STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019107	A. BUILDING: _____ B. WING _____	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMA HOMES	110 EMMA CT MADISON, WI 53716

(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 01/06/2025, Surveyor conducted a standard survey at Emma Homes, an AFH in Madison. Six deficiencies were identified. Census: 4	M 000		
M 436	88.07(2)(a) SERVICES The licensee shall provide or arrange for the provision of individualized services specified in a resident's individual service plan that are the licensee's responsibility. This Rule is not met as evidenced by: Based on record review and interview, Licensee A did not ensure services specified in resident individual service plans (ISP) were provided. Licensee A did not ensure supervision was provided as indicated in 4 of 4 resident ISPs. Findings include: On 01/06/2025 at approximately 8:20 a.m., Surveyor entered the home. Surveyor was greeted by Caregiver B and Caregiver C, who reported they were working along with Caregiver D. On 01/06/2025 at approximately 8:50 a.m., Surveyor reviewed resident records, provided by Licensee A. Records documented the following: - Resident 1 admitted to the provider's home on	M 436		

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
	0019107	A. BUILDING: _____ B. WING _____	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMA HOMES	110 EMMA CT MADISON, WI 53716

(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 436	Continued From page 1 12/21/2023. Resident 1's behavioral support plan, dated 10/01/2024, indicated s/he required 1:1 supervision 24 hours/day. - Resident 2 admitted to the provider's home on 07/03/2024. Resident 2's behavioral support plan, dated 06/27/2024, indicated s/he required 1:1 supervision 24 hours/day. - Resident 3 admitted to the provider's home on 11/19/2024. Resident 3's ISP, dated 05/08/2024, indicated s/he required 24-hour supervision. - Resident 4 admitted to the provider's home on 03/23/2023. Resident 4's behavioral support plan, dated 10/01/2024, indicated s/he required 1:1 supervision 16 hours/day. *Behavioral Support Plans are an extension of the ISP. On 01/06/2025 at approximately 9:30 a.m., Surveyor interviewed Licensee A regarding the supervision needs of residents. Licensee A confirmed Resident 1 and Resident 2 required 1:1 supervision 24 hours/day. Licensee A stated Resident 4 recently changed from requiring 1:1 supervision 24 hours/day to 16 hours/day and that the 1:1 supervision should start at 7:00 a.m. Licensee A stated Resident 3 required 24 hour supervision, but not dedicated staffing. Surveyor shared concern that 3 of 4 residents required 1:1 supervision starting at 7:00 a.m., which would indicate a 4th staff member should be present to provide supervision for Resident 3, who required 24 hour supervision as 1:1 staff should not be responsible for any other residents. Surveyor shared that upon entry to the home at 8:20 a.m., only 3 staff were present. Licensee A confirmed Surveyor's understanding of the home's supervision needs and observation that only 3 staff members were present. Licensee A stated a caregiver had reported s/he would be late and didn't plan arriving to the home until 11:00 a.m.	M 436		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019107	A. BUILDING: _____ B. WING _____	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMA HOMES	110 EMMA CT MADISON, WI 53716

(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 436	Continued From page 2 Licensee A stated s/he received late notice regarding the caregiver arriving late and didn't have time to find a replacement by the 7:00 a.m. start time. Licensee A did not have a staff schedule for Surveyor to review stating "Caregivers know the days they are here."	M 436		
M 464	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written order from the resident's physician permitting the provider's staff to administer medications was received before administering medications for 2of 2 residents reviewed. The provider did not have a written order to administer medications to Resident 1 or Resident 2. Findings include: On 01/06/2025 at approximately 8:50 a.m., Surveyor reviewed Resident 1 and Resident 2's records, provided by Licensee A. Records	M 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019107	A. BUILDING: _____ B. WING _____	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMA HOMES	110 EMMA CT MADISON, WI 53716

(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 464	Continued From page 3 documented the following: - Resident 1 admitted to the provider's home on 12/21/2023. Resident 1's record indicated the provider's staff administered Resident 1's medications. Resident 1's record did not include a physician order to administer medications. - Resident 2 admitted to the provider's home on 07/03/2024. Resident 2's record indicated the provider's staff administered Resident 2's medications. Resident 2's record did not include a physician order to administer medications. On 01/06/2025 at approximately 10:30 a.m., Surveyor interviewed Licensee A and asked if s/he had a physician order permitting the provider's staff to administer medications to Resident 1 and Resident 2. Licensee A stated s/he had physician orders for the medications, but not a physician order permitting the home's staff to administer medications. Licensee A asked Surveyor if the physician order permitting the home's staff to administer medications was "best practice" or required. Licensee A and Surveyor then reviewed Chapter 88 regulations together and Licensee A stated s/he would follow up with the residents' physicians to obtain an order for medication administration.	M 464		
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	M 466		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019107	A. BUILDING: _____ B. WING _____	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMA HOMES	110 EMMA CT MADISON, WI 53716

(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 466	Continued From page 4 medication controlled by the licensee shall be kept in a locked place. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure 2 of 2 residents reviewed had accurate records of their medication administration. Resident 1's record of Polyethylene Glycol administration was not accurate. Resident 2's record of Polyethylene Glycol and Reguloid was not accurate. Findings include: On 01/06/2025 at approximately 9:50 a.m., Surveyor reviewed the provider's medication storage and resident records. The following concerns were identified: Example 1 - Resident 1: Resident 1 admitted to the provider's home on 12/21/2023. Resident 1's record indicated the provider's staff administered Resident 1's medications. Resident 1's physician orders included Polyethylene Glycol - Mix 17 grams (fill cap) in 4-8 ounces daily (Start Date: 06/28/2024). Resident 1's medication administration record (MAR), dated 10/01/2024 through 01/06/2025, documented s/he received Polyethylene Glycol daily for all except 6 days. Resident 1's medications included a 238-gram bottle of Polyethylene Glycol with a dispense date of 07/02/2024 that was approximately half full. Surveyor raised concern that the bottle of Polyethylene Glycol was greater than 5 months old and still half full when the medication was ordered daily. Licensee A acknowledged concern	M 466		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019107	A. BUILDING: _____ B. WING _____	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMA HOMES	110 EMMA CT MADISON, WI 53716

(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 466	Continued From page 5	M 466		

and stated liquid and powder medications were difficult for him/her to follow up on to ensure they were being administered as prescribed.

On 01/06/2025 at 2:10 p.m., Surveyor interviewed Pharmacy Staff E. Pharmacy Staff E stated the Polyethylene Glycol bottle with a dispense date of 07/02/2024 was the only bottle of Polyethylene Glycol the pharmacy had sent to the provider and if administered daily should have been depleted within 14 days, indicating Resident 1 did not receive his/her Polyethylene Glycol as prescribed.

Resident 1's MAR, dated 10/01/2024 to 01/06/2025, documented 92 administrations of Polyethylene Glycol; however, the provider had only received a 14 day supply of the medication from pharmacy, which was approximately ½ full.

Example 2 - Resident 2:

Resident 2 admitted to the provider's home on 07/03/2024. Resident 2's record indicated the provider's staff administered Resident 2's medications. Resident 2's physician orders included Polyethylene Glycol - Mix 17 grams (fill cap) in 4-8 ounces daily (Start Date: 03/14/2024) and Reguloid - Mix 12.2 grams in 8 ounces of water (Start Date: 11/03/2023). Resident 2's MAR, dated 10/01/2025 to 01/06/2025, indicated s/he received the Polyethylene Glycol and Reguloid daily with the only missed dose being 01/06/2025. Resident 2's medications included a 510 gram bottle of Polyethylene Glycol that had a dispense date of 03/14/2024 and was approximately half full and 2 - 13 ounce containers of Reguloid that had expired on 10/22/2024 and 11/02/2024 that were approximately 1/3 full each. Surveyor raised concern that the bottle of Polyethylene Glycol was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019107	A. BUILDING: _____ B. WING _____	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMA HOMES	110 EMMA CT MADISON, WI 53716

(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 466	Continued From page 6 greater than 10 months old and still half full when the medication was ordered daily and that Resident 2's Reguloid powders were expired. Licensee A acknowledged concern and stated liquid and powder medications were difficult for him/her to follow up on to ensure they were being administered as prescribed. On 01/06/2025 at 2:10 p.m., Surveyor interviewed Pharmacy Staff E. Pharmacy Staff E stated the Polyethylene Glycol bottle with a dispense date of 03/14/2024 was the most recent bottle of Polyethylene Glycol dispensed to the provider for Resident 2 and was a 30-day supply, indicating Resident 2 did not receive his/her Polyethylene Glycol as prescribed. Pharmacy Staff E stated the Reguloid bottles that had expired would have lasted approximately 30 days each, indicating Resident 2's Reguloid was not administered daily as prescribed. Resident 2's MAR, dated 10/01/2024 to 01/06/2025, documented 97 administrations of Polyethylene Glycol and Reguloid; however, the provider had last received a 30-day supply of Polyethylene Glycol in March 2024 and the Reguloid, had expired on 11/02/2024. On 01/06/2024 at approximately 2:20 p.m., Surveyor followed up with Licensee A to share findings from Surveyor's interview with Pharmacy Staff E, which indicated Resident 1 and Resident 2 did not receive their medications as prescribed and documented. Licensee A had no further comments for Surveyor. Cross Reference: M0582 DHS 88.10(3)(q) Medications	M 466		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019107	A. BUILDING: _____ B. WING _____	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMA HOMES	110 EMMA CT MADISON, WI 53716

(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 474	Continued From page 7	M 474		
M 474	88.07(4)(c) FOOD PREPARED AND STORED SANITARY WAY Food shall be prepared and stored in a sanitary manner. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was stored in a sanitary manner. Findings include: On 01/06/2024 at approximately 8:25 a.m., Surveyor toured the provider's home. Surveyor observed the following concerns with food storage: - The provider's chest freezer, located off the kitchen, contained a pancake and Eggo waffle that had no packaging around it. The freezer also contained a hot dog with the packaging unsecured. - The provider's freezer, attached to the refrigerator, contained a green substance in a plastic container that was not secured, not labeled and not dated. The freezer contained 2 pieces of chicken that were wrapped in a grocery bag (no additional packaging separating the meat from the bag). The freezer had hardened liquid on the surface. - The provider's refrigerator contained an unidentifiable liquid mix and green substance that were not labeled or dated. Caregiver B was unable to identify what the liquid mix or green substance was. The refrigerator contained pesto, spaghetti sauce, bologna and juice that were	M 474		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019107	A. BUILDING: _____ B. WING _____	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMA HOMES	110 EMMA CT MADISON, WI 53716

(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 474	Continued From page 8 open and not dated. The refrigerator contained cooked spaghetti and bean mix that were not secured, labeled or dated. Caregiver C reported the spaghetti and bean mix were his/hers. - The provider's microwave had hardened food covering the surface. Caregiver C reported appliances were cleaned daily. "Date marking is a way to control the growth of a bacteria called Listeria, which grows under refrigeration and is the third leading cause of death from foodborne illness in the United States." (Source: Wisconsin Food Code Fact Sheet, Date Marking of Ready-to-Eat Time-Temperature Control for Safety Foods, April 2022) On 01/06/2025 at approximately 10:30 a.m., Surveyor reviewed food safety and storage concerns with Licensee A. Licensee A stated s/he wasn't aware food needed to be dated, labeled, and replied, "Okay" to cleanliness concerns.	M 474		
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019107	A. BUILDING: _____ B. WING _____	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMA HOMES	110 EMMA CT MADISON, WI 53716

(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 570	Continued From page 9 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure residents were safeguarded from environmental hazards. The home's water temperature exceeded 120 degrees F. Findings include: On 01/06/2025 at approximately 10:00 a.m., Surveyor tested the water temperature of the provider's bathroom located on the main floor. Surveyor's thermometer read a temperature peaking at 134 degrees 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 01/06/2025 at approximately 10:15 a.m., Surveyor reviewed the provider's documentation regarding water temperature monitoring. The documentation indicated water temperature monitoring occurred monthly, but did not document the water temperature. On 01/06/2025 at approximately 10:30 a.m., Surveyor reviewed concern with Licensee A that the home's water temperature exceeded 120	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019107	A. BUILDING: _____ B. WING _____	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMA HOMES	110 EMMA CT MADISON, WI 53716

(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 570	Continued From page 10 degrees F. Licensee A stated s/he typically monitored the water temperature and was unaware the temperature was a concern. Surveyor asked Licensee A if the home had a thermometer available to compare readings. Licensee A was unable to locate a thermometer to compare readings.	M 570		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure 2 of 2 residents reviewed received all prescribed medications in the dosage and at the intervals prescribed by the residents' physicians. Resident 1 did not receive his/her Polyethylene Glycol as prescribed. Resident 2 did not receive his/her Polyethylene Glycol and Reguloid as prescribed. Findings include: On 01/06/2025 at approximately 9:50 a.m., Surveyor reviewed the provider's medication storage and resident records. The following concerns were identified:	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019107	A. BUILDING: _____ B. WING _____	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMA HOMES	110 EMMA CT MADISON, WI 53716

(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 582	Continued From page 11 Example 1 - Resident 1: Resident 1 admitted to the provider's home on 12/21/2023. Resident 1's record indicated the provider's staff administered Resident 1's medications. Resident 1's physician orders included Polyethylene Glycol - Mix 17 grams (fill cap) in 4-8 ounces daily (Start Date: 06/28/2024). Resident 1's medication administration record (MAR), dated 10/01/2024 through 01/05/2025, documented s/he received Polyethylene Glycol daily for all except 6 days. Resident 1's medications included a 238-gram bottle of Polyethylene Glycol with a dispense date of 07/02/2024 that was approximately half full. Surveyor raised concern that the bottle of Polyethylene Glycol was greater than 5 months old and still half full when the medication was ordered daily. Licensee A acknowledged concern and stated liquid and powder medications were difficult for him/her to follow up on to ensure they were being administered as prescribed. On 01/06/2025 at 2:10 p.m., Surveyor interviewed Pharmacy Staff E. Pharmacy Staff E stated the Polyethylene Glycol bottle with a dispense date of 07/02/2024 was the only bottle of Polyethylene Glycol the pharmacy had sent to the provider and if administered daily should have been depleted within 14 days, indicating Resident 1 did not receive his/her Polyethylene Glycol as prescribed. Example 2 - Resident 2: Resident 2 admitted to the provider's home on 07/03/2024. Resident 2's record indicated the provider's staff administered Resident 2's medications. Resident 2's physician orders included Polyethylene Glycol - Mix 17 grams (fill	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019107	A. BUILDING: _____ B. WING _____	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMA HOMES	110 EMMA CT MADISON, WI 53716

(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 582	Continued From page 12	M 582		

cap) in 4-8 ounces daily (Start Date: 03/14/2024) and Reguloid - Mix 12.2 grams in 8 ounces of water (Start Date: 11/03/2023). Resident 2's MAR, dated 10/01/2025 to 01/06/2025, indicated s/he received the Polyethylene Glycol and Reguloid daily with the only missed dose occurring 01/06/2025. Resident 2's medications included a 510-gram bottle of Polyethylene Glycol that had a dispense date of 03/14/2024 that was approximately half full and 2 - 13-ounce containers of Reguloid that had expired on 10/22/2024 and 11/02/2024 that were approximately 1/3 full each. Surveyor raised concern that the bottle of Polyethylene Glycol was greater than 10 months old and still half full when the medication was ordered daily and that Resident 2's Reguloid powders were expired. Licensee A acknowledged concern and stated liquid and powder medications were difficult for him/her to follow up on to ensure they were being administered as prescribed. Licensee A stated pharmacy staff had assured him/her the Reguloid was still "okay" to administer but was unable to provide documentation or a contact of whom had given this instruction. Surveyor asked Licensee A how his/her staff measured the Reguloid dose daily as the dosage was in weight and did not have a cap or scoop to use for measurement like the Polyethylene Glycol did. Licensee A reviewed the order and stated staff did not have a scale to use for measurement. Licensee A followed up with caregivers present who stated they had not administered Resident 2's Reguloid and were unaware how to measure the dose.

On 01/06/2025 at 2:10 p.m., Surveyor interviewed Pharmacy Staff E. Pharmacy Staff E stated Resident 2's Polyethylene Glycol bottle with a dispense date of 03/14/2024 was the most recent bottle of Polyethylene Glycol dispensed to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019107	A. BUILDING: _____ B. WING _____	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMA HOMES	110 EMMA CT MADISON, WI 53716

(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 582	Continued From page 13 provider for Resident 2 and was a 30-day supply, indicating Resident 2 did not receive his/her Polyethylene Glycol as prescribed. Pharmacy Staff E stated the Reguloid bottles that had expired would have lasted approximately 30 days each, indicating Resident 2's Reguloid was not administered daily as prescribed. On 01/06/2024 at approximately 2:20 p.m., Surveyor followed up with Licensee A to share findings from Surveyor's interview with Pharmacy Staff E, which indicated Resident 1 and Resident 2 did not receive their medications as prescribed. Licensee A had no further comments for Surveyor. Cross Reference: M0466 DHS 88.07(3)(e)1. Medication - Record Keeping	M 582		