STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016208	A. BUILDING: _____ B. WING _____	C 08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTHEA HOUSE	2404 MONIQUE LANE MARSHFIELD, WI 54449

(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 On 08/25/2023, with information gathered through 08/29/2023, Surveyor conducted an abbreviated licensure survey, a complaint investigation, and a self-report review. Three deficiencies were identified. Complaint was substantiated. Census: 2	M 000		
M 276	88.05(3)(a) HOME ENVIRONMENT An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on interview and observations, the provider did not maintain a safe, clean, and homelike environment. Findings include: On 08/25/2023, at approximately 10:30 AM, Surveyor toured facility and observed: Resident Bathroom: -Only 3 out of 4 lightbulbs in vanity light worked -Towel rack on wall facing the door, was missing a bracket and the bar that completed the towel rack. There was a wash cloth hanging on the available bracket. -Towel rack on wall to left while standing at vanity, was missing a bracket and the bar that completed the towel rack	M 276		

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

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M 276	Continued From page 1 Common Area - Lower Level: -Broken rocking chair -Carpeting had numerous circular stains throughout Common Area - Upper Level: -Floral print couch displayed darker stained material where individuals would sit and/or rest their arms. -Floral print sofa chair displayed darker stained material where individuals would sit and/or rest their arms. -Floral print ottoman displayed darker stained material where individuals would sit and/or rest their feet. Resident Bedrooms: -Dressers and tables displayed a thick layer of dust. Stairwell: -The carpeting had what appeared to be dark stained and matted down carpeting due to repeat usage of individuals walking up and down the stairs. Carpeting displayed black circular stains that appeared to be caused from spillage. -Hexagon shaped windowsill had numerous dead bugs sitting on it. On 08/25/2023, at approximately 11:30 AM, Surveyor interviewed Office Manager B. Office Manager B stated s/he would discuss the concerns with Facility Manager A.	M 276		
M 462	88.07(3)(c) MEDICATION ASSISTANCE If the licensee or service provider assists a resident with prescription	M 462		

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M 462	Continued From page 2	M 462		

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 1 resident's prescribed medications were refilled on a timely basis. Resident 1's Enulose (medication for liver damage) was not refilled in a timely manner resulting in him/her being hospitalized.

Findings include:

The licensee can provide cares for up to 3 residents in the client groups: traumatic brain injury, advanced aged, irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, and developmentally disabled.

On 03/27/2023, the department received a complaint that alleged residents did not receive prescribed medications.

On 08/25/2023, Surveyor reviewed Resident 1's record.

Resident 1 admitted to the home with diagnoses including major depressive disorder, anxiety, transient alteration of awareness, cirrhosis (liver damage), irreversible dementia, and traumatic brain injury.

Resident 1's April 2023 Medication Administration

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M 462	Continued From page 3	M 462		

Record (MAR) documented:
"Enulose - Take 45 ML (milliliter) (30 GM [grams]) by mouth 3 times daily at 8AM, 12PM, 5PM"
The MAR documented 04/14/2023 8:00 AM to 04/18/2023 8:00 AM the medication had not been administered due to "Not here - Not Given."

Resident 1's staff shift charting documented:
"04/15/2023 - If you take a new bottle of Enulose out of the box throw the box away otherwise we think there is a full bottle in there and don't order it on time."
"04/17/2023 - Enulose should be here tonight they didn't send Friday because they were out at the pharmacy."
"04/18/2023 - IR (incident report) #3806 for [Resident 1's] missed medication Enulose 04/14, 04/15, 04/16, 04/17, 04/18. [S/he] may need to be seen at the clinic for missing this medication."
"04/19/2023 - We got Constulose from [store] which is the same as [Resident 1's] Enulose we got a 30 day supply we will be continue to get that from [store] when we get down to the last 4 bottles I want to reorder then."
"04/19/2023 - IR #3812 for [Resident 1] was admitted to the hospital."

Resident 1's "Report of Medical Visit," dated 04/18/2023, documented:
"Reason for Visit: Shacky [sic: shaky], confused, ammonia level checked. Was admitted - discharged 04/20/2023."

On 08/25/2023, at approximately 11:30 AM, Surveyor interviewed Office Manager B and Caregiver C. Office Manager B stated the pharmacy had stated the medication could be refilled and then there was a delay and the provider had not been informed that there would be a delay. Caregiver C stated that Resident 1

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M 462	Continued From page 4 had to be sent out to the hospital to get the medication that [s/he] needed. On 08/28/2023 at 5:34 PM, Surveyor emailed Facility Manager A and Director D and asked for clarification as to why [Resident 1] did not receive his/her Enulose starting 04/14/2023 until s/he was hospitalized 04/18/2023, and if [Resident 1's] primary care physician was aware of the concern. On 08/29/2023 at 10:04 AM, Facility Manager A emailed Surveyor and stated, "The [provider] had to order the Enulose when it was getting low (it was not an automatic monthly order through the pharmacy), we should have ordered it sooner than we did, there was not clear communication from the pharmacy that they did not have Enulose in stock at their pharmacy any longer. The PCP (primary care physician) did not handle this, [the provider] switched pharmacies for [Resident 1's] Enulose."	M 462		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability.	M 570		

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M 570	Continued From page 5 This Rule is not met as evidenced by: Based on observation and interview, the provider did not safeguard residents from environmental hazards. The provider's water temperature exceeded 115° Fahrenheit (F) at resident bathroom sink faucet. Findings include: The licensee can provide cares for up to 3 residents in the client groups: traumatic brain injury, advanced aged, irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, and developmentally disabled. On 08/25/2023, at approximately 10:30 AM, Surveyor toured the environment. Surveyor tested the hot water temperatures at the residents' bathroom sink faucet which tempted at 123.5 °F. 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. (DQA publication P-01942, Hot Water Temperatures in Adult Family Homes, 08/2017). On 08/25/2023, at approximately 11:30 AM, Surveyor interviewed Office Manager B. Office Manager B stated s/he would inform maintenance to adjust the hot water heater.	M 570		

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