STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016020	A. BUILDING: _____ B. WING _____	C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A SAFE HAVEN HEALTH AND SUPPORTIVE CA	8329 W POTOMAC AVE MILWAUKEE, WI 53218

(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 05/06/2025 with information gathered through 05/08/2025, Surveyor conducted a standard survey and complaint investigation, at A Safe Haven Health and Supportive Care Service, an Adult Family Home (AFH) in Milwaukee, WI. Five deficiencies were identified. One of 5 deficiencies is a repeat deficiency, see Statement of Deficiency (SOD) 12T611, dated 01/19/2022. Complaint unsubstantiated. Census: 3	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 a clean, well-maintained and homelike environment. The home required cleaning and/or repairs. This had the potential to affect 3 of 3 residents (Resident 1, Resident 2, and Resident 3) residing in the facility. Findings include: On 05/06/2025, at approximately 11:30 AM, Surveyor conducted a tour of the facility with	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
	0016020	A. BUILDING: _____ B. WING _____	C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A SAFE HAVEN HEALTH AND SUPPORTIVE CA	8329 W POTOMAC AVE MILWAUKEE, WI 53218

(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 Licensee A and observed the following: -Front entrance living room door stripping was cracked. -Walls had a white chalk substance throughout facility . -Walls throughout facility contained numerous dark scuff and scratch marks. -Living room wall vents were rusted and caked with dust. -Living room wall below window sill had marker/ink lines. -Living room wall had a hole with a black cord sticking out. -Living room vinyl window frame was melted. -Carpet in living room was stained throughout. -Wall trimming missing throughout facility. -Walls had holes throughout facility -Bathroom door missing frame strip. -Bedroom doors missing frame strip. -Door frame gaps throughout facility due to missing frame strips. -Kitchen floor had the appearance of dirt build-up along the cabinetry and dishwasher. -Kitchen countertops were peeling. -Kitchen cabinets wood was peeling. -Kitchen cabinets did not close. -Flooring cracked and dirty throughout facility. -There was no electrical cover for the outlet in the kitchen. -Kitchen floor vent was rusted and caked with dust. On 05/06/2025, at approximately 2:00 PM, Surveyor interviewed License A. Licensee A stated s/he was aware of the home environment issues throughout the facility. Licensee A stated s/he would have the maintenance person fix the issues.	M 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016020	A. BUILDING: _____ B. WING _____	C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A SAFE HAVEN HEALTH AND SUPPORTIVE CA	8329 W POTOMAC AVE MILWAUKEE, WI 53218

(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 332	Continued From page 2	M 332		
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 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 3 of 3 fire extinguishers were inspected annually by an authorized dealer and had an attached tag showing the date of inspection. The fire extinguisher, located in the basement was last serviced January 2024. The fire extinguishers, located near the kitchen and at the head of hallway stairway did not have an attached tag showing the date of the last inspection.	M 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016020	A. BUILDING: _____ B. WING _____	C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A SAFE HAVEN HEALTH AND SUPPORTIVE CA	8329 W POTOMAC AVE MILWAUKEE, WI 53218

(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 332	Continued From page 3 This is a repeat deficiency. See Statement of Deficiency (SOD) 12T611, dated 01/19/2022. Findings include: The provider is licensed to care for up to 4 residents within the following client groups: developmentally disturbed, irreversible dementia/Alzheimer's, advanced aged, and emotionally disturbed/mental illness. On 05/06/2025, at approximately 11:30 AM, Surveyor conducted a tour of the facility with Licensee A and observed the following: -Fire extinguisher located in the basement had an inspection tag dated January 2024. -Fire extinguishers located near the kitchen and at the head of hallway stairway did not have an attached tag showing the date of the last inspection. On 05/06/2025, at approximately 2:00 PM, Surveyor interviewed Licensee A. Licensee A stated s/he was aware of this requirement. Licensee A reported s/he would take the fire extinguishers in to be serviced.	M 332		
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.	M 458		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016020	A. BUILDING: _____ B. WING _____	C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A SAFE HAVEN HEALTH AND SUPPORTIVE CA	8329 W POTOMAC AVE MILWAUKEE, WI 53218

(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 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 1 resident's (Resident 1) prescription medication was securely stored. Resident 1's insulin pen was not securely stored in the kitchen refrigerator. Findings include: On 05/06/2025, at approximately 11:30 AM, Surveyor toured the kitchen and observed a clear Ziploc sandwich bag, which contained Resident 1's Humulin 70/30 Kwikpen in the kitchen refrigerator. On 05/06/2025, at approximately 2:00 PM, Surveyor interviewed Licensee A. Licensee A confirmed the insulin pen was to be securely stored. Licensee A stated s/he was not aware Resident 1's insulin was delivered to the facility. Licensee A stated moving forward s/he will ensure Resident 1's insulin is securely stored in home's refrigerator.	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),	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016020	A. BUILDING: _____ B. WING _____	C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A SAFE HAVEN HEALTH AND SUPPORTIVE CA	8329 W POTOMAC AVE MILWAUKEE, WI 53218

(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 5 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 his/her physician ordered medications as prescribed. The provider did not obtain Resident 1's amiodarone hydrochloric acid, atorvastatin, carvedilol, clopidogrel, eliquis, entresto, folic acid, hydralazine, isosorbide mononitrate extended-release, multivitamin, pantoprazole sodium delayed release, torsemide, trazodone, and vitamin B-1 for 5 days after admission to the facility. The provider did not obtain Resident 1's humulin for 10 days after admission to the facility. Findings include: On 05/06/2025, Surveyor reviewed Resident 1's record and identified the following: -Resident 1 was admitted to the provider's home on 04/25/2025. -Resident 1 had diagnoses including type 2 diabetes with insulin, left ventricular thrombus, peripheral artery disease, chronic acute congestive heart failure, acute kidney injury, and atrial fibrillation. -Resident 1 required staff assistance with	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016020	A. BUILDING: _____ B. WING _____	C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A SAFE HAVEN HEALTH AND SUPPORTIVE CA	8329 W POTOMAC AVE MILWAUKEE, WI 53218

(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 6	M 582		

medication administration administration.

On 05/06/2025, at approximately 11:41 AM, Surveyor reviewed Resident 1's medication administration record (MAR) and the following was identified:

Resident 1 started receiving the following medications on 04/30/2025:

- Amiodarone hydrochloric acid 200 milligram (mg) take 1 tablet by mouth once daily.
- Atorvastatin 80 mg take 1 tablet by mouth once daily at bedtime.
- Carvedilol 12.5 mg take 1 tablet by mouth twice daily.
- Clopidogrel 75 mg take 1/2 tablet by mouth once daily.
- Eliquis 2.5 mg take 1 tablet by mouth twice daily.
- Entresto 24 mg - 26 mg take 1 tablet by mouth twice daily.
- Folic acid 1 mg take 1 tablet by mouth once daily.
- Hydralazine 50 mg take 1 tablet by mouth three times daily.
- Isosorbide mononitrate extended-release 60 mg take 1 tablet by mouth once daily.
- Multivitamin take 1 tablet by mouth once daily.
- Pantoprazole sodium delayed release 40 mg take 1 tablet by mouth once daily.
- Torsemide 20 mg take 1 tablet by mouth twice daily.
- Trazodone 50 mg take 1/2 tablet by mouth once daily at bedtime.
- Vitamin B-1 100 mg take 1 tablet by mouth once daily.

On 05/06/2025, at approximately 9:00 AM, Surveyor interviewed Caregiver B. Caregiver B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016020	A. BUILDING: _____ B. WING _____	C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A SAFE HAVEN HEALTH AND SUPPORTIVE CA	8329 W POTOMAC AVE MILWAUKEE, WI 53218

(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 7 reported that Resident 1's Humulin 70/30 Kwikpen was delivered to facility on 05/05/2025. On 05/06/2025, at approximately 2:00 PM, Surveyor interviewed Licensee A. Licensee A stated that Resident 1 did not receive his/her medications as prescribed because s/he did not have Resident 1's medications to administer. Licensee A stated s/he did not receive Resident 1's medications from the hospital. Licensee A stated stated s/he worked with the hospital doctors and pharmacy to get Resident 1's medications.	M 582		
Z 022	50.065(3)(b) COMPLETE BACKGROUND CHECK PROCESS Every 4 years or at any other time within that period that an entity considers appropriate, the entity shall request the information specified in sub. (2) (b) 1. to 5. for all caregivers of the entity. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a complete caregiver background check (CBC) was complete for 1 of 1 caregiver (Caregiver B) reviewed. At minimum, a CBC contains 3 parts:	Z 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016020	A. BUILDING: _____ B. WING _____	C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A SAFE HAVEN HEALTH AND SUPPORTIVE CA	8329 W POTOMAC AVE MILWAUKEE, WI 53218

(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
Z 022	Continued From page 8 1) Background information disclosure form (BID) 2) Criminal history report from the Department of Justice (DOJ) 3) A report from the Department of Health Services integrated background information system (IBIS) Findings include: The provider is licensed to care for up to 4 residents within the following client groups: developmentally disturbed, irreversible dementia/Alzheimer's, advanced aged, and emotionally disturbed/mental illness. On 05/06/2025, Surveyor reviewed Caregiver B's record and identified the following: -Caregiver B was hired on 01/01/2021. -Caregiver B's record included an incomplete BID, dated 12/06/2020. -Caregiver B's record did not include an DOJ. -Caregiver B's record did not include an IBIS. -Caregiver B's record did not contain any of the three necessary parts of the four-year background check due December of 2024. On 05/08/2025, at approximately 7:09 AM, Surveyor interviewed Licensee A. Licensee A confirmed Caregiver B's record did not contain any of the three necessary parts of the four-year background check. Licensee A stated that s/he did not complete a four-year CBC for Caregiver B.	Z 022		