s/he consumes medications. Surveyor reviewed concerns the administration of prescribed bowel preparation medication was not documented on the MAR, it was not administered at the times and intervals prescribed and it was not all consumed. Administrator A did not provide additional

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 02/03/2026

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 432	Continued From page 70 information. Administrator A said s/he has not had follow up with Doctor BB's office since the procedure on 01/23/2026 and was unaware of the message left on 01/26/2026 indicating they were unwilling to reschedule. Cross Reference: N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0214 DHS 83.15(3)(b) Administrator Shall Supervise Daily Operation N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0415 DHS 83.37(2)(c)Documentation Of Medication Administration	N 432		
N 435	83.38(1)(k) Transportation. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Transportation. The CBRF shall provide or arrange for transportation when needed for medical appointments, work, educational or training programs, religious services and for a reasonable number of community activities of interest. CBRFs that transport residents shall develop and implement written policies addressing the safe and secure transportation of residents. This Rule is not met as evidenced by: Based on record review and interview, the CBRF	N 435		

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 02/03/2026

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 435	Continued From page 71	N 435		

did not ensure transportation services were provided to meet Resident 2's needs. On 11/24/2025 and 12/04/2025, the provider did not ensure Resident 2 was transported to medical appointments and on 12/01/2025, the provider did not ensure Resident 2 was transported to work.

Findings include:

The Department received a complaint alleging resident transportation needs were not met.

On 01/27/2026 and 01/28/2026, Surveyor received and reviewed documentation from Resident 2's managed care organization (MCO) including case notes and the member centered plan (MCP).

The MCP dated 07/14/2025, identified Resident 2's need for full assistance with transportation and documented the provider's responsibility to ensure transportation to medical appointments and work. The MCP noted, if Guardian E was visiting from out of town, then s/he would drive Resident 2 to medical appointments.

The MCO case notes documented concerns with transportation including at least 2 missed medical appointments and 1 missed day of work:
--11/14/2025: Review of potential missed appointments. Guardian E indicated Administrator A "is ignoring [him/her]." Administrator A denied but noted "having multiple appointments is tedious."
--11/24/2025: The driver "forgot to pick [Resident 2] up for [his/her] lab appointment as the van had a flat tire." Administrator A "acknowledges responsibility" and said s/he would educate the driver.
--12/01/2025: "[Resident 2] was unable to go to

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 02/03/2026

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 435	Continued From page 72	N 435		

[work] today due to driver being out."
--12/02/2025: MCO followed up with Administrator A to ensure s/he had a black up plan for when the driver is unavailable.
--12/04/2025: Resident 2 missed a medical appointment because the provider did not transport.
--12/08/2025: "[Administrator A] reports that [s/he] does not have an appointment listed for 12/4."
--01/09/2026: "Contacted by [ombudsman]...Discussed missteps regarding healthcare. Writer shared that this may be due to transportation issues which usually stem from miscommunication between [Guardian E] and Bethel Assisted Living."

On 01/29/2026 at 9:30 AM, Surveyor interviewed the MCO care team. Care Coordinator W explained the provider is responsible for providing transportation to work daily and for appointments. The plan is for Guardian E to email the list of upcoming appointments to the MCO and Administrator A. At that time, Guardian E will also indicate if s/he will be in the area and able to provide transportation for any appointments. During the interview, the team indicated there was email correspondence about the 12/04/2025 appointment demonstrating Administrator A was aware.

On 01/29/2026 at 10:50 AM, MCO Registered Nurse (RN CC) forwarded an email string. On 11/26/2025, Guardian E emailed Administrator A and the care team a list of appointments, including the 12/04 medical appointment. On the same day, Care Coach AA emailed Administrator A requesting confirmation transportation would be provided for appointments, including 12/04 which was highlighted in yellow. In the email correspondence, it was never stated Guardian E

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 02/03/2026

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 435	Continued From page 73 would provide transportation to the appointment. Surveyor reviewed Resident 2's current individual service plan (ISP) on 01/26/2026 at 11:00 AM and noted it was silent to Resident 2's need for transportation assistance from the provider or the plan to coordinate appointments and transportation with Guardian E. On 02/02/2026 at 10:00 AM, Surveyor interviewed Administrator A. S/he acknowledged the provider transports Resident 2 to work daily and to medical appointments. S/he said the plan is for Guardian E to set up the appointments and let the facility know so they can arrange transportation. Administrator A acknowledged at times there had been miscommunication and blamed it on Guardian E. Surveyor identified the missed appointments on 11/24, 12/01 and 12/04/2025 and indicated there was no evidence those appointments were missed due to Guardian E. Administrator A did not offer additional information. Cross Reference: N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0214 DHS 83.15(3)(b) Administrator Shall Supervise Daily Operation N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 435		
N 448	83.41(2)(a) Nutrition: diet. Diets. 1. The CBRF shall provide each resident with palatable food that meets the recommended dietary allowance based on current dietary guidelines for Americans and any special dietary needs of each resident. 2. The CBRF shall	N 448		

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 02/03/2026

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 448	Continued From page 74 provide a therapeutic diet as ordered by a resident ' s physician. This Rule is not met as evidenced by: Surveyor: Hall, Nichole J. Based on observation, interview and record review, the provider did not ensure residents were served palatable food and did not ensure food was provided to meet the recommended dietary allowance for fruits and vegetables or to meet special dietary needs. --The breakfast, lunch and dinner meals on 01/26/2026 did not meet the recommended dietary allowance for fruits and vegetables and portions of the lunch and dinner meals were not palatable. Resident 2 has dietary needs for increased consumption of fiber to include fruits and vegetables. --Resident 4 did not receive her/his Ensure nutritional supplement as ordered by the physician, three times a day, from 12/01/2025 through 01/26/2026. The supplement was not given eighty-four (84) times out of 171 opportunities as caregivers continued to note the supplement was either not available or not documented as given. Resident 4's weight decreased 7.8 lbs (pounds) from 12/01/2025 through 01/22/2026. Findings include: The Department received a complaint regarding food supply and that the food was not palatable or nutritious.	N 448		

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 02/03/2026

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 448	Continued From page 75 PALATABLE FOOD & FOOD TO MEET RECOMMENDED DIETARY ALLOWANCES: BREAKFAST During an interview with Caregiver M on 01/26/2026 at 8:07 AM, s/he confirmed cereal was served for breakfast as identified on the menu. On 01/26/2026, Surveyor observed the lunch meal at 12:30 PM and the dinner meal at 5:15 PM. LUNCH --Tuna sandwich on white bread, potato chips and a small serving (approximately 1/4 cup) iceberg lettuce with chopped tomato. There was no dressing or topping for the salad. Caregiver M said s/he felt bad because there was no dressing in the building so s/he topped the salad with salt to add flavor. The beverage was Kool-Aid. --Resident 4 declined the lunch meal and ate a peanut butter sandwich. DINNER --Instant mashed potatoes without topping or seasoning, canned peas (approximately 1/2 cup) and pork. The beverage was Kool-Aid. --Surveyor sampled the meal. The potatoes had formed into a hard lump and were dry. Surveyor took the first bite of pork and it contained a piece of bone approximately 1/4". Surveyor tried another piece of pork and it was room temperature, hard, dry and difficult to chew. After Caregiver CC observed Surveyor place the bone on a napkin, s/he put on gloves and went through all the plated meat (not yet served), removing at least 5 more pieces of bone. --Surveyor observed Resident 3 had no bottom	N 448		

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 02/03/2026

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 448	Continued From page 76	N 448		

teeth and spit out 3 pieces pork on the table and Resident 5 had no teeth and chewed the meat with his/her gums.
--Resident 2 declined the dinner meal. Resident 2 said s/he would prefer to eat the sandwich in his/her fridge, purchased from a vending machine.
--Resident 4 said s/he doesn't like pork, was worried about choking and declined the meal. S/he had another peanut butter sandwich.

Surveyor observed the food storage in the home on 01/26/2026 at 8:17 AM and 2:30 PM. The fruit and vegetable supply consisted of; 1 grapefruit (remained on the kitchen counter all day), 1 can of mixed vegetables, 1 bag of frozen corn and the iceberg lettuce that was served at lunch. The only cereal present was an opened bag of a generic brand of Fruit Loops. Surveyor made a return visit to the facility on 02/02/2026 at 9:45 AM, and did not observe additional supplies of fruits, vegetables or high fiber cereal. During both of the aforementioned observations, Surveyor also observed the food supply was not plentiful, did not match the menu and consisted of highly processed foods like frozen pizza, chips, cookies, pasta and Jello.

RESIDENT 4:
See information below related to Resident 4's needs for Ensure during meals, for a soft diet and about a fear of choking on meat. During Surveyor's observation of the dinner meal, Resident 4 was not offered Ensure.

Surveyor interviewed Resident 4 at 9:04 AM and asked about the food. Surveyor observed s/he frowned and replied, "I don't like it. I don't like hot dogs. They serve them a lot. I don't chew them good. I will throw up. I eat peanut butter

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 02/03/2026

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 448	Continued From page 77 sandwiches." RESIDENT 5: Surveyor interviewed Resident 5 at 11:45 AM on 01/26/2026. S/he said there have "been cycles" where the food has not been good and said, "sometimes there is just a little, a couple of tablespoons on a plate and that is at night." Resident 5 added, "They say if you don't like what we have we have an alternative for you but that isn't always necessarily true. I have a supply of food too. " Resident 5 pointed to the closet where s/he had food stored. RESIDENT 3: Surveyor interviewed Resident 3's power of attorney for healthcare (POA Q) on 01/28/2026 and 3:04 PM. When asked about the food s/he replied, "It is not what I would normally expect to see. They serve a lot of sandwiches and spaghetti. The food is not the most nutritious." Surveyor asked if fruits and vegetables are offered and s/he said, "No, I don't see a lot. [Resident 3] likes bananas. We do ask if [s/he] eats bananas. I drop some off but they never ask me to bring more and it doesn't seem like they offer any." RESIDENT 2: Surveyor interviewed Resident 2 on 01/28/2026 at 4:23 PM. Resident 2 said the food is usually bad, there is not enough of it and that is why s/he buys sandwiches from the vending machine at work or the gas station. Resident 2 described some of the meat as unidentifiable, referring to it as "mystery meat" that even the staff can't identify. Resident 2 added, "Fruit is pretty much nonexistent" and later said "once in a while" an orange or apple is offered.	N 448		

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 02/03/2026

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 448	Continued From page 78 Surveyor interviewed Resident 2's guardian on 1/28/2026 1:01 PM. Guardian E said s/he has "concerns they don't provide enough fiber in [his/her] diet and it's not nutritionally based." Guardian E went on to say the food is generally terrible, there is not enough of it and Resident 2 frequently buys sandwiches from the gas station or vending machines because of food concerns at the facility. In 01/27/2026 and 01/28/2026, Surveyor reviewed Resident 2's 01/13/2026 member centered plan (MCP) and case notes from the managed care organization (MCO). The records indicated Resident 2 had needs for bowel management due to chronic constipation with a plan to follow his/her physician's dietary recommendations. On 01/29/2026 at 9:30 AM, Surveyor interviewed MCO Registered Nurse (RN) R about Resident 2's dietary needs and s/he said Resident 2 should consume high fiber foods from sources to include fruits and vegetables. NOTE: "Use the same home-based methods you used to treat constipation to prevent it from becoming a chronic problem: Eat a well-balanced diet with plenty of fiber. Good sources of fiber are fruits, vegetables, legumes, and whole-grain breads and cereals. Fiber and water help your colon pass stool. Most of the fiber in fruits is found in the skin, such as in apples. Fruits with seeds you can eat, like strawberries, have the most fiber. Bran is a great source of fiber, too. Eat bran cereal or add bran cereal to other foods, like soup and yogurt. People with constipation should eat between 18 and 30 grams of fiber every day." Source: https://my.clevelandclinic.org/health/diseases/4059-constipation - retrieval date 01/28/2026	N 448		

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 02/03/2026

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 448	Continued From page 79 NOTE: The current Dietary Guidelines for Americans recommend adults consume 2 cups of fruit and 2.5 cups of vegetables daily (on a 2,000-calorie diet) to fill half their plate with nutrient-dense, whole foods. Key principles include eating a variety of colors, prioritizing whole fruits over juice, and choosing fresh, frozen, or canned options without added sugars or excessive sodium. Source: https://www.ers.usda.gov/amber-waves/2024/September/satisfying-fruit-and-vegetable-recommendations-possible-for-under-3-a-day-data-analysis-shows#:~:text=The%20current%20recommendation%20is%202,standard%201%2Dcup%20measuring%20cup - retrieval date 01/28/2026 RESIDENT 4 ENSURE ORDER: On 01/26/2026 at 1:38 PM, Surveyor was in the medication room with Caregiver M, when Resident 4 approached the med room door and asked Caregiver M, "Can I get some Ensure?" Caregiver M replied, "It's on order." Resident 4 then said, "Can you tell [Administrator A]?" Caregiver M agreed s/he would tell [Administrator A] and Resident 4 walked away without the Ensure. Surveyor then asked Caregiver M how long the Ensure had been on order. Caregiver M stated, "Every time I come over here [Resident 4] is out of Ensure. Sometimes I will go to the [sister facilities] and get Ensure from another resident's supply, but I can't always do that because it's not [Resident 4's] supply, it's someone else's...[Resident 4] has probably been without [her/his] own supply of Ensure for a couple of months now." Surveyor then asked if Resident 4's electronic medication administration record (eMAR) prompts staff to administer	N 448		

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 02/03/2026

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 448	Continued From page 80	N 448		

Resident 4's Ensure three times daily. Caregiver M confirmed the eMAR does prompt staff to administer, but some staff document s/he refused, but really, it's because the Ensure is not in the building. Caregiver M then looked in Resident 4's eMAR and stated, "The eMAR says it's currently on order."

On 01/26/2026, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the facility on 01/07/2022 with diagnoses including depression, bulimia and ADHD (attention deficit disorder). On 11/23/2023, Resident 4 was seen by a physician who directed facility staff to obtain Resident 4's weight daily and indicated, "Weight loss-Bulimia...increased depression (family member died), daily weights...Ensure liquid clear nutritional drink three times daily with meals. (Facility to provide)."

On 01/26/2026, Surveyor reviewed Resident 4's most recent ISP (Individual Service Plan) dated 01/26/2026, which indicated, "Eating- [Resident 4] will make [her/himself] throw up for attention or if [s/he] doesn't like something. [S/he] needs to drink Ensure three times a day for weight loss. [S/he] should be on a soft diet due to [s/he] is afraid to eat meats...Daily weights to be done..."

On 01/28/2026, Surveyor reviewed Resident 4's December 2025 eMAR from 12/01/2025 through 12/31/2025. The eMAR indicated, "Ensure Clear Mixed Berry. Drink one can three times a day daily with meals at 8:00 AM, 12:00 PM and 4:00 PM." Surveyor identified concerns with the Ensure not being provided as ordered because it was either not available or not documented as given. The eMAR documented Resident 4 did not receive the physician ordered nutritional supplement thirty-nine (39) times out of 93

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 02/03/2026

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 448	Continued From page 81	N 448		

opportunities.

On 01/28/2026, Surveyor reviewed Resident 4's January 2026 eMAR from 01/01/2026 through 01/26/2026. The eMAR indicated, "Ensure Clear Mixed Berry. Drink one can three times a day daily with meals at 8:00 AM, 12:00 PM and 4:00 PM." Surveyor identified concerns with the Ensure not being provided as ordered because it was either not available or not documented as given. The eMAR documented Resident 4 did not receive the physician ordered nutritional supplement forty-five (45) times out of 78 opportunities.

On 01/28/2026, Surveyor reviewed Resident 4's weight history report which identified a loss of weight from 12/01/2025 through 01/22/2026. The following weights were recorded for Resident 4:

~12/01/2025--100 lb.
~12/03/2025-- 97.2 lb. (a 2.8 lb. decrease)
~12/21/2025-- 93.4 lb. (a 3.8 lb. decrease)
~01/14/2026-- 92.6 lb. (a 0.8 lb. decrease)
~01/22/2026-- 92.2 lb. (a 0.4 lb. decrease)

Resident 4's weight decreased 7.8 lb. from 12/01/2025 through 01/22/2026.

On 01/27/2026 at 4:10 PM, Surveyor discussed Resident 4's Ensure liquid nutritional supplements with Caregiver O. Caregiver O told Surveyor s/he was aware of Resident 4's nutritional supplement order but indicated it has not been given to Resident 4. When Surveyor asked why, Caregiver O stated, "There's no supply in house. The facility had been out of [Resident 4's] nutritional supplement for "at least a month." Caregiver O went on to say, "[Resident 4] would always ask me for the Ensure and I would have to

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 02/03/2026

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 448	Continued From page 82 tell [Resident 4] there wasn't any available...I told [Administrator A], [Resident 4] was out of the Ensure and [Administrator A] would say it's in [her/his] locked office and when [s/he] gets in, [s/he] would get it, but it was never brought over to the building." On 01/28/2026 at 12:30 PM, Surveyor discussed Resident 4's Ensure supplement with Caregiver N. Caregiver N told Surveyor the facility provided Resident 4's nutritional supplement, and the supply has been gone for over a month. Caregiver N indicated Administrator A orders the supply and was aware of this concern. Caregiver N then stated, "[Resident 4] would always ask me for [her/his] Ensure when I would work, but I could never give it to [her/him] because there was no supply in the facility." On 01/26/2026 at 4:15 PM, Administrator A told Surveyor s/he was not aware Resident 4's Ensure supplement was gone. Administrator A stated, "I will get [Resident 4] some...I have some instant breakfast here in my office [s/he] can have." ***Surveyor noted Instant Breakfast and Ensure Clear liquid were not the same, because they contained different ingredients and nutritional content. In conclusion, Resident 4 had a physician's order for the facility to provide Ensure clear liquid drink three times daily as a nutritional supplement. The nutritional supplement had been a long-standing order for Resident 4. The supplement was not given as caregivers continued to note the supplement was not available. Resident 4 had a 7.8 lbs. weight loss from 12/01/2025 through 01/22/2026. Cross Reference:	N 448		

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 02/03/2026

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 448	Continued From page 83 N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0214 DHS 83.15(3)(b) Administrator Shall Supervise Daily Operation N0431 DHS 83.38(1)(g) Health Monitoring N0448 DHS 83.41(2)(a) Nutrition: Diet N0452 DHS 83.41(3)(b) Food Safety	N 448		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation, record review and interview, the CBRF did not make the weekly menus available to residents or document deviations on the menu. Findings include: The Department received a complaint alleging the menu was not posted in the common area or otherwise made available to residents. On 01/26/2026 at 8:00 AM, Surveyor entered the facility and did not observe a weekly menu posted. At 8:18 AM, Surveyor interviewed Caregiver M in the kitchen. Surveyor observed a menu on an 8.5x11" piece of paper on the exterior of the	N 450		

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 02/03/2026

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 450	Continued From page 84 refrigerator for the previous week beginning 01/18/2026. Caregiver M said that was the only place the menu is kept. S/he said a large whiteboard that was in the kitchen used to be in the common area and the menu was written on it, but it fell and remained in the kitchen. No menu items were listed on the whiteboard. Surveyor observed 2 residents approached Caregiver M while s/he was in the kitchen talking to Surveyor. S/he met them at the door and asked what they needed. Throughout the remainder of the day until 6:20 PM, Surveyors did not observe residents accessing the kitchen where they could view the menu. On 01/26/2026 at 9:52 AM, Surveyor asked Caregiver S to join Surveyor in the kitchen. Caregiver S opened the door to grant Surveyor access. Caregiver S located 2 more menus on papers lying on the counter. Surveyor and Caregiver S reviewed the menu for the day and the scheduled lunch meal was pork chops, potatoes and a vegetable and the dinner menu was chili cheese fries and fruit. On 01/26/2026 at 11:37 AM, Surveyor observed Resident 4 approach Caregiver M and asked what was for lunch. Caregiver M told Resident 4 the meal was pork chops. Resident 4 said s/he didn't like that and wanted a sandwich instead. --Surveyors observed Caregiver M serve the lunch meal at approximately 12:45 PM; it was tuna sandwiches, potato chips and salad and did not match the menu. --Surveyor reviewed the menu again at 4:17 PM, after Caregiver M left the building when his/her shift ended. The deviation from the lunch meal was not documented on the menu.	N 450		

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 02/03/2026

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 450	Continued From page 85 --Surveyor observed the dinner meal at approximately 5:30 PM; it was pork, instant potatoes and canned peas and did not match the menu. During an interview with Administrator A on 02/02/2026 at 10:00 AM, Surveyor reviewed the concerns about menu accessibility and accuracy and that the 01/26/2026 lunch deviation was not documented. Administrator A did not offer additional information. Cross Reference: N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0214 DHS 83.15(3)(b) Administrator Shall Supervise Daily Operation N0448 DHS 83.41(2)(a) Nutrition: Diet	N 450		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving.	N 452		

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 02/03/2026

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 452	Continued From page 86	N 452		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not seal food stored in the pantry, did not label or date leftovers in the refrigerator and did not ensure the dinner meal was held at 140° or higher prior to serving.

This is a repeat deficiency. See Statement of Deficiency S8KF12, dated 10/12/2022.

Findings include:

The Department received a complaint about the food.

Surveyor observed the food storage in the home on 01/26/2026 at 8:17 AM and 2:30 PM.

PANTRY STORAGE:
--A box of instant potatoes was wide open at the top, exposing the contents.
--A jar of nuts was missing the cover, exposing the contents.
--A tray of store bought cookies was not covered, exposing the contents.
--The box of potatoes and jar of nuts were at the edge of the shelving unit, approximately 1 foot from the open door of the laundry room. Surveyor observed dirty laundry stored just inside the laundry room.
--Other pantry items were not sealed including a bag of cereal and a bag of chips.
--At 8:18 AM, Surveyor observed a resident asking for a cookie and Caregiver M provided 2 from the unsealed tray.

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 02/03/2026

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 452	Continued From page 87	N 452		

REFRIGERATOR STORAGE:
--metal pot covered in plastic wrap contained what appeared to be spaghetti
--metal baking pan covered in plastic wrap contained what appeared to be chicken, potatoes and green beans
--large plastic container covered in plastic wrap had food that was unidentifiable
--unsealed bag of flour tortilla shells that were crispy to the touch

At 9:52 AM, Surveyor interviewed Caregiver S. S/he said sometimes residents "refuse" the food so staff offer alternatives. Caregiver S said sometimes they don ' t have the requested alternative so they offer what they have. Surveyor asked what alternative s/he would serve today and s/he said leftovers. Surveyor and Caregiver S went to the kitchen and Caregiver S said s/he would offer the leftover spaghetti. Surveyor asked how long the spaghetti had been in the refrigerator and Caregiver S said s/he had no idea. S/he also stated s/he did not know what food was in the plastic container or how long it had been there. Caregiver S said " we used to put a date " on the food but acknowledged currently the leftovers were not dated or labeled.

SAFE HOLDING TEMPERATURES:
--The lunch meal was tuna salad sandwiches. The tuna salad was mixed with mayonnaise and was delivered in an unlabeled gallon size plastic bag from the sister facility. Lunch was served beginning at approximately 12:30 PM and the bag remained unrefrigerated on the counter until at least 2:30 PM.
--The dinner meal included pork and canned peas. Caregiver CC completed plating the dinner meal by 5:12 PM. Surveyor sampled an extra plate at 5:15 PM. Surveyor found a bone in the

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 02/03/2026

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 452	Continued From page 88 pork. Caregiver CC then inspected the meat on all residents ' plates, removing more pieces of bone. Caregiver CC served the food to residents at approximately 5:30 PM. Surveyor tested the temperature of the food at that time; the pork was 75.6 °F and the peas were 104° F. Surveyor informed Caregiver CC of the temperatures and s/he said s/he did not make it and it came from the other building. SURVEYOR NOTE: 4 Steps to Food Safety - How do you prevent food poisoning? Did you know that an estimated 1 in 6 Americans will get sick from food poisoning this year alone? Food poisoning not only sends 128,000 Americans to the hospital each year-it can also cause long-term health problems. You can help keep your family safe from food poisoning at home by following these four simple steps: clean, separate, cook and, chill. Keep food hot (140°F (60°C) or above) after cooking: If you ' re not serving food right after cooking, keep it out of the temperature danger zone (between 40°F (4°C) - 140°F (60°C)) where germs grow rapidly by using a heat source like a chafing dish, warming tray, or slow cooker...Chill: Refrigerate and Freeze Food Properly - Refrigerate perishable foods within 2 hours: Bacteria that cause food poisoning multiply quickest between 40°F (4°C) and 140°F (60°C). Never leave perishable foods out of refrigeration for more than 2 hours..." Source: https://www.foodsafety.gov/keep-food-safe/4-steps-to-food-safety, retrieval date 02/11/2026 Cross Reference: N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0214 DHS 83.15(3)(b) Administrator Shall	N 452		

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 02/03/2026

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 452	Continued From page 89 Supervise Daily Operation N0448 DHS 83.41(2)(a) Nutrition: Diet N0450 DHS 83.41(2)(c) Nutrition: Menus N0452 DHS 83.41(3)(b) Food Safety	N 452		
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 clean, comfortable, well maintained and homelike. Findings include: On 01/26/2026 Surveyor observed the following: North Bathroom: (photos 0701, 0697, 0698 and 0711) --The linoleum floor adjacent to the tub, had an area of residual black adhesive in the shape of a bathmat (approximately 3" x 2"). --The vanity cabinets and drawers had visible wear and discoloration. Where the vanity met the floor, the entire piece of trim was missing (approximately 5 feet). --The wall showed scuff marks, discoloration and staining, particularly along the lower portion near the baseboard. --The recessed toilet paper holder was missing the holder rod, and the toilet paper rested on the	N 481		

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 02/03/2026

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 481	Continued From page 90	N 481		

toilet tank.
--The sink drained slow, filling to the top until it reached the overflow drain.
--The floor register was painted white with underlying chipping and uneven application.

Kitchen: (photos 0690, 0689, 0691 and 0695)
--Cabinet surfaces showed significant wear, discoloration and stains. At least 3 cabinet doors would not close tightly and remained slightly open approximately 1-2 inches.
--Vertical blinds were in poor repair with broken and protruding slats.

Other: (photos 0689, 0687, 0688, 0717, 0672 and 0801)
--Eight (8) of 8 dining room chairs were missing nearly all of the previously affixed vinyl covering, requiring users to sit directly on the foam cushion of the chair.
--The floor register in the small west bathroom was at least 50% covered in a thick, dark brown substance resembling rust.
--One cushion of a living couch was missing all the suede material, exposing the entire interior yellow foam cushion. Sections of the foam had black spots resembling dirt or mold. When Surveyors returned on 01/28/2026, the yellow foam cushion had not been replaced or repaired.
--Surveyor interviewed Resident 2 on 01/26/2026 at 4:23 PM. Resident 2 kept his/her door locked because s/he wants privacy. Surveyor observed the door was unlocked, it was very difficult to open and close and would stick in the door frame. Resident 2 had to push hard to open the door and pull hard to shut the door. Resident 2 said it had been like that for a while and s/he also has concerns with functionality of the lock on the north bathroom door. Resident 2 took Surveyor to the bathroom and demonstrated that when the

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 02/03/2026

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 481	Continued From page 91 door is locked, if the handle is jiggled a few times from the hallway side, the door unlocks. Resident 2 said s/he prefers to take baths and the malfunctioning door lock makes him/her nervous that someone will walk in. Surveyor reviewed the aforementioned concerns with Administrator A during interviews on 01/26/2026 at 6:08 PM and 02/02/2026 at 10:00 AM. Administrator A did not provide additional information. Cross Reference: N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0214 DHS 83.15(3)(b) Administrator Shall Supervise Daily Operation	N 481		
N 492	83.45(1)(a) Exterior areas. Exterior areas. The CBRF shall maintain the yard, any fences, sidewalks, driveways and parking areas of the CBRF in good repair and free of hazards. This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure exterior areas including parking lots were free from hazards. Findings include: The provider is licensed to serve up to 8 semi-ambulatory residents from the following client groups: developmentally disabled, irreversible dementia/Alzheimer's, physically disabled, terminally ill, traumatic brain injury and emotionally disturbed/mental illness.	N 492		

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 02/03/2026

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 492	Continued From page 92 Upon arrival at the facility on 01/26/2026 at 8:00 AM, Surveyors observed the parking lot was covered in a layer of hard packed snow and ice. This caused extremely slippery conditions as Surveyors navigated to the entrance (photo 0728 and 0772.) Surveyors returned for an onsite visit on 02/02/2026 and the parking lot conditions remained the same (photo 0774.) Surveyor reviewed historical weather data recorded snow 6 days between 01/13/2026 and 01/26/2026 and temperatures during that same timeframe were frigid. The combination of snow followed by frigid temperatures was consistent with the hard packed, slippery surfaces observed on 01/26/2026 and 02/02/2026. -Source: https://weatherspark.com/h/m/13612/2026/1/Historical-Weather-in-January-2026-in-Appleton-Wisconsin-United-States#Figures-ColorTemperature, retrieval date 02/09/2026. Surveyor observed at least one resident ambulate across the parking lot on 01/26/2026 at 4:00 PM; Resident 2 was dropped off in the company van after work and walked approximately 15 feet on the slippery surface. During an interview with Administrator A on 02/02/2026 at 10:00 AM, Surveyor reviewed the concerns with the hazardous condition of the parking lot due to lack of snow removal. Administrator A did not provide additional information. Cross Reference: N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0214 DHS 83.15(3)(b) Administrator Shall Supervise Daily Operation	N 492		

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 02/03/2026

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 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure toxic cleaning supplies were stored in secure areas. This is a repeat deficiency. See Statement of Deficiency R1F011, dated 10/28/2024. Findings include: The provider is licensed to serve up to 8 semi-ambulatory residents from the following client groups: developmentally disabled, irreversible dementia/Alzheimer's, physically disabled, terminally ill, traumatic brain injury and emotionally disturbed/mental illness. On 01/26/2026 beginning at 11:00 AM, Surveyor reviewed Resident 2 and Resident 3's records. --Resident 2 had diagnoses to include anxiety disorder, bipolar disorder and frontal lobe and executive function deficit and an ISP category last updated 06/10/2024 titled, "Attitude" read in part, "[Resident 2] told Winnebago crisis that [s/he] ate razor blades yesterday and drank toilet bowl cleaner. No signs or symptoms of this has been noted yesterday or today. [S/he] is looking for attention to get out of the facility..." --Resident 3 had diagnoses to include early onsite Alzheimer's and a history of wandering. On 01/26/2026 at 10:24 AM, Surveyor observed	N 499		

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 02/03/2026

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 499	Continued From page 94 the large west side bathroom. The following cleaning supplies were stored in an unlocked cabinet under the bathroom sink. --Two bottles of spray bathroom cleaner with bleach and a label that read, "CAUTION: EYE IRRITANT. Do not swallow. Do not get in eyes. Do not get on skin...Do not breathe fumes. KEEP OUT OF REACH OF CHILDREN...If swallowed, call a Poison Control Center." --Two bottles of toilet bowl cleaner with bleach and a label that read, "WARNING: CORROSIVE. CAUSES SEVERE BURNS. CAUSES SERIOUS EYE DAMAGE. HARMFUL IF SWALLOWED...IF SWALLOWED: CONTACT LOCAL POISON CONTROL CENTER IMMEDIATELY." In an unlocked closet in the same bathroom, Surveyor observed a bottle of liquid drain opener was stored in an unlocked closet with a label that read, "POISON!" At 10:35 AM, Surveyor observed the small north side bathroom. In an unlocked cabinet under the bathroom sink the same brand of spray bathroom cleaner with bleach was stored. From 9:02 AM until at least 10:44 AM, Surveyor observed the same brand of spray bathroom cleaner on the kitchen counter. The bottle remained there throughout the morning. At 10:44 AM Surveyor observed Resident 3 wandering unsupervised in the facility and lingering at the counter in the immediate vicinity of the cleaner. At 4:27 PM during an interview with Resident 2 in his/her room, Surveyor observed a bottle of 409 multi-surface cleaner with a label, "CAUTION CAUSES MODERATE EYE IRRITATION...KEEP OUT OF REACH OF CHILDREN."	N 499		

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 02/03/2026

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 499	Continued From page 95 During an interview with Administrator A on 01/26/2026 at 6:08 PM, Surveyor reviewed the concerns with unsecured toxic chemicals. Administrator A acknowledged the observations. The only explanation s/he offered was that Resident 2 may have bought the 409 cleaner on his/her own. Surveyor returned to the facility on 02/02/2026 at 9:45 AM and made observations in the large west side bathroom and small north side bathroom. The cleaning chemicals remained unsecured under the bathroom sinks. Cross Reference: N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0214 DHS 83.15(3)(b) Administrator Shall Supervise Daily Operation	N 499		
N 617	83.55(6)(b) Bath and toilet areas: water temperature The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency. This Rule is not met as evidenced by: Based on observation and interview, the temperature of water at 3 of 4 bathroom sinks accessible by residents exceeded 115 °F; the temperatures were 139.8°F, 135.3°F and 126.5°F	N 617		

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 02/03/2026

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 617	Continued From page 96 Findings include: The provider is licensed to serve up to 8 semi-ambulatory residents from the following client groups: developmentally disabled, irreversible dementia/Alzheimer's, physically disabled, terminally ill, traumatic brain injury and emotionally disturbed/mental illness. On 01/26/2026 at beginning at 10:23 AM, Surveyor tested the water temperatures at the sinks of 3 bathrooms accessible to residents. --north hall/large bathroom: 135.3°F --north hall/small bathroom 139.8°F --west hall/small bathroom 126.5°F On 01/26/2026 at 11:35 AM, Surveyor interviewed Caregiver M. S/he stated s/he has noticed the water can get "super hot, I didn't know that was a problem." Caregiver M acknowledged some of the residents might not be able to recognize risks associated with hot water, including Resident 3 who has progressed dementia. S/he added that Resident 3 does not like his/her water too hot. SURVEYOR NOTE: "Exposure to hot water is a potential environmental danger for clients. Elderly clients and clients with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding, e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability." Sustained contact with dangerously hot water can result in second	N 617		

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 02/03/2026

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 617	Continued From page 97 and third degree burns according to the following thresholds: -120°F: 10 minutes -127°F: 1 minutes -130°F: 30 seconds -140°F: 6 seconds Source: DQA publication P-01942, Hot Water Temperatures in Adult Family Homes, 08/2017 Cross Reference: N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0214 DHS 83.15(3)(b) Administrator Shall Supervise Daily Operation	N 617		
Y3244	50.09(1)(L) Care (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 (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by:	Y3244		

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 02/03/2026

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
Y3244	Continued From page 98 Based on record review and interviews, the provider did not ensure Resident 6 received adequate and appropriate care within the capacity of the facility. On 01/01/2026, during the AM shift, Caregiver N noticed Resident 6 began experiencing a physical change in condition including abnormal gait, shakiness, a decrease in appetite, alertness and responsiveness. Caregiver N notified Administrator A of these changes during the AM shift and Administrator A told Caregiver N "[Resident 6] has episodes like that, it's normal and to keep an eye on [him/her]." There was no notification to the resident's physician or guardian regarding the changes, increased monitoring or added intervention(s) for staff to monitor [Resident 6's] health. When Caregiver O arrived for the PM shift on 01/01/2026, s/he discovered Resident 6 was not him/herself and was "Sitting on the couch slouched over, not responding to anything." At 3 PM, Caregiver O notified Administrator A of his/her findings. Administrator A told Caregiver O "[Resident 6] goes through episodes like that, has a few bad days then good days," without asking Caregiver O any additional questions or providing further instructions. Caregiver O left Resident 6 who was not responding to any stimuli, slouched over on the couch from approximately 4 PM until 7:35 PM, without seeking further medical treatment or notifying the resident's legal representative regarding the changes. At 7:35 PM, Caregiver O reaches back out to Administrator A indicating, "[Resident 6] was very,very sick and not really responding." Administrator A then begins asking additional questions and directs Caregiver O to active EMS (Emergency Medical Services). EMS was notified at 8:03 PM and transferred Resident 6 to the hospital. Resident 6 presented to the	Y3244		

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 02/03/2026

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
Y3244	Continued From page 99 hospital with life threatening findings and transition to acute inpatient hospice care. Findings include: The facility's policy and procedure undated and titled "Serious Illness or Accidents" indicated, "Response to serious illness or accidents. 1. In an emergency or when a resident is unconscious or unresponsive, call 911 immediately... 2. If a resident is extremely ill and uncomfortable or bleeding or has injured their head, call 911. 3. If a resident falls or there is an accident and the resident appears to be seriously injured, call 911... 4. If a resident falls or there is an accident and there are no injuries noted, call administrator or nurse on-call immediately for further instructions...Note: Regardless of illness or accidents, the Administrator/Nurses are to be notified as soon as possible...In case of a serious illness or accident, contact in order of sequence: 1. [Administrator A]..." On 01/26/2026, Surveyor reviewed Resident 6's closed record. Resident 6 was admitted to the facility on 08/12/2024 with diagnoses including cognitive disorder, anxiety and hypertension. The record indicated Resident 6 had a guardian and was discharged from the facility on 01/01/2026. On 01/26/2026, Surveyor reviewed Resident 6's most recent ISP (Individual Service Plan) dated 01/26/2026, which indicated, the resident ambulated independently with no assistive device, required as needed assistance with dressing, eating, mobility and walking. Additionally, Resident 6's ISP indicated, "Eating: document how much [s/he] eats, staff to assist with toileting. Staff initiate and assist with two hour toileting schedule on an ongoing basis.	Y3244		

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 02/03/2026

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
Y3244	Continued From page 100	Y3244		

Displays effective verbal skills. Can speak and sound out words. Sometimes [his/her] sentences are quite confused."

On 01/28/2026, Surveyor reviewed Resident 6's record including observation notes, vital history, current ISP, care history, TAR (treatment administration record) and eMARs (electronic Medication Administration Record) from 12/01/2025 through 01/26/2026 and the following was noted:

Resident 6's observation notes revealed the following:
~01/01/2026 at 11:30 AM- "Vitals for [Resident 6] P:72, BP: 141/65, Temp: 98.7, RR: 15, Sp 02: 97."
~01/01/2026 at 7:38 PM- "Simvastatin 40 mg tablet. No Pass: Other Problems. Resident was non-responsive during med time."
~01/01/2026 at 7:38 PM- "Quetiapine Fumarate 50 mg tablet. No Pass: Other Problems. Resident was non-responsive during med time."
~01/01/2026 at 8:30 PM- "[Resident 6] was competent but shaky and seemed a little confused when [s/he] received [his/her] 4 PM medications, which staff assisted with verbal cues, and holding med cup at an angle for resident to then use [his/her] mouth and tongue to try and get them, succeeded at taking meds, became tired and was sleeping after that. Staff had attempted at waking resident up by saying resident's name around 7:30 PM, shaking resident and bringing food to [him/her] to where resident did not move [his/her] eyes or body at all, as [s/he] was slumped over, staff wiped [his/her] nose due to it dripping excessively. Staff had then kept an eye on resident, saying [his/her] name, multiple times, around 7:45 PM, staff had rubbed resident's shoulders, saying [his/her] name,

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 02/03/2026

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
Y3244	Continued From page 101	Y3244		

rubbing ears and feet, and took temperature where [his/her] temp was at 99.8. 7:45 PM staff had prepped meds, but resident was not moving, and was in same position slumped over with snot out of [his/her] nose, staff cleaned up. Staff had attempted with no response just heavy deep breathing. Administrator was called and was told to call 911, guardian was called and was ok with sending [him/her] out. [Resident 6] was then sent to hospital by emergency services shortly after." ~01/08/2026- "[Resident 6] was discharged from the system. Discharge Reason: Hospital (unlikely to return)."

Resident 6's vital history record revealed the following blood pressure readings:
12/31/2025 at 8:31 AM- 178/113
12/31/2025 at 8:41 AM- 178/113
01/01/2026 at 9:47 AM- 170/117
01/01/2026 at 11:30 AM- 141/65
***Surveyor noted Resident 6 had an elevated blood pressure on 12/31/2025 and 01/01/2026, and no additional monitoring or physician notification was documented regarding the readings. (Normal blood pressure is less than 120/80.)

Resident 6's ISP and care history did not document any new or added cares from 12/31/2025 to 01/01/2026.

Resident 6's TARs documented toileting checks every 2 hours; No checks were documented for Resident after 2:10 PM on 12/31/2025. There was no documentation of Resident 6's food intake on 01/01/2026. Additionally, the TARs did not document any new intervention or administration of any new treatments from 12/31/2025 to 01/01/2026.

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 02/03/2026

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
Y3244	Continued From page 102	Y3244		

Resident 6's eMARs for December 2025 and January 2026 did not document any new medication or administration of any PRN (as needed) medication from 12/31/2025 to 01/1/2026.

On 01/28/2026, Surveyor reviewed an "Ambulance Service" report for Resident 6 which indicated, "Dispatch notify: 01/01/2026 at 8:03 PM, at scene: 01/01/2026 at 8:08 PM...Staff at facility called for EMS due to resident being unresponsive. Staff states the resident was unresponsive for approximately 3-4 hours, but it is unknown why 911 was not called earlier for the resident. Staff states the resident is normally alert and responds to simple commands...No other history is given. Resident also has copious amounts of brown snot coming from [his/her] right nostril, leaving a puddle on [his/her] shirt as well as a pillow...Upon arrival, crew found resident laying supine on a couch. Resident was responsive to painful stimuli...Resident was hypotensive (50s systolic)...A BGL was obtained at 224, and a tympanic temperature taken at 99.1...Due to resident's mental status, resident was unable to deny any head, neck, back, or chest pain, dizziness, nausea, vomiting, shortness of breath, headache, vision changes, fever, chills, or LOC. Resident was transported to hospital..."

Resident 6's ED (Emergency Department) report dated 01/01/2026 indicated, "[Resident 6] arrived via ambulance on 01/01/26 at 8:38 PM...Chief Complaint-Unresponsive...History of present illness: [Resident 6] arrives from local Assisted Living facility due to non-responsive episode. Resident has reportedly been non-responsive for 4 hours. Was then noted to be responsive to only pain. On EMS arrival patient had blood pressure

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 02/03/2026

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
Y3244	Continued From page 103	Y3244		

with systolic in the 60s, a lot of nasal drainage. Was provided with 1L of normal saline enroute, as well as, 10 mcg push of epinephrine x 2. Improved blood pressure and slight improvement in responsiveness. No additional information is available...Unable to perform ROS (Review of Systems): Mental status change...Physical Exam: ...General: [Resident 6] is in acute distress. Appearance: [Resident 6] is ill-appearing. Comments: Cachectic, disheveled, dried emesis on the pants and face...Mouth: Mucus Membranes are dry...Medical decision making: Discussed case, reviewed test results and consultant agrees to admit resident to the hospital for further care...Critical Care Note: [Resident 6] demonstrates life-threatening findings with the following organ system at risk: Septic shock due to aspiration pneumonia and COVID-19 infection. Due to the high probability of life threatening deterioration, the resident required complex management while in the ED...Final Diagnostic Impression: ...Septic shock-Primary, Unresponsive (Acute), COVID-19 virus infection (Acute), Hyponatremia (Acute), AKI (acute kidney injury), Aspiration pneumonia of right lower lobe, unspecified aspiration pneumonia type (Acute), Volvulus (Acute), Acute respiratory failure with hypoxia (Acute)..."

Resident 6's Hospital Discharge Summary indicated, "Date of admission: 01/01/2026. Date of discharge: 01/02/2026...Primary discharge diagnosis: Septic shock secondary to aspiration pneumonia...Hospital Course : 1. Acute hypoxic respiratory failure secondary to aspiration pneumonia and COVID infection. The resident presented from [his/her] assisted living facility after being found unresponsive with profound hypotension and hypoxia. Imaging revealed mucus plugging, tree-in-bud opacities, and debris

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 02/03/2026

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
Y3244	Continued From page 104	Y3244		

throughout the esophagus consistent with aspiration, COVID infection was also confirmed. [Resident 6] required high-flow oxygen support and broad-spectrum antibiotics. Despite therapy, [s/he] remained oxygen-dependent with progressive physiologic decline. 2. Acute metabolic encephalopathy superimposed on advanced dementia. On arrival [Resident 6] was minimally responsive, improving only slightly with resuscitation. [His/her] baseline dementia was reported as end-stage, with prior hospice discussions already underway. Throughout admission [s/he] remained encephalopathic and unable to meaningfully interact or participate in care. 3. Septic shock secondary to aspiration pneumonia and suspected sigmoid volvulus. [Resident 6] presented in shock requiring IV fluids and vasopressor support. Clinical concerns included aspiration pneumonia, COVID, hypovolemia, and possible sigmoid volvulus. [Resident 6's] legal guardian declined endoscopic or surgical intervention given [his/her] critical illness and end-stage dementia, as the likelihood of meaningful recovery was extremely low. Medical therapy and comfort-focused supportive care were continued. 4. Acute kidney injury-Creatinine was elevated on admission and improved modestly with fluid resuscitation... 5. Severe protein-calorie malnutrition. [Resident 6] appeared cachectic with minimal muscle mass, reflecting chronic progressive decline and advanced frailty. After ongoing discussions with [Resident 6's] court-appointed guardian, the care team and guardian agreed that further life-prolonging treatment would not be consistent with [his/her] values or goals, given [his/her] end-stage dementia, severe infection, and dependence on high-level medical support with no realistic chance of meaningful recovery. [Resident 6's] code status was changed to DNR,

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 02/03/2026

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
Y3244	Continued From page 105	Y3244		

and plans were made to transition to acute inpatient hospice for compassionate withdrawal of life-sustaining treatment and to allow a natural death with comfort and dignity. Hospice consulted and working to transition care..."

On 01/26/2026, Surveyor reviewed text messages between Administrator A and Caregiver O regarding Resident 6 which revealed the following:

~01/01/2026 at 3 PM Caregiver O sent Administrator A a text stating, "[Resident 6] is very out of it. We have [him/her] on the couch and snuggled however [s/he] is not [him/herself] at all."
~01/01/2026 at 3:57 PM Administrator A replies "[S/he] goes thru episodes like that."
~01/01/2026 at 4:01 PM Caregiver O states "The month that I've been here, I have not endured what I'm enduring now. But noted."
~01/01/2026 at 4:04 PM Administrator A replies "[S/he] has a few bad days then good days, it is like [his/her] brain shuts down. Then [s/he] wakes up again."
~01/01/2026 at 4:11 PM Caregiver O states, "Gotcha."
***Surveyor noted Administrator A does not ask Caregiver O any probing questions about Resident 6 being "out of it and not him/herself" or give Caregiver O any further instructions.
~01/01/2026 at 7:35 PM Caregiver sent Administrator A another text stating, "[Resident 6] is very, very sick. [His/her] nose has been just pouring out all day and been in the same spot sleeping. I got [his/her] 4 PM meds however tonight in this moment [s/he's] not really responding. I tapped [him/her] a few times, said [his/her] name. Approached [him/her] a few times already just to see how [s/he] would

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 02/03/2026

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
Y3244	Continued From page 106	Y3244		

respond and [s/he] hasn't. Wiping [his/her] nose the few times I have as well no reaction. So I may put [his/her] meds in as other problems and not give them as I don't think [s/he] is able to take them."
~01/01/2026 at 7:36 PM Administrator A replies, "Who."
~01/01/2026 at 7:36 PM Caregiver O states, "[Resident 6]."
~01/01/2026 at 7:39 PM Administrator replies, "[Resident 6]? Give [him/her] Tylenol [s/he] probably has the cold that [Resident 3] had. Does [s/he] have any quafenison? Does [s/he] have a cough? Does [s/he] have a fever?"
~01/01/2026 at 7:40 PM Caregiver O states, "I'm unable to give [him/her] any meds [s/he's] non-responsive...I attempted to give [his/her] regular meds and [s/he] doesn't even move. [S/he's] breathing, but I tapped as I mentioned, I said [his/her] name shook [him/her] etc."
~01/01/2026 at 7:41 PM Administrator A replies, "Is [s/he] breathing? Is [s/he] sleeping? Does [s/he] have a fever? Did [s/he] eat at all? Does [s/he] need to be sent out to the ED?"
~01/01/2026 at 7:45 PM Caregiver O states, "[His/her] temp 99.8."
~01/01/2026 at 7:46 PM Administrator A replies, "Is [s/he] coughing? [S/he] won't take Tylenol? I am sure [s/he] has a virus but [s/he] is so fragile."
~01/01/2026 at 7:47 PM Caregiver O states, "It's like [s/he's] sleeping but [s/he's] not. [S/he] won't wake up or react to anything. [S/he] don't move or even have reaction to the thermometer. I rubbed [his/her] ears etc. I tried for the past 30 minutes and [s/he] didn't eat. [S/he] won't respond or even be alert. [S/he's] slumped. [S/he] was coughing earlier but now it's just silence. [S/he] hasn't moved for the past 3 hours. I attempted to feed him/her on the couch and [s/he] didn't wake up for that either. I shook [him/her]. I said loudly

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 02/03/2026

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
Y3244	Continued From page 107	Y3244		

[his/her] name, and did the same just now and have been. [S/he] seems like [s/he's] resting but no movement or reaction. Not even [his/her] eyes move. When they're closed normally you can see them moving..."
~01/01/2026 at 7:54 PM Administrator A replies, "Ok lets send [him/her] out, I just talked to [his/her] guardian send [him/her] out to the hospital for change of condition. Due to fever and unable to arouse [him/her]. Go print out a face sheet and call non emergency."
~01/01/2026 at 7:55 PM, Caregiver O states, "Okay will do."
~01/01/2026 at 7:55 PM Administrator replies, "Let them know [s/he] is not responding call 911."
~01/01/2026 at 8:24 PM Administrator states, "I was not updated that [s/he] had been unresponsive."
~01/01/2026 at 8:28 PM, Caregiver O replies, "Yeah, I understand that. The two paramedics asked me "How long did you say [s/he] was like this?" I said well 3 hours but I figured [s/he] was asleep, [s/he] moved around 4p but became like this at 5p, and I kept an eye on [him/her]...Paramedics questioned the throw up on the pillow and said, "Do you know about this? I said I thought it was snot I didn't see that much..."
~01/01/2026 at 8:28 PM, Administrator A replies, "I was not aware of that either."

Interviews

On 01/26/2026 at 12:02 PM, Surveyors interviewed Caregiver M regarding Resident 6. Caregiver M stated, "[Resident 6] had dementia... [S/he] loved to eat, like a horse. [Resident 6] would feed [him/herself] and would never miss a meal. [Resident 6] was able to walk on [his/her] own. [Resident 6] was incontinent at times of urine and stool...[S/he] did wear an incontinent

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 02/03/2026

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
Y3244	Continued From page 108	Y3244		

brief...When taking medications [Resident 6] would always take the med cup and pour the meds into [his/her] mouth, without staff helping. [Resident 6] never needed assistance with holding the med cup and never used [his/her] tongue to get the meds out." Surveyors asked if Resident 6 had episodes of unresponsiveness. Caregiver M stated, "I've never experienced an episode of unresponsiveness with [Resident 6]... [Resident 6] has no known history of episodes where [s/he] goes in and out of responsiveness." Surveyors questioned Caregiver M if s/he had any knowledge of the 01/01/2026 incident with Resident 6. Caregiver M indicated the building was staffed with one caregiver on the AM shift, PM and night shift and stated, "On 01/01/2026, [Caregiver N] was here during the AM shift, and [Caregiver O] was here during the PM shift. I heard [Resident 6] was found unresponsive...I don't know why it took staff so long to send [him/her] out, it's frustrating...It's really sad [s/he's] not here anymore." Surveyor and Caregiver M then looked at Resident 6's record. Caregiver M confirmed Resident 6's record did not contain documentation of the resident's meal intakes or any additional monitoring or added intervention(s) on 01/01/2026. Caregiver M also confirmed the last documented 2 hour toileting checks completed for Resident 6 was on 12/31/2025 at 2:10 PM, and there were no additional checks documented.

On 01/28/2026 at 11:50 AM, Surveyor interviewed Caregiver N regarding Resident 6. Caregiver N indicated Resident 6 ambulated on his/her own, ate 100% of meals, toileted [him/herself] at times and was alert and awake throughout the day. Caregiver N stated, "[Resident 6] would talk often to other residents and had no problems taking [his/her] meds. [Resident 6] would take the cup

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 02/03/2026

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
Y3244	Continued From page 109	Y3244		

of meds from me and dump them into [his/her] mouth." Surveyor asked Caregiver N about Resident 6 on 01/01/2026. Caregiver N verified s/he worked the AM shift alone on 01/01/2026 and stated, "During the AM shift on 01/01/2026, I notified [Administrator A] through the home base app (a facility app for communication, etc.) and by the facility land line [Resident 6] was shaky, lethargic, more confused than normal, wasn't eating, having issues sitting up, and that something was really wrong with [Resident 6]. [Administrator A's] response was that's normal for [Resident 6], [s/he] has episodes like that and to keep and eye on [him/her]. I remember during lunch on 01/01/2026, [Resident 6] was shaky, flaring [his/her] arms around and almost fell off the dining room chair. I called [Administrator A] on the facility land line and told [her/her] this information and said [Resident 6] definitely needs to be send out, but again [Administrator A] told me that's normal for [Resident 6]...[Administrator A] did tell me to get a set of vitals on [him/her], which I did take at 11:30 AM and charted them. I asked [Administrator A] what I should do and [s/he] said "Just keep an eye on [Resident 6]." Surveyor questioned Caregiver N if Resident 6's noted changes were reported to the resident's physician and guardian. Caregiver N stated, "No, they weren't, and I didn't send [Resident 6] out to the hospital because [Administrator A] said not to." Caregiver N indicated s/he kept an eye on Resident 6 during the AM shift on 01/01/2026, but did not document any increased monitoring or checks, except for the set of vitals at 11:30 AM. Caregiver N stated, "If staff do document something on a resident, [Administrator A] deletes it from the computer charting." Surveyor asked Caregiver N what the facility's policy and procedure was when a resident has a noted change of condition. Caregiver N stated, "My

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 02/03/2026

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
Y3244	Continued From page 110	Y3244		

understanding is we need to go through [Administrator A] for further instructions." Surveyor then ask what s/he reported to the oncoming staff (Caregiver O) regarding Resident 6. Caregiver N stated, "When [Caregiver O] came in I told [him/her], [Resident 6] was off, not really talking or eating, and was very stubbly and shaky. I told [Caregiver O] if [Resident 6] would get up to walk on [his/her] own [s/he] would fall."

On 01/27/2026 at 4:10 PM, Surveyor interviewed Caregiver O regarding Resident 6. Caregiver O stated, "[Resident 6] was energetic, helpful and very talkative, even through the words coming out of [his/her] mouth didn't make sense. [Resident 6] would walk all the around the building 24/7 and loved to eat...[Resident 6] was constantly eating, [s/he] would eat all [his/her] meals and sometimes ask for seconds or thirds. [Resident 6] was incontinent of urine and stool and needed prompting and cueing." Surveyor asked Caregiver O about Resident 6 on 01/01/2026. Caregiver O verified working the PM shift alone on 01/01/2026 and stated, "I arrived for the PM shift around 2:30 PM and relieved [Caregiver N] from [her/his] shift. [Caregiver N] told me to keep an eye on [Resident 6] because [s/he] wasn't [him/herself] and [s/he] was running a fever. [Caregiver N] told me [s/he] notified [Administrator A] and [Administrator A] won't do [explicit]. [Caregiver N] told [Administrator A] [Resident 6] was barely eating and kept saying something serious is going on with [Resident 6], but [Administrator A] wouldn't do anything. [Administrator A] blew [Caregiver N] off when [s/he] notified [her/him] saying something like "[Resident 6] goes thru episodes like that." When I arrived and looked at [Resident 6] I noticed [s/he] wasn't feeling well. [Resident 6] was sitting on the couch slouched over with [his/her] head

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 02/03/2026

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
Y3244	Continued From page 111	Y3244		

down, not really responding to anything. That's when I texted [Administrator A] at 3 PM to tell [her/him] [Resident 6] was not [him/herself]. [Administrator A] didn't give me any instructions or ask me any questions, but what I was seeing was totally out of character for [Resident 6], [s/he] was going down hill fast and it was more then a fever..." Surveyor then asked Caregiver O if a set of vitals were completed for Resident 6 at that time. Caregiver O stated, "No. I didn't document any vitals or extra monitoring...At some point I did take [Resident 6's] temperature and it was almost 100 degrees....[Resident 6] didn't eat supper, [s/he] was nonverbal, not really moving and almost looked deceased around supper time..." Surveyor questioned Caregiver O if Resident 6's noted changes were reported to the resident's physician and guardian. Caregiver O stated, "No. Only [Administrator A] notifies the doctors and guardians." Surveyor asked if s/he attempted to reach back out to Administrator A after 4:11 PM on 01/01/2026." Caregiver O stated, "No, I was waiting it out a little bit, because [Administrator A] usually yells at me or hangs up on me when I call to ask questions...It did come to my mind to text [Administrator A] back or call [her/him] sooner, but I didn't and probably should've." Surveyor asked Caregiver O what the policy and procedure was when a resident has a noted change of condition. Caregiver O stated, "I believe protocol is to call [Administrator A] first and [s/he] gives the approval to send the resident out." Caregiver O confirmed [s/he] left [Resident 6] sitting on the couch slouched over with [his/her] head down for approximately three (3) to 4 hours without reaching out to the resident's physician, guardian or EMS regarding the changes. Caregiver O then stated, "I did text [Administrator A] again at 7:35 PM to tell [her/him] [Resident 6] was very sick. [Administrator A] told me I could send [Resident

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 02/03/2026

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
Y3244	Continued From page 112	Y3244		

6] out, which I did." Caregiver O indicated s/he kept an eye on Resident 6 during the PM shift on 01/01/2026, but did not document any increased monitoring or checks.

On 02/02/2026 at 11:30 AM, Surveyors interviewed Administrator A regarding the incident with Resident 6 on 01/01/2026. Administrator A indicated facility staff called his/her sometime on 01/01/2026 and reported Resident 6 was "Not feeling good, and [s/he] was taking a nap on the couch." Administrator A confirmed s/he received a call from Caregiver N around lunch time on 01/01/2026 regarding Resident 6. Administrator A indicated, "I directed [Caregiver N] to take [Resident 6's] vitals, put [him/her] on thirty-minute checks and to update me with any changes." Administrator A stated, "I never received another call back from [Caregiver N], if I would've, [Resident 6] would've been sent out." Surveyors told Administrator A there was no evidence of documented thirty-minute checks for Resident 6 on 01/01/2026 or additional vital signs after 11:30 AM. Administrator A confirmed the record did not contain evidence and indicated, "Staff should've documented the checks and vitals." Surveyors then asked Administrator A about the above text message s/he received from Caregiver O regarding Resident 6 on 01/01/2026 at 3 PM and questioned if s/he asked Caregiver O any additional questions regarding the resident's status or provided Caregiver O with further instructions. Administrator A denied receiving the 3 PM text message on 01/01/2026 from Caregiver O. (***Surveyors noted Administrator A did receive the 3 PM text message on 01/01/2026 from Caregiver O based on the above documented text message conversation.) Administrator A then stated, "I didn't receive any call or notification from [Caregiver O] about

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 02/03/2026

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
Y3244	Continued From page 113 [Resident 6] until sometime around 7:15 PM on 01/01/2026. Around 7:15 PM, I told [Caregiver O] to get a set of vitals and update me. About twenty minutes later [Caregiver O] said [Resident 6] had a fever. I then called the guardian and told [Caregiver O] to send [Resident 6] out...I called the guardian around 8 PM on 01/01/2026 and told the guardian [Resident 6] wasn't responding to staff stimuli and staff couldn't get [Resident 6] awake." Administrator A confirmed there was no documented communication with Resident 6's physician or guardian until 8 PM on 01/01/2026. Administrator A also verified Resident 6's record did not contain documentation of additional monitoring or interventions when Resident 6 had a noted change of condition. Surveyors then asked Administrator A what s/he would expect staff to do if they noticed a resident with a change of condition. Administrator A stated, "Staff can update a resident's physician and guardian if needed and then call me and update me... If staff feel something is not right with a resident, they can call an ambulance and then me." ***Surveyor noted Resident 6's record did not contain any documentation regarding Resident 6's change of condition that began during the AM shift on 01/01/2026 except for a set of vitals at 11:30 AM. The record contained no documentation of any monitoring or added intervention(s) when the resident was noted to have a physical/mental change in condition. Additionally, the record contained no documentation regarding communication with Resident 6's physician or guardian regarding the change noted during the AM and PM shift on 01/01/2026 until sometime right before 8 PM. In conclusion, Resident 6 experienced a physical/mental change in condition during the	Y3244		

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 02/03/2026

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
Y3244	Continued From page 114 AM shift on 01/01/2026. There was no notification to the resident's physician or guardian regarding the changes, no increased monitoring or added intervention(s) for staff to monitor [Resident 6's] health. During the PM shift on 01/01/2026, Resident 6's condition worsened and s/he was unresponsive for three to four hours before EMS was contacted. Once EMS was contacted Resident 6 was transferred to the hospital with life threatening findings and placed on acute inpatient hospice care.	Y3244		