STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014482	A. BUILDING: _____ B. WING _____	R 09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHSAIDA FAMILY HOME 4	2521 SCENIC RIDGE DR MADISON, WI 53719

(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
{M 000}	INITIAL COMMENTS From 09/20/2023 to 09/25/2023, Surveyor conducted a verification visit and self-report review at Bethsaida Family Home 4, an AFH in Madison. Three deficiencies were identified. Two deficiencies are repeat deficiencies - See Statement of Deficiency (SOD) 00BF13, dated 09/28/2022, 00BF14, dated 01/25/2023 and 00BF15, dated 06/12/2023. The self-report review resulted in a deficiency. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 3	{M 000}		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian.	M 424		

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

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 3's individual service plan (ISP) was updated, in writing, when Resident 1's needs changed. Resident 1's need for an AngelSense tracker and alarmed doors was not included in his/her ISP.

Findings include:

On 09/20/2023 at approximately 8:00 a.m., Surveyor reviewed a self-report submitted to the department by the provider that stated Resident 3 eloped from the provider's home on 09/10/2023. The report stated Resident 3's 1:1 caregiver left Resident 3 in his/her room to gather laundry from the home's basement and Resident 3 left the home at that time. Resident 3 was not wearing his/her tracking device. Resident 3 was found at a park near the home with law enforcement present.

On 09/20/2023 at approximately 9:00 a.m., Surveyor interviewed Caregiver G. Caregiver G stated as Resident 3's 1:1 caregiver, s/he should have "eyes on [Resident 3] at all times, but on 09/10/2023, Caregiver G went to the home's basement to gather laundry. Caregiver G stated Resident 3 was content in his/her room on a tablet when Caregiver G went downstairs. Caregiver G stated Caregiver S was also present at the home, but responsible for the other 2 residents. Caregiver G stated when s/he returned from the basement, Resident 3 was gone. Caregiver G stated after searching the home, Caregiver G noted the front door was alarming very quietly. Caregiver G went to the park nearby and found Resident 3 with law enforcement

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present. Caregiver G stated s/he estimated Resident 3 was gone for approximately 10 minutes.

On 09/20/2023 at approximately 9:15 a.m., Surveyor reviewed resident records. Resident 3 was admitted to the provider's home on 09/04/2017 with diagnosis of autism. Resident 3's ISP, dated July 2023, stated Resident 3 was an elopement risk and needed 24/7 close supervision. The ISP did not indicate Resident 3 wore an AngelSense tracker or that the home had alarmed doors. The ISP referenced an updated behavioral support plan (BSP) that was not in Resident 3's record.

On 09/25/2023 at approximately 10:00 a.m., Surveyor received Resident 3's BSP. Resident 3's BSP did not indicate Resident 3 wore an AngelSense tracker or that the home's doors were alarmed.

On 09/25/2023 at approximately 4:00 p.m., Surveyor interviewed Administrator F. Surveyor asked Administrator F when Resident 3 began wearing an AngelSense tracker and when the home's doors were alarmed. Administrator F stated the AngelSense tracker should have been included in Resident 3's July 2023 ISP and that the home's doors had been alarmed "for a long time." Administrator F stated Resident 3's AngelSense tracker was not on him/her on 09/10/2023 because the device was charging, but that charging should occur during the overnight hours.

Resident 3's ISP was not updated to include his/her AngelSense tracker and the home's alarmed front doors, both which are interventions due to Resident 3's risk of elopement.

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{M 462}	88.07(3)(c) MEDICATION ASSISTANCE If the licensee or service provider assists a resident with prescription medication, the licensee or service provider shall help the resident securely store the medication, take the correct dosage at the correct time and communicate effectively with his or her physician. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the provider had all prescribed medications available for 1 of 3 residents reviewed. Resident 1 did not have his/her Risperidone, prescribed as needed, available to him/her. This is a repeat deficiency. See Statement of Deficiency (SOD) 00BF13, dated 09/28/2022 and 00BF15, dated 06/12/2023. Findings include: On 09/20/2023 at approximately 9:15 a.m., Surveyor reviewed resident records and resident medications. Resident 1 was admitted to the provider's home on 11/18/2013 with diagnosis of seizure disorder. Surveyor reviewed Resident 1's physician orders, which included Risperidone 1 mg (Start Date: 08/04/2023) - Take 1 tablet by mouth once daily PRN for agitation. Surveyor reviewed Resident 1's medications stored in the home and was unable to locate Risperidone PRN for Resident 1. On 09/20/2023 at approximately 9:30 a.m.,	{M 462}		

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{M 462}	Continued From page 4 Surveyor shared concern with Administrator F, Medical Coordinator B and House Manager Q that Resident 1 did not have his/her Risperidone PRN available to him/her. Administrator F reviewed medications in the home and confirmed Risperidone PRN was not available. Medical Coordinator B stated, "We may need to reorder." On 09/20/2023 at approximately 12:00 p.m., Surveyor interviewed Pharmacy Tech R. Pharmacy Tech R confirmed Resident 1 had an active order for Risperidone PRN and that refills were available, but not requested from the provider.	{M 462}		
{M 466}	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications controlled, dispensed or administered by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication and errors and omissions. The medication controlled by the licensee shall be kept in a locked place. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the medications administered or omitted to 3 of 3 residents reviewed were recorded. Resident 1 had medications administered and omitted without being documented. Resident 3 and Resident 4 had medications administered that were not documented.	{M 466}		

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{M 466}	Continued From page 5 This is a repeat deficiency. See Statement of Deficiency (SOD) 00BF13, dated 09/28/2022, 00BF14, dated 01/25/2023 and 00BF15, dated 06/12/2023. Findings include: On 09/20/2023 at approximately 9:15 a.m., Surveyor reviewed resident records with Caregiver S, including Medication Administration Records (MAR), which documented the following: Example 1 - Resident 1: Resident 1 was admitted to the provider's home on 11/18/2013 with diagnosis of seizure disorder. - Resident 1's physician orders included, "Polyethylene Glycol 3350 Powder (Start Date: 05/11/2023) - Mix 17 grams in 4-8 oz of liquid, stir well and drink once daily. If loose stools, decrease to half capful once daily for constipation." Resident 1's MAR, dated 09/01/2023 to 09/20/2023, had 0 entries or notations regarding the administration of his/her Polyethylene Glycol. Surveyor asked Caregiver S if s/he administered Resident 1 his/her Polyethylene Glycol. Caregiver S stated s/he had not administered Polyethylene Glycol because Resident 1 had routine bowel movements and the bowel movements became "runny" if the medication was administered. Surveyor asked Caregiver S if s/he documented anywhere that the medication was offered but refused. Caregiver S replied, "No." - Resident 1's 8:00 a.m. medications for 09/20/2023, including Calcium 600 mg, Calcium Citrate 200 mg, Cetirizine 10 mg, Lamotrigine 150, Multivitamin, Omeprazole 20 mg, Vitamin D3	{M 466}		

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{M 466}	Continued From page 6 2000 IU and Clobazam 10 mg, were not documented as administered in the MAR. Caregiver S stated s/he had administered the medications that morning (09/20/2023), but had not documented the administration yet. Example 2 - Resident 3: Resident 3 was admitted to the provider's home on 09/04/2017 with diagnosis of autism. - Resident 3's 8:00 p.m. medications for 09/19/2023, including Clonidine .2 mg, Melatonin 3 mg, Risperidone 2 mg, Trazadone 100 mg, Vraylar 6 mg and Valproic Acid 250 mg/5ml, were not documented as administered. Caregiver S stated s/he had administered the medications that evening, but had not documented the administration yet. - Resident 3's 8:00 a.m. medications, including Risperidone 2 mg, Vitamin D3 2000 IU, Vyvanyse 50 g and Valproic Acid 250 mg/5 ml, were not documented as administered. Caregiver S stated s/he had administered the medications that morning (09/20/2023), but had not documented the administration yet. Example 3 - Resident 4: Resident 4 was admitted to the provider on 03/25/2014 with diagnoses of autism and developmental delay. - Resident 4's 8:00 a.m. medications, including Propranolol, Vitamin D3 1000 IU, Acetaminophen 50 mg and Docusate 100 mg, were not documented as administered in the MAR. Caregiver S stated s/he had administered the medications that morning (09/20/2023), but had not documented the administration yet.	{M 466}		

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{M 466}	Continued From page 7 On 09/20/2023 at approximately 9:30 a.m., Surveyor shared concern with Administrator F, Medical Coordinator B and House Manager Q that medications were administered or omitted without being documented. Medical Coordinator B stated s/he was aware Resident 1's Polyethylene Glycol was not being administered daily and stated s/he should reach out to the physician to change the order. Administrator F acknowledged documentation was a concern. Administrator F stated, "It was a concern last time too. I'm embarrassed."	{M 466}		