STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019112	A. BUILDING: _____ B. WING _____	C 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE HEART LLC INFINITY	4020 N SHERMAN BLVD MILWAUKEE, WI 53216

(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 02/11/2025, with information gathered through 02/25/2025, Surveyor conducted a standard survey and 3 complaint investigations. Three complaints were substantiated, and 4 deficiencies were identified. Census: 3	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 observation and interview, the provider did not ensure the home was well-maintained, clean, and a homelike environment. The kitchen, hallways and resident bedrooms required cleaning and repairs. The kitchen, the hallway and the resident bathroom required cleaning and repairs. Findings include: On 02/11/2025, from 10:30 AM to 11:15 AM, Surveyor toured the home and observed the following: Hallways: · 3 of 3 Resident doors and door frames had splotches of white paint and scratches throughout the frames. Doors appeared to be made of composite and were unpainted with white splotches. · Hallway walls were dirty and stained, from a	M 276		

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

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M 276	Continued From page 1 height of about 3 feet and below Kitchen: · Paint on the cabinets in the kitchen were peeling and were missing from some areas of cabinet doors. · There was 1 tile missing from the backsplash. Bathroom: · Threshold water barrier in the shower was broken which appeared would allow water to drain out of the shower and to the main bathroom floor · Screen behind bathroom window was torn and dusty. On 02/11/2025, at 11:50 AM, Surveyors interviewed Licensee A. Licensee A was asked about the concerns in home environment. Licensee A confirmed the observations and stated, "Sometimes you get used to seeing things ...maybe fresh eyes would help."	M 276		
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS Fire extinguishers. Every adult family home shall be equipped with one or more fire extinguishers on each floor. Each required fire extinguisher shall have a minimum 2A, 10-B-C rating. All required fire extinguishers shall be mounted. A fire extinguisher is required at the head of each stairway and in or near the kitchen except that a single fire extinguisher located in close proximity to the kitchen and the head of a stairway may be used to meet the requirement for an extinguisher at	M 332		

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M 332	Continued From page 2 each location. Each required fire extinguisher shall be maintained in readily usable condition and shall be inspected annually by the authorized dealer or the local fire department and have an attached tag showing the date of the last dealer or fire department inspection. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure each fire extinguisher was inspected annually by an authorized dealer or fire department for 3 of 3 fire extinguishers. The fire extinguishers, located in the living room, basement and the kitchen, had an annual inspection tag dated March 2023. The fire extinguishers were almost 23 months overdue for inspection. Findings include: On 02/11/2025 at approximately 10:30 AM, Surveyor toured the facility. During the tour, 3 fire extinguishers were noted. All 3 fire extinguishers had inspection tags punched for March 2023 and due for inspection by March 2024. On 02/11/2025, at 11:55 AM, Surveyor interviewed Licensee A regarding the fire extinguishers. Licensee A confirmed the fire extinguishers were overdue for inspection, and that s/he would take them in right away to be reinspected.	M 332		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months	M 424		

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M 424	Continued From page 3 by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 resident service plans were reviewed at least once every 6 months by the licensee, the resident, the resident's guardian and the placing agency, to determine the appropriateness of the care plan and to update the care plan as necessary. Resident 1's ISP was due for review, at minimum, by 11/2024 and had not been reviewed. Resident 2's ISP was due for review, at minimum, by 12/2024 and had not been reviewed. Findings include: On 2/11/2025 at approximately 12:00 PM, Surveyor reviewed Resident 1's and Resident 2's records. Resident 1 was admitted on 05/08/2024. Resident 1 had 1 ISP in his/her record dated	M 424		

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M 424	Continued From page 4 05/08/2024. There was no evidence a review was completed after the 05/08/2024 ISP. Resident 2 was admitted on 5/31/2023. Resident 2 had 2 ISPs in his/her record dated 05/31/2023 and 06/03/2024. There was no evidence a review was completed after the 06/03/2024 ISP. On 02/11/2025 at approximately 12:30 PM, Surveyor interviewed Licensee A. Survey asked if there were any other more current ISPs other than those in the resident records. Licensee A stated the only ISPs were those in the resident records. Licensee A stated s/he was not sure why the ISPs were not done every 6 months.	M 424		
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 staff interview and record review, the provider did not ensure 1 of 1 resident (Resident 1) received all prescribed medications in the dosage and at the intervals prescribed by the resident's physician. Resident 1 did not receive insulin at the dosage prescribed by his/her physician.	M 582		

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M 582	Continued From page 5 Findings include: On 02/18/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 05/08/2024 with a diagnosis of diabetes. Resident 1's Individual Service Plan (ISP), dated 05/08/2024, identified Resident 1 required staff assistance with medication administration. Surveyor reviewed Resident 1's Medication Administration Record (MAR) for insulin given on 02/18/2025. There were no values recorded for how much insulin was given. On 02/18/2025 at approximately 1:30 PM, Surveyor interviewed Caregiver B and Licensee A regarding insulin administration for Resident 1. According to Caregiver B, Resident 1 has a sliding scale for insulin administration. Surveyor then asked how Caregiver B knew how much insulin Resident 1 was to receive. Caregiver B showed Surveyor a printed document in the binder used when administering medication. The document, which was not signed by a physician or had any indication of a physician's order, stated, " ... Mealtime insulin, Give Humalog 6 units with meals ...If blood glucose above range use additional sliding scale below: -Less than 150 no additional insulin -150-200 give additional 3 units -201-250 give additional 5 units -251-300 give additional 7 units -301-350 give additional 10 units -351-400 give additional 12 units If BS (blood sugar) greater than 400 call MD (medical doctor)." Surveyor asked Caregiver B what Resident 1's blood sugar readings were and how much insulin	M 582		

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M 582	Continued From page 6	M 582		

was given on 02/18/2025. There was no documentation in the record for these values. Caregiver B stated the morning blood sugar reading on 02/18/2025 was, "over 400," and the resident received 15 units of insulin. According to the printed document, the MD should have been called with the result. According to Caregiver B and Licensee A, the MD was not called. According to Caregiver B the lunch time blood sugar reading on 02/18/2025 was 280, and the resident received 12 units. According to the printed document resident should have received 13 units.

On 02/25/2025 at 10:18 AM, Surveyor received an email from Resident 1's endocrinologist which contained the insulin dosage ordered for Resident 1 from 11/19/2024 to 02/20/2025. The order states: "Sig- Route: Inject 5 units into the skin in the morning and 5 units at noon and 5 units in the evening. Inject with meals."

Summary:

Resident 1 had a physician's order for insulin. From 11/19/2024 to 02/20/2025, the order for insulin was 5 units with each meal. Facility staff had been using a sliding scale for insulin that was not in accordance with the doctor's order. On the day Surveyor was in the facility, the insulin received by Resident 1 was neither the dose prescribed by the physician nor the dose printed in the medication book.