STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018010	A. BUILDING: _____ B. WING _____	R-C 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE HEART LLC INDIGO	7810 WEST BEACHWOOD AVENUE MILWAUKEE, WI 53223

(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 05/07/2025, Surveyor completed a verification visit and 3 complaint investigations. As a result, 1 of the previous deficiencies was corrected, 1 was recited and 3 new deficiencies were identified for a total of 4 deficiencies. Three complaints were substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 4	{M 000}		
M 216	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the home and operations complied with all laws governing the home and its operation. Licensee A did not ensure utilities bills and mortgage were paid. Findings include: On 09/20/2024, the department received a complaint alleging concerns with the finances of the adult family home. Record Review On 02/03/2025, at 3:00 PM Surveyor reviewed the following billing statements for the home: City of Milwaukee Water Bill	M 216		

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

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M 216	Continued From page 1 Billing date 12/20/2024 Previous Bill: $1,586.99 New Charges: $434.54 WE Energies Electric Bill Billing date 09/23/2024 Previous Balance: $2,049.44 Current Charges: $355.01 Total Current Balance: $2,034.30 Billing date 10/22/2024 Previous Balance: $2,034.30 Current Charges: $208.26 Total Current Balance: $1,428.56 Billing date 11/20/2024 Previous Balance: $1,428.56 Current Charges: $231.75 Total Current Balance: $1,384.25 Billing date 12/20/2024 Previous Balance: $1,384.25 Current Charges: $925.13 Total Current Balance: $2,033.32 Billing date 01/22/2025 Previous Balance: $2,033.32 Current Charges: $447.02 Total Current Balance: $2,499.71 Mortgage Statements Statement date 10/18/2024 Overdue payment: $1,196.94 Regular monthly payment: $1,161.00 Total amount due: $2,393.88 Statement date 11/18/2024	M 216		

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M 216	Continued From page 2 Overdue payment: $1,161.00 Regular monthly payment: $1,161.00 Total amount due: $2,322.00 Statement date 12/19/2024 Overdue payment: $1,161.00 Regular monthly payment: $1,161.00 Total amount due: $2,357.94 Statement date 01/18/2025 Overdue payment: $1,161.00 Regular monthly payment: $1,161.00 Total amount due: $2,322.00 Interviews On 01/31/2025, at 1:45 PM, Surveyor interviewed Caregiver D. Caregiver D reported staff paychecks had been late for the past 3 months. Caregiver D reported 1 time, her/his paycheck was a month late. Caregiver D reported Licensee A did not give any reason for the late paychecks. Caregiver D reported s/he was not aware of any loss of utilities. On 02/18/2025, at 2:00 PM, Surveyor interviewed Caregiver H. Caregiver H reported her/his paycheck had been late numerous times. Caregiver H reported s/he went 3 weeks without a paycheck. On 05/07/2025, at 2:00 PM, Surveyor interviewed Licensee A. Licensee A reported maybe the bills were behind due to issues with back taxes. Licensee A reported s/he had hired someone to assist her/him with taxes, and the person did not pay the taxes, which caused Licensee A to become behind. Licensee A reported the electric and water were never shut off due to nonpayment. Licensee A reported s/he was	M 216		

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M 216	Continued From page 3 caught up with bills. When Surveyor inquired about concerns with staff paychecks, Licensee A reported staff were always paid on time. When Surveyor inquired about further information regarding the past due bills, Licensee A reported s/he was current. Licensee A reported s/he thought s/he had corrected the exits, but acknowledged safety concerns with the movable ramps. Licensee A acknowledged residents were to have their prescribed medications. Licensee A raised concerns with the pharmacy would send a 28 day supply of medications for the residents and it was not her/his fault if pharmacy would not send all of the medications. When Surveyor inquired about the text messages from Manager F to the staff, Licensee A reported s/he was not aware of the messages. Licensee A reported s/he was unaware of reporting misconduct to the department, as s/he thought as a provider s/he was responsible for putting a staff member on the registry. Licensee A reported s/he would send reports to the Department.	M 216		
{M 262}	88.05(2)(a) DIFFICULTY WALKING If a resident is not able to walk at all or able to walk only with difficulty, or only with the assistance of crutches, a cane, or walker or is unable to easily negotiate stairs without assistance: 1. The exits from the home shall be ramped to grade with a hard surfaced pathway with handrails. 2. All entrance and exit doors and interior doors serving all common living areas and all bathrooms and bedrooms used by a resident not able to walk at all shall have a clear	{M 262}		

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{M 262}	Continued From page 4 opening of at least 32 inches. 3. Toilet and bathing facilities used by a resident not able to walk at all shall have enough space to provide a turning radius for the resident's wheelchair and provide accessibility appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 2 exits were ramped to grade. The rear exit of the home contained a 1 ½ inch rise between the interior floor and the exterior landing. The front exit contained a 1-inch rise between the interior floor and the exterior ramp. This deficiency is being cited for a 3rd time. See Statement of Deficiency (SOD) RUK011, dated 08/09/2023 and SOD RUK012, dated 01/18/2024. Findings include: The facility was licensed as a non-ambulatory adult family home on 05/06/2020 to serve client groups in advanced aged, developmentally disabled, emotionally disturbed/mental illness, terminally ill, irreversible dementia/Alzheimer's, physically disabled and traumatic brain injury. On 01/31/2025, at 1:30 PM, Surveyors toured the facility and observed the following: Rear Exit The rear door consisted of French doors which led to a ramp. There was a threshold ramp located on the interior floor. There was a 1-inch gap between the threshold ramp and the door frame. Surveyor was able to move the threshold	{M 262}		

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{M 262}	Continued From page 5 ramp away from the doorframe with no force. By moving the threshold ramp from the doorway, there was a 1 ½ inch rise between the interior floor and the doorframe. Front exit There was a threshold ramp located on the interior floor. Surveyor was able to move the threshold ramp away from the doorframe with no force. By moving the threshold ramp from the doorway, there was a 1-inch rise between the interior floor and the exterior landing of the ramp. The posted floor plan identified the front and rear exits as emergency exits. Resident 1 required a wheelchair for mobility. Resident 4 required a cane for mobility. On 05/07/2025, at 2:00 PM, Surveyor interviewed Licensee A. Licensee A reported s/he placed the threshold ramps by the exit doors. Licensee A confirmed the threshold ramps were not secured to the floor which caused the ramps to be movable. Licensee A reported s/he would secure the ramps to ensure they would not move from the doors.	{M 262}		
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.	M 582		

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M 582	Continued From page 6	M 582		

This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure 3 of 3 residents (Resident 1, Resident 4, and Resident 5) received prescribed medications in the dosage and at the intervals prescribed by the resident's physician. Resident 1, Resident 4, and Resident 5 did not receive their prescribed medications on 02/13/2025.

Findings including:

On 02/12/2025 and 04/15/2025, the Department received 2 complaints alleging residents were not receiving medications.

Record Review

On 02/18/2025, at 1:30 PM, Surveyor reviewed resident records and identified the following:

- Resident 1 was admitted on 10/22/2020, with diagnoses including schizophrenia, chronic obstructive pulmonary disease (COPD) and depression. Resident 1's medication administration record (MAR) dated 02/14/2025 - 03/13/2025 indicated Resident 1 was prescribed Advair inhaler twice a day, amlodipine 5 milligrams (mg) at 8:00 AM, baclofen 20 mg at 8:00 PM, bumetanide 2 mg at 8:00 AM, bupropion 100 mg at 8:00 AM, fluoxetine 60 mg at 8:00 AM, gabapentin 400 mg at 8:00 PM, lurasidone 40 mg at 8:00 PM, metformin 500 mg at 8:00 AM, Mounjaro 10 mg once a week on Mondays, omeprazole 20 mg at 8:00 AM, oxybutynin 5 mg at 8:00 AM and 8:00 PM,

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M 582	Continued From page 7	M 582		

tizanidine 8 mg at 8:00 AM, 4:00 PM, and 8:00 PM, vitamin B1 100 mg at 8:00 AM, vitamin B6 50 mg at 8:00 AM, and vitamin E 180 mg at 8:00 AM.
Resident 1's MAR was not signed for indication of medications administered as follows:

02/14/2025 at 8:00 AM - Advair inhaler, bupropion 100 mg, fluoxetine 20 mg, metformin 500 mg, omeprazole 20 mg, oxybutynin 5 mg, tizanidine 8 mg, vitamin B6 50 mg, and vitamin E 180 mg.

02/17/2025 at 8:00 AM - Mounjaro 10 mg

- Resident 4 was admitted on 07/20/2023, with diagnoses including anoxic brain injury, bilateral leg pain, and portal vein thrombosis. Resident 4's MAR, dated 02/14/2025 - 03/13/2025 indicated Resident 4 was prescribed aripiprazole 2 mg at 8:00 AM, mirtazapine 30 mg at 8:00 PM, pantoprazole 40 mg at 8:00 AM, trazodone 50 mg at 8:00 PM, and venlafaxine 75 mg at 8:00 AM.

Resident 4's MAR was not signed for indication of medication administered as follows:

02/14/2025 at 8:00 AM aripiprazole 2 mg, pantoprazole 40 mg, and venlafaxine 75 mg.

Resident 5 was admitted on 11/15/2023, with diagnoses including anxiety disorder, seizures, suicidal behavior with attempted self-injury, and hoarding behavior. Resident 5's MAR, dated 02/14/2025 - 03/13/2025 indicated Resident 5 was prescribed carbamazepine 200 mg at 8:00 AM and 8:00 PM, folic acid 1 mg at 8:00 AM, lisinopril 20 mg at 8:00 AM, multivitamin at 8:00 AM, naltrexone 50 mg at 8:00 AM, prazosin 2 mg at 8:00 PM, quetiapine 300 mg at 8:00 PM, quetiapine 50 mg at 8:00 AM and 12:00 PM,

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M 582	Continued From page 8	M 582		

rosuvastatin 10 mg at 8:00 AM, sertraline 100 mg at 8:00 AM, trazodone 100 mg at 8:00 PM, vitamin B1 100 mg at 8:00 AM, and vitamin D3 at 8:00 AM.

Resident 5's MAR was not signed for indication of medication administered as follows:

02/14/2025 at 8:00 AM folic acid 1 mg at 8:00 AM, lisinopril 20 mg, multivitamin, naltrexone 50 mg, quetiapine 50 mg, rosuvastatin 10 mg, sertraline 100 mg, vitamin B1 100 mg, and vitamin D3.

02/14/2025 at 12:00 PM quetiapine 50 mg.

On 02/18/2025, at 1:40 PM, Surveyor observed the medication closet and identified the following:

- Resident 1's medication cards cycle start date 02/14/2025

amlodipine 5 mg had 4 pills punched out, there should have been 5 pills punched out

baclofen 20 mg had 3 pills punched out, there should have been 4 pills punched out
bumetanide 2 mg had 4 pills punched out, there should have been 5 pills punched out

bupropion 100 mg had 4 pills punched out, there should have been 5 pills punched out

fluoxetine 20 mg had 4 pills punched out, there should have been 5 pills punched out

gabapentin 400 mg had 3 pills punched out, there should have been 4 pills punched out

lurasidone 40 mg had 0 pills punched out, there

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M 582	Continued From page 9 should have been 4 pills punched out metformin 500 mg had 4 pills punched out, there should have been 5 pills punched out omeprazole 20 mg had 4 pills punched out, there should have been 5 pills punched out oxybutynin 5 mg at 8:00 AM and 8:00 PM had 4 pill bubbles punched out, there should have been 8 pill bubbles punched out tizanidine 8 mg at 8:00 AM had 3 pills punched out, there should have been 5 pills punched out tizanidine 8 mg at 4:00 PM had 1 pill punched out, there should have been 4 pills punched out tizanidine 8 mg at 8:00 PM had 3 pills punched out, there should have been 4 pills punched out - Resident 4's medication cards cycle start date 02/14/2025 aripiprazole 2 mg had 4 pills punched out, there should have been 5 pills punched out mirtazapine 30 mg had 3 pills punched out, there should have been 4 pills punched out venlafaxine 75 mg had 4 pills punched out, there should have been 5 pills punched out pantoprazole 40 mg medication card was not located in the medication closet - Resident 5's medication cards cycle start date 02/14/2025 carbamazepine 200 mg had 4 pills punched out,	M 582		

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M 582	Continued From page 10 there should have been 5 pills punched out naltrexone 50 mg 6 pills punched out, there should have been 5 pills punched out quetiapine 50 mg at 12:00 PM 4 pills punched out, there should have been 5 pills punched out On 02/18/2025 at 1:58 PM, Surveyor reviewed a text message thread which had a message from Manager F, which stated, "I got the new cycle it will start on 2/14/25 so they will be without meds for 2/13/25 ...whoever works first shift on 2/14/25 is when I will bring the new MARs and MEDs and I will get the old one." On 02/18/2025, at 2:00 PM, Surveyor interviewed Caregiver G. Caregiver G reported residents run out of medications for days. Caregiver G reported Manager F would bring the medications to the house on the day the cycle starts, even if the residents do not have medications for 2 or 3 days. On 05/07/2025, at 2:00 PM, Surveyor interviewed Licensee A. Licensee A confirmed residents were to receive their medications as prescribed. Licensee A reported Guardian pharmacy only sent enough medications for 28 days. Licensee A reported s/he would need to speak with the pharmacy or find a new pharmacy to ensure residents had medications for every day of the month.	M 582		
M 610	88.11(1) REPORTING OF ABUSE AND NEGLECT A licensee or service provider who knows or has reasonable cause to	M 610		

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M 610	Continued From page 11	M 610		

suspect that a resident has been abused or neglected as defined in s. 46.90 or 940.285, Stats., shall immediately contact the licensing agency. Providing notice under this subsection does not relieve the licensee or other person of the obligation to report an incident to law enforcement authorities. If the licensee has reason to believe a crime has been committed, the incident shall immediately be reported to law enforcement authorities.

This Rule is not met as evidenced by:
Based on observation, interview and record review, the provider did not ensure the licensing agency was immediately notified when there was an allegation of caregiver misconduct affecting 4 of 4 residents in the adult family home (AFH). In the first incident, residents were left unsupervised. The second incident, a staff member borrowed money from a resident.

Findings include:

On 09/20/2024, the department received a complaint alleging residents were being left unsupervised.

Incident 1

Interviews

On 01/31/2025, at 1:30 PM, Surveyor entered the

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M 610	Continued From page 12 AFH. Surveyor observed a mechanical lift by the front door. On 01/31/2025, at 2:00 PM, Surveyor interviewed Caregiver D. Caregiver D reported Resident 1 was the only resident to utilize the mechanical lift. On 01/31/2025 at 3:18 PM, Surveyor interviewed Resident 4. Resident 4 reported staff had left the home unsupervised. Resident 4 reported s/he did assist Resident 1 with using the bathroom. Surveyor inquired how Resident 4 assisted Resident 1; Resident 4 reported s/he used "the machine". Resident 4 reported s/he used to be a caregiver but had never used a machine before. Resident 4 reported Resident 1 walked her/him through it. Record Review On 01/31/2025, at 3:30 PM, Surveyor reviewed resident files and identified the following: Resident 1 was admitted on 10/22/2020, with diagnoses including schizophrenia, chronic obstructive pulmonary disease (COPD) and depression. Resident 1's individual service plan (ISP), dated 04/07/2024, indicated Resident 1 required 24-hour supervision and the use of a sit to stand machine for transfers for toileting. Resident 1 also required staff assistance with meal preparation and bathing tasks. Resident 2 was admitted on 01/06/2021, with diagnoses including schizophrenia and COPD. Resident 2's ISP, dated 04/13/2024, indicated Resident 2 required 24-hour supervision. Resident 2 required supervision due to smoking in the home. Resident 2 required assistance with her/his nebulizer or inhaler for breathing issues.	M 610		

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M 610	Continued From page 13 Resident 4 was admitted on 07/20/2023, with diagnoses including anoxic brain injury, bilateral leg pain, and portal vein thrombosis. Resident 4's ISP, dated 07/30/2024, indicated Resident 4 required 24-hour supervision and required assistance with toileting, mobility, meal preparation, bathing and dressing tasks. Resident 5 was admitted on 11/15/2023, with diagnoses including anxiety disorder, seizures, suicidal behavior with attempted self-injury, and hoarding behavior. Resident 5's ISP, dated 11/24/2024, indicated Resident 5 required 24-hour supervision for redirection due to short term memory loss. Resident 5 required reminders when in public so s/he does not walk away from the group. On 02/06/2025, at 10:30 AM, Surveyor reviewed an investigation report. The report indicated Licensee A conducted an interview with Case Manager E on 09/29/2024 at 1:00 PM. The report stated, "Case Manager E stated that when [s/he] arrived at the beechwood residence that there was no staff presence [sic] upon entering the home. Once this was notice [s/he] proceeded to [her/his] visit with a client and did not contact the owner or management regarding this issue. Case manager stated to owner that [s/he] knew about it days prior at the time of speaking to the owner." On 10/05/2024, at 2:00 PM, Licensee A conducted an interview with Caregiver D. The report indicated Caregiver D confirmed s/he left the residents unattended to make a store run for a resident. Caregiver D reported s/he was gone between 15-20 minutes. Caregiver D reported s/he was unaware s/he was not allowed to leave.	M 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018010	A. BUILDING: _____ B. WING _____	R-C 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 610	Continued From page 14 The investigation report indicated Caregiver D was placed on a 1-month suspension without pay. Surveyor reviewed staff schedules provided by Licensee A. Caregiver D was listed on the schedule to work on 09/30/2024 at 7:00 AM - 3:00 PM, 10/01/2024 at 7:00 AM - 3:00 PM, 10/02/2024 at 7:00 AM - 3:00 PM, 10/03/2024 at 7:00 AM - 3:00 PM, 10/04/2024 at 7:00 AM - 3:00 PM and 10/05/2024 at 7:00 AM - 7:00 PM. Caregiver D was removed from the schedule on 10/06/2024. Incident 2 On 02/06/2025, at 10:30 AM, Surveyor reviewed an investigation report, dated 01/26/2025, which indicated Caregiver G borrowed money from Resident 1. Caregiver G came to the home to repay Resident 1. Caregiver G was placed under investigation and was terminated on 02/01/2025. On 05/07/2025, at 2:00 PM, Surveyor interviewed Licensee A. Licensee A confirmed Caregiver G was terminated due to borrowing money from Resident 1. Licensee A reported Caregiver D was suspended for 1 month due to leaving the clients home alone. When Surveyor inquired about how Licensee A kept the residents safe while Caregiver D continued to work on the floor during the investigation, Licensee A reported s/he did not become aware of the situation until weeks later. Surveyor attempted to explain to Licensee A, s/he interviewed Case Manager E on 09/29/2025, but did not interview Caregiver D until 10/05/2025, and Caregiver D continued to work on the floor. Licensee A repeated s/he was not told about the incident until weeks after it happened. Licensee A reported s/he was unaware of the requirement of reporting incidents to the department. Licensee	M 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 610	Continued From page 15 A confirmed s/he did not report the misconduct to the department.	M 610		