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 02/07/2024

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 02/05/2024 to 02/07/2024, Surveyor conducted a verification visit at Bethsaida Family Home 4, an AFH in Madison. Two deficiencies were identified. Both are repeat deficiencies - See Statement of Deficiency (SOD) 00BF13, dated 09/28/2022; SOD 00BF14, dated 01/25/2023; SOD 00BF15, dated 06/12/2023 and SOD 00BF16, dated 09/25/2023. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 3	{M 000}		
{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 1 of 3 residents received the correct medication at the correct time. Resident 1 was administered his/her Melatonin at 8:00 a.m. rather than 8:00 p.m. Resident 1 did not receive his/her Aspirin 81 mg as prescribed 3 times in 5 days. This is a repeat deficiency. See Statement of	{M 462}		

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

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{M 462}	Continued From page 1 Deficiency (SOD) 00BF13, dated 09/28/2022; 00BF15, dated 06/12/2023 and SOD 00BF16, dated 09/25/2023. Findings include: On 02/05/2024 at approximately 1:00 p.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's home on 11/18/2013 with diagnosis of seizure disorder. Resident 1's record included the following orders: - Melatonin 5 mg (Start Date: 03/14/2023): Take 1 tablet every night. - Melatonin 10 mg (Start Date: 02/01/2024): Take 1 tablet every night. - Aspirin 81 mg (Start Date: 01/31/2024): Take 1 tablet every morning. On 02/05/2024 at approximately 1:30 p.m., Surveyor reviewed Resident 1's medications that remained available in his/her medication bin with Medical Coordinator B. The following concerns were identified: - Resident 1's Melatonin 10 mg for 02/05/2024 at 8:00 p.m. was not in his/her medication bin. - Resident 1's Aspirin 81 mg for 02/03/2024, 02/04/2024 and 02/05/2024 remained in his/her medication bin. On 02/05/2024 at approximately 2:00 p.m., Surveyor and Medical Coordinator B interviewed Caregiver T. Caregiver T stated s/he administered Resident 1 his/her medications that morning. Caregiver T reviewed Resident 1's medication packages and realized s/he administered Resident 1 Melatonin 10 mg rather than Aspirin 81 mg. Caregiver T stated s/he had not worked over the weekend and was confused	{M 462}		

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{M 462}	Continued From page 2 by some medications being packaged separately from a pouch that contained the majority of Resident 1's medications. Medical Coordinator B acknowledged Caregiver T's medication error and that Resident 1's Aspirin 81 mg had not been administered 02/03/2024 through 02/05/2024. Medical Coordinator B stated s/he provided education, but caregivers continued to change at the home.	{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 to 1 of 3 residents reviewed were recorded. Resident 1's medications were not recorded as administered. This is a repeat deficiency. See Statement of Deficiency (SOD) 00BF13, dated 09/28/2022; SOD 00BF14, dated 01/25/2023; SOD 00BF15, dated 06/12/2023 and SOD 00BF16, dated 09/25/2023. Findings include:	{M 466}		

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{M 466}	Continued From page 3 On 02/05/2024 at approximately 1:00 p.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's home on 11/18/2013 with diagnosis of seizure disorder. Resident 1's record included the following orders: - Melatonin 5 mg (Start Date: 03/14/2023): Take 1 tablet every night. - Melatonin 10 mg (Start Date: 02/01/2024): Take 1 tablet every night. - Aspirin 81 mg (Start Date: 01/31/2024): Take 1 tablet every morning. On 02/05/2024 at approximately 1:30 p.m., Surveyor reviewed Resident 1's medications available at the home and Resident 1's Medication Administration Record (MAR), dated 02/01/2024 - 02/05/2024, with Medical Coordinator B. The following concerns were identified: - Melatonin 5 mg: Blank entries on 02/02/2024 and 02/04/2024. Resident 1's medication bin did not contain the Melatonin for these dates. Medical Coordinator B informed Surveyor the medications were administered, but not documented. - Melatonin 10 mg: Blank entries from 02/01/2024 through 02/04/2024. Resident 1's medication bin did not contain medications for 02/01/2024 through 02/04/2024. Medical Coordinator B stated the Melatonin 10 mg was a new order, which was delivered on 02/03/2024, and administered on 02/03/2024 and 02/04/2024. Medical Coordinator B stated caregivers forgot to document the administration. - Aspirin 81 mg: Documented as administered 02/01/2024 through 02/05/2024; however, the medications for 02/03/2024, 02/04/2024 and 02/05/2024 remained in Resident 1's medication	{M 466}		

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{M 466}	Continued From page 4 bin. Medical Coordinator B stated the medications were missed because they were new and packaged separately from the other medications. On 02/05/2024 at approximately 2:00 p.m., Medical Coordinator B acknowledged record keeping concerns with medication administration and stated s/he provided education, but caregivers continued to change at the home.	{M 466}		