STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018314	A. BUILDING: _____ B. WING _____	C 12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDY PROGRAM	2380 INDY CT DE PERE, WI 54115

(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 12/18/2025 with additional information gathered through 12/22/2025, Surveyor conducted a complaint investigation at Indy Program. As a result, 1 of 1 complaint was substantiated and 3 deficiencies were identified. Census: 4	M 000		
M 276	88.05(3)(a) Homelike 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 observation and interview, the provider did not ensure the adult family home was well-maintained and provide a homelike environment for 4 of 4 residents. Findings include: The provider is licensed to provide care for up to 4 residents who may be developmentally disabled, emotionally disturbed/mentally ill, physically disabled, advanced age, terminally ill, alcohol/drug dependent, irreversible dementia/Alzheimer's and/or have a traumatic brain injury. On 09/19/2025, the Department received a complaint alleging environmental concerns at the	M 276		

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
	0018314	A. BUILDING: _____ B. WING _____	C 12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDY PROGRAM	2380 INDY CT DE PERE, WI 54115

(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 276	Continued From page 1 home. On 12/18/2025, Surveyor conducted an onsite visit to the home. At 12:30 PM, during a tour of the home accompanied by Executive Director (ED) A, Surveyor observed the following: Shared bathroom: - 1 of 3 lightbulbs was missing from the light fixture. - The towel bar on the wall was broken. Resident 1's bedroom: - There was carpeting covering the entire floor. The carpet was dirty with dark stains, lint and other debris. - A vent on the wall near the floor was covered in a layer of dust. - There was a black-like substance resembling mold on 2 of 2 windows. - The vinyl flooring in the attached bathroom had debris and wrappers. - There was a black-like substance resembling mold in the grout on the outside of the shower. Resident 2's bedroom: - There was carpeting covering the entire floor. The carpet was dirty with dark stains, lint and other debris. Resident 3's bedroom (located in the basement): - There was a large area rug covering a tiled floor. The rug was dirty with dark stains, lint, wrappers and other debris. - The tiled flooring had crumbs, dust and other debris throughout the room. Resident 4's bedroom:	M 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018314	A. BUILDING: _____ B. WING _____	C 12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDY PROGRAM	2380 INDY CT DE PERE, WI 54115

(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 276	Continued From page 2 - The vinyl window blind was broken. - There was carpeting covering the entire floor. The carpet was dirty with dark stains, lint and other debris. Main areas: - There were bi-fold doors covering the washer and dryer in the hallway. One (1) of 2 doors was broken and was leaning up against the wall in the hallway. - The vinyl flooring behind the washer and dryer was covered in lint. It appeared the dryer vent was not secured to the dryer. - The inside of the stove in the kitchen was not clean and had a buildup of what appeared to be burnt food residue. On 12/18/2025 at 1:15 PM, Surveyor interviewed ED A and House Manager (HM) B who acknowledged Surveyor's findings. HM B reported, "The stove hasn't been cleaned in probably a year when I last cleaned it." ED A reported, "It's the staff's responsibility to clean resident rooms and [HM B's] job to follow up on it." ED A and HM B confirmed all residents in the home need cleaning assistance. ED A discussed there should be a "daily housekeeping" task in each resident's electronic record to remind staff. HM B confirmed after checking the electronic records the task was deleted in each resident record. ED A reported the task has been re-added and it includes more specific cleaning duties. On 12/22/2025 at 4:00 PM, Surveyor interviewed ED A, Licensee C and Licensee D who acknowledged Surveyor's findings. Licensee C stated they will address the concerns and work with maintenance to correct what is needed. ED A reported, "The home has already been cleaned top to bottom."	M 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018314	A. BUILDING: _____ B. WING _____	C 12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDY PROGRAM	2380 INDY CT DE PERE, WI 54115

(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 276	Continued From page 3 The provider did not ensure the home was clean and well-maintained, having the potential to affect 4 of 4 residents.	M 276		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure every prescription medication was securely stored and that it remained in its original container as received from the pharmacy for 3 of 3 residents (Resident 1, Resident 2 and Resident 3). Resident 1's prescribed Lorazepam 1 milligram (mg) tablets were repackaged in a small envelope without the pharmacy label. Resident 2's prescribed Oxcarbazepine 300 mg tablets and Quetiapine 100 mg tablets were repackaged in a small envelope without the pharmacy label.	M 458		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018314	A. BUILDING: _____ B. WING _____	C 12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDY PROGRAM	2380 INDY CT DE PERE, WI 54115

(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 458	Continued From page 4 Resident 3's prescribed Timolol 0.5% Gel Solution and Travoprost 0.004% Eye Drops were expired and not securely stored in the kitchen refrigerator. Findings include: The provider is licensed to provide care for up to 4 residents who may be developmentally disabled, emotionally disturbed/mentally ill, physically disabled, advanced age, terminally ill, alcohol/drug dependent, irreversible dementia/Alzheimer's and/or have a traumatic brain injury. On 09/19/2025, the Department received a complaint alleging concerns with food storage and medication administration. On 12/18/2025 at 9:00 AM, Surveyor conducted an onsite visit to the home. A sample of resident records were requested to include Resident 1, Resident 2 and Resident 3. At 11:00 AM during a tour of the kitchen accompanied by Executive Director (ED) A, Surveyor observed the common refrigerator. Inside the door of the refrigerator, Surveyor observed 3 packages of eye drops and a single bottle of eye drops that were unsecured in the top of the refrigerator door. The medications belonged to Resident 3 and were as follows: -Travoprost 0.004% Eye Drop, 20-day supply, dispensed 09/26/2025 with instructions to "instill 1 drop into both eyes nightly" and expires 28 days after opening. The "date opened" and "expiration date" were blank. -Travoprost 0.004% Eye Drop, 20-day supply,	M 458		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018314	A. BUILDING: _____ B. WING _____	C 12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDY PROGRAM	2380 INDY CT DE PERE, WI 54115

(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 458	Continued From page 5 dispensed 11/06/2025 with instructions to "instill 1 drop into both eyes nightly" and expires 28 days after opening. The "date opened" and "expiration date" were blank. -Timolol 0.5% Gel/Solution, 28-day supply, dispensed 10/20/2025 with instructions to "instill 1 drop into both eyes every morning (unspecified glaucoma)" and expires 28 days after opening. The "date opened" and "expiration date" were blank. -Timolol 0.5% Gel/Solution, a single unpackaged bottle. Resident 3's medications were not securely stored in the kitchen refrigerator. Surveyor also reviewed the provider's medication storage system located in a secured filing cabinet in the kitchen. ED A unlocked the medication file cabinet and Surveyor observed the following: -Resident 1's medications were located in the top drawer of the filing cabinet. There were file dividers in the drawer and there was a divider labeled with "[Resident 1] 2 PM." Hanging on the divider was a small yellow envelope with a handwritten note on the outside that read, "Weekend Lorazepam 14 now 12-1." The envelope was stapled to an empty blister pack for another medication. The envelope did not contain a pharmacy label. -Resident 2's medications were located near the bottom of the filing cabinet. There were file dividers in the drawer and there was a divider labeled with "[Resident 2] 2 PM." Inside the divider was 2 small yellow envelopes with handwritten notes on the outside. One of the	M 458		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018314	A. BUILDING: _____ B. WING _____	C 12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDY PROGRAM	2380 INDY CT DE PERE, WI 54115

(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 458	Continued From page 6	M 458		

envelopes read, "[Resident 2] Quetiapine - Weekends 12 PM - To Start." The other envelope read, "[Resident 2] Oxcarbazepine - Weekends 2 PM - To Start." Both envelopes did not contain a pharmacy label.

On 12/18/2025 at 11:15 AM, Surveyor interviewed ED A and House Manager (HM) B. ED A acknowledged the prescription medications should be secured in the refrigerator. HM B stated s/he did not have a lock box for the refrigerator. ED A stated s/he would obtain one and reiterated to HM B any resident medications need to be secured in the refrigerator. HM B acknowledged the packaged eye drops for Resident 3 were expired and proceeded to throw them in the garbage. ED A and HM B acknowledged all residents in the home ambulate independently and have access to the kitchen refrigerator. Surveyor inquired about Resident 1 and Resident 2's medications in the small envelopes located in the filing cabinet. HM B discussed Resident 1 and Resident 2 go to day program during the weekdays and they will only take the blister pack with the pharmacy label. S/he stated, "When I get the blister packs from pharmacy, I take out the weekend medications and put them in the envelopes for the weekends. The blister pack then goes to day program." ED A explained to HM B resident medications need to stay in their original packaging. ED A acknowledged Surveyor's concern and stated s/he followed up with pharmacy and they will change their packaging to ensure this does not happen again.

On 12/22/2025 at 4:00 PM, Surveyor interviewed ED A, Licensee C and Licensee D who acknowledged Surveyor's findings. Licensee C stated, "I was not aware this was happening" and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018314	A. BUILDING: _____ B. WING _____	C 12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDY PROGRAM	2380 INDY CT DE PERE, WI 54115

(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 458	Continued From page 7 they would address the concerns with HM B as it is his/her responsibility. The provider did not ensure all prescription medications were securely stored and that they remained in the original container as received from the pharmacy. Cross Reference: M0582 DHS 88.10(3)(q) Medications	M 458		
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 record review and interview, the provider did not ensure 1 of 1 resident (Resident 1) received all prescribed medications in the dosage and intervals prescribed by the resident's physician. The provider was out of Resident 1's scheduled Benztropine 1 milligram (mg) tablets and scheduled Lorazepam 1 mg tablets. Resident 1 missed a total of 6 scheduled doses of Benztropine 1 milligram (mg) tablets on 11/01/2025, 11/10/2025, 11/11/2025, 11/12/2025	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018314	A. BUILDING: _____ B. WING _____	C 12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDY PROGRAM	2380 INDY CT DE PERE, WI 54115

(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 8	M 582		

and 11/13/2025. Additionally, Resident 1 missed a total of 4 scheduled doses of Lorazepam 1 mg tablets on 11/01/2025, 11/15/2025 and 11/16/2025.

Findings include:

The provider is licensed to provide care for up to 4 residents who may be developmentally disabled, emotionally disturbed/mentally ill, physically disabled, advanced age, terminally ill, alcohol/drug dependent, irreversible dementia/Alzheimer's and/or have a traumatic brain injury.

On 09/19/2025, the Department received a complaint alleging concerns with medication administration.

On 12/18/2025 at 9:00 AM, Surveyor conducted an onsite visit to the facility. A sample of resident records were requested. Surveyor requested Resident 1's record from Executive Director (ED) A to include his/her face sheet, medication administration records (MARs), individual service plan (ISP) and physician orders. The following was identified:

Resident 1 admitted to the facility on 10/06/2017 with diagnoses to include epilepsy, developmental disorder of speech and language and other specified mental disorders due to known physiological condition. Resident 1 had a legal guardian and managed care organization (MCO). Resident 1 required staff assistance with medication administration.

Resident 1's physician orders indicated s/he was prescribed Benztropine 1 mg tablets with a start date of 07/29/2025 with instructions to "take 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018314	A. BUILDING: _____ B. WING _____	C 12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDY PROGRAM	2380 INDY CT DE PERE, WI 54115

(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 9	M 582		

tablet by mouth 3 times a day" at 8:00 AM, 12:00 PM and 8:00 PM and "reorder when needed ..." Resident 1 was also prescribed Lorazepam 1 mg tablets with a start date of 08/13/2025 with instructions to "take one tablet by mouth 3 times a day" at 8:00 AM, 2:00 PM and 8:00 PM.

Resident 1's November 2025 MAR from 11/01/2025 to 11/30/2025 reflected s/he was not administered Benztropine 1 mg tablets as scheduled on the following dates, times and reasons:

11/01/2025, 12:00 PM, "out of medication due to theft"
11/10/2025, 8:00 PM, "on reorder"
11/11/2025, 8:00 PM, "on reorder"
11/12/2025, 8:00 PM, "on reorder"
11/13/2025, 8:00 PM, "out"
11/13/2025, 8:00 AM, "out of medication"

Resident 1's November 2025 MAR also reflected s/he was not administered Lorazepam 1 mg tablets as scheduled on the following dates and times:

11/01/2025, 2:00 PM, "out of medication due to theft"
11/01/2025, 8:00 PM, "out needs to be ordered"
11/15/2025, 2:00 PM, "med was not available"
11/16/2025, 2:00 PM, "medication was not available"

Additionally, Surveyor observed "blank" dates on Resident 1's November 2025 MAR where his/her Benztropine 1 mg tablets and Lorazepam 1 mg tablets were not documented as administered. The following dates and times for Benztropine 1 mg tablets include: 11/02/2025, 12:00 PM; 11/08/2025, 12:00 PM and 8:00 PM; and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018314	A. BUILDING: _____ B. WING _____	C 12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDY PROGRAM	2380 INDY CT DE PERE, WI 54115

(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 10 11/09/2025, 12:00 PM and 8:00 PM. The following dates and times for Lorazepam 1 mg tablets include: 11/02/2025, 2:00 PM; 11/08/2025, 2:00 PM and 8:00 PM; 11/09/2025, 2:00 PM and 8:00 PM; 11/29/2025, 2:00 PM; and 11/30/2025, 2:00 PM. On 12/18/2025 at 11:00 AM, Surveyor interviewed House Manager (HM) B. Surveyor reviewed the notation on Resident 1's November 2025 MAR on 11/01/2025 which reflects "out of medication due to theft" for his/her scheduled Benztropine 1 mg tablets and Lorazepam 1 mg tablets. HM B acknowledged it was his/her initials on the MAR for 11/01/2025 and the notation was incorrect and should have reflected "out of medication." On 12/22/2025 at 4:00 PM, Surveyor interviewed ED A, Licensee C, and Licensee D who acknowledged Surveyor's findings. Licensee C stated they would address the concerns with HM B as it is his/her responsibility. Cross Reference: M0458 DHS 88.07(3)(a) Prescription Medication	M 582		