



CMS Certification Number (CCN): 525591

April 8, 2021
By Fax

Bethel Home and Services
Attn: Administrator
614 S Rock Ave
Viroqua, WI 54665

Dear Administrator:

**SUBJECT: FEDERAL MONITORING SURVEY RESULTS AND
NOTICE OF IMPOSITION OF REMEDIES
Cycle Start Date: February 4, 2021**

STATE SURVEY RESULTS

On February 3, 2021, February 4, 2021 March 2, 2021, and March 24, 2021, Life Safety Code, Health, and Complaint Surveys were completed at Bethel Home and Services by the Wisconsin Department of Health Services (WDHS) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance with the most serious deficiencies at Scope and Severity (S/S) level F, cited as follows:

- F0812 -- S/S: F -- 483.60(i)(1)(2) -- Food Procurement, Store/prepare/serve-Sanitary
- K0920 -- S/S: F -- NFPA 101 -- Electrical Equipment - Power Cords and Extensions

The February 4, 2021 survey also revealed that your facility was not in substantial compliance with Federal requirements related to infection prevention and control, cited as follows:

- F0880 -- S/S: E -- 483.80(a)(1)(2)(4)(e)(f) -- Infection Prevention & Control

The State agency advised you of the deficiencies that led to these determinations and provided you with a copy of the survey reports (CMS-2567).

FEDERAL MONITORING SURVEY (FMS)

In addition, a surveyor representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a FMS of your facility on March 25, 2021. As the surveyor informed you during the exit conference, the FMS has revealed that your facility continues to not be in substantial compliance. The FMS found deficiencies, with the most serious being at S/S level F, cited as follows:

- K0372 -- S/S: F -- NFPA 101 -- Subdivision of Building Spaces - Smoke Barrier
- K0711 -- S/S: F -- NFPA 101 -- Evacuation and Relocation Plan
- K0911 -- S/S: F -- NFPA 101 -- Electrical Systems - Other

The findings from the FMS are enclosed with this letter on form CMS-2567.

PLAN OF CORRECTION (POC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable POC for the enclosed deficiencies cited at the FMS. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's POC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice;
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and
- The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Please send your POC by fax or email to the following:

Stephen Pelinski, Branch Manager
Fax: (443) 380-6716
Email: Stephen.Pelinski@cms.hhs.gov

Please note, if you choose to email the POC, you must not include any resident personal identifiable information (PII) or personal health information (PHI). Such information may be sent by fax.

If you are unable to send the POC electronically, you may send it to the following address:

Stephen Pelinski, Branch Manager
Centers for Medicare & Medicaid Services
CMS-Chicago, Survey & Operations Group
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

INFORMAL DISPUTE RESOLUTION (IDR)

The State agency offered you an opportunity for IDR following its survey visits. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

CMS has established an IDR process to give providers one opportunity to informally refute deficiencies cited at a Federal survey, in accordance with the regulation at 42 CFR § 488.331. To request an IDR for the findings on the March 25, 2021 FMS survey, fax or email your request identifying the specific deficiencies being disputed along with an explanation of why you are disputing them and all supporting documentation to the following:

Stephen Pelinski, Branch Manager
Fax: (443) 380-6716
Email: Stephen.Pelinski@cms.hhs.gov

Please note, email requests for IDR that include any resident personal identifiable information (PII) or personal health information (PHI), must be sent encrypted.

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

You must submit your request for IDR within ten (10) calendar days from the receipt of this notice. We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution, so that CMS may also have counsel present.

The facility must request independent IDR in writing within 10 days of receipt of CMS's offer. However, a facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the civil money penalty.

LIFE SAFETY CODE (LSC) WAIVERS

If you request an annual waiver for a LSC deficiency cited during the FMS, the request must indicate why correcting would impose an unreasonable hardship on the facility; if high cost is the hardship, you must include recent, bona fide cost estimates. In addition, the request must indicate how continued non-correction of the deficiency will not pose a risk to resident safety, based on additional compensating features or other reasons.

Each cited deficiency (other than those which receive annual waivers) must be corrected within a reasonable timeframe. If a reasonable correction date falls beyond your enforcement cycle's denial of payment effectuation date, you may request a temporary waiver to allow correction by the reasonable date, and without the specific noncompliance leading to the imposition of remedies. Include a request for a temporary waiver as part of your POC, indicating the basis for the length of correction time needed, and include a timetable for correction. A temporary waiver may be granted if the POC date extends beyond the date that a denial of payment remedy will effectuate for this enforcement cycle and if the correction timeframe is reasonable, in CMS' judgment. Your enforcement cycle's denial of payment effectuation date is March 20, 2021.

SUMMARY OF ENFORCEMENT REMEDIES

As a result of the survey findings, and as authorized by the Centers for Medicare & Medicaid Services (CMS), the WDHS notified you on February 18, 2021, of the imposition of the following remedies, as well as your appeal rights:

- Directed Plan of Correction effective March 5, 2021
- Discretionary Denial of Payment for New Admissions effective March 20, 2021

In addition, CMS is imposing the following remedy:

- Federal Civil Money Penalty

The authority for the imposition of remedies is contained in subsections 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR § 488 Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

DENIAL OF PAYMENT FOR NEW ADMISSIONS

WDHS notified you that denial of payment for all new Medicare admissions was imposed effective March 20, 2021. This action is taken pursuant to § 1819(h)(2)(B) of the Act. We will notify National Government Services that the denial of payment for all new Medicare admissions is effective on March 20, 2021. We will further notify the State Medicaid agency that they must also deny payment for all new Medicaid admissions effective March 20, 2021 pursuant to § 1919(h)(2)(A) of the Act and Federal regulations at 42 CFR § 488.417(a).

You should notify all Medicare and Medicaid residents admitted on or after this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payment for new admissions.

CIVIL MONEY PENALTY

In determining the amount of the CMP that we are imposing, we have considered your facility's history, including any repeated deficiencies; its financial condition; and the factors specified in the Federal requirement at 42 CFR § 488.404. We are imposing the following CMP:

- Federal Civil Money Penalty of \$15,000.00 per instance for the instance of noncompliance at F0880 (S/S: E) identified in the CMS-2567 for the survey ending February 4, 2021

If you believe that you have documented evidence that should be considered in establishing the amount of the CMP, the following documents should be submitted electronically to Tasha Y. Fisher at Tasha.Fisher@cms.hhs.gov within fifteen (15) days from the receipt of this notice:

- Written, dated request specifying the reason financial hardship is alleged
- List of the supporting documents submitted
- Current balance sheet
- Current income statements
- Current cash flow statements
- Most recent full year audited financial statements prepared by an independent accounting firm, including footnotes
- Most recent full year audited financial statements of the home office and/or related entities, prepared by an independent accounting firm, including footnotes
- Disclosure of expenses and amounts paid/accrued to the home office and/or related entities
- Schedule showing amounts due to/from related companies or individuals included in the balance sheets. The schedule should list the names of related organizations or persons and indicate where the amounts appear on the balance sheet (e.g., Accounts Receivable, Notes Receivable, etc.)
- If the nursing home requests an extended payment schedule of more than twelve (12) months duration, the provider must submit a letter from a financial institution denying the provider's loan request for the amount of the CMP

The CMP is due and payable and may be placed in escrow account fifteen days after one of the following, whichever occurs first:

- The date on which an Independent IDR process is completed, if applicable or
- The date which is 90 calendar days after the date of the notice of imposition of the CMP.

CMP REDUCED IF HEARING WAIVED

If you waive your right to a hearing, **in writing**, within 60 calendar days from receipt of this notice, the amount of your CMP will be reduced by thirty-five percent (35%). To receive this reduction, the written waiver should be sent to CMS-Chicago at CMSChicagoLTCHearingWaivers@cms.hhs.gov. **Please include your CCN and the Cycle Start Date in the subject line of your email.**

The failure to request a hearing within 60 calendar days from your receipt of this notice does not constitute a waiver of your right to a hearing for purposes of the 35% reduction.

Any subsequent survey that results in a finding of continued noncompliance may affect the CMP. If, based on the new finding, the previously imposed CMP amount is continued or the CMP amount is changed, and you choose not to accept the new finding, it will be necessary for you to submit an

additional request for a hearing on the subsequent survey finding. Alternatively, you may submit a written waiver of your right to a hearing on the subsequent survey finding.

A CMP case number will be assigned to your case only when the final CMP is due and payable. At that time you will receive a notice from this office with the CMP case number and payment instructions. Prior to the assignment of a CMP case number, you must ensure that your facility's name, Your CMS Certification Number (CCN), and the enforcement cycle start date appear on any correspondence pertaining to this CMP.

- Your CMS Certification Number (CCN) is 525591.
- The start date for this cycle is February 4, 2021.

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with § 488.431, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy) to:

MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
Attention: State Appeals/IDR Review

You may also submit the information electronically through MAXIMUS Federal's Secure File Exchange. Instructions may be requested by sending an email to: StateAppealsEast@maximus.com

A request must be sent within 10 calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Please note, in accordance with 42 CFR § 488.431, the facility must request independent IDR in writing within 10 days of receipt of CMS's offer. However, a facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the civil money penalty.

TERMINATION PROVISION

If your facility has not attained substantial compliance by August 4, 2021, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the Act at §§ 1819(h) and 1919(h) and Federal regulations at 42 CFR § 488.456 and § 489.53.

We are required to provide the general public with notice of an impending termination and will publish a notice prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and

reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Social Security Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR § 489.57 will apply.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 20, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Bethel Home and Services will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 20, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS

The State survey agency previously advised of your right to appeal the noncompliance that resulted in the imposition of the following remedies:

- Directed Plan of Correction effective March 5, 2021
- Discretionary Denial of Payment for New Admissions effective March 20, 2021

Please refer to that notice and note the deadline for that appeal. As of this date, we have not received a request for a hearing.

This formal notice imposed:

- Federal Civil Money Penalty

If you disagree with the findings of noncompliance which resulted in this imposition, and the continuation of the previously imposed remedies, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR § 498.

You are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>. To file a new appeal using DAB

E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking **Civil Remedies Division** on the File New Appeal screen.
- Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at [**OSDABImmediateOffice@hhs.gov**](mailto:OSDABImmediateOffice@hhs.gov).

Please note that **all** hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing must be filed no later than 60 days from the date of receipt of this notice. Failure to do so could result in our office proceeding with collection of the CMP.

CONTACT INFORMATION

If you have any questions regarding the Federal Monitoring Life Safety Code survey, please contact Bruce W. Wexelberg at (312) 353-2859. For questions regarding this enforcement case, please contact Tasha Y. Fisher, Principal Program Representative at (312) 353-7362. Information may also be faxed to (443) 380-7567.

Sincerely,

A handwritten signature in blue ink that reads "Beth A. Karpiak". The signature is fluid and cursive, with the first name "Beth" being particularly prominent.

Beth A. Karpiak
Long Term Care Branch Manager
CMS-Chicago, Survey & Operations Group

Enclosure: Statement of Deficiencies (CMS-2567)

cc: Wisconsin Department of Health Services
Wisconsin Division of Medicaid Services
Wisconsin LTC Ombudsman
MetaStar
Maximus
U.S. Department of Justice, Western District of Wisconsin