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	0016698	A. BUILDING: _____ B. WING _____	R-C 09/17/2025

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EXCEL R3	2019 GREEN ST LOWER RACINE, WI 53402

(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 09-16-2025, Surveyors conducted a standard survey, verification visit, and complaint investigation at Excel R3. As a result, 18 deficiencies were identified, 3 deficiencies were repeat violations, and 1 complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 4	{M 000}		
M 114	88.03(3)(b) CRIMINAL RECORDS CHECK Criminal records check. Prior to an initial license the licensing agency shall ask the Wisconsin department of justice to conduct a criminal records check on the license applicant and on any other adult household member. The licensee shall arrange for a criminal records check of all service providers. At least every second year following issuance of an initial license the licensing agency shall request a criminal records check on the licensee and all other adult household members and the licensee shall arrange for a criminal records check on any service provider. In addition, during the period of the licensure, the licensee shall arrange for a criminal records check on any new service provider. If any of these persons has a conviction record or a pending criminal charge which substantially relates to the care of a dependent population, the funds or property of adults or minors or	M 114		

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

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M 114	Continued From page 1 activities of the adult family home, the licensing agency may deny, revoke, refuse to renew or suspend a license, initiate other enforcement action provided in this chapter or in ch. 50, Stats., or place conditions on the license. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 service providers had background check upon hire. Caregiver C did not have a completed background check at the time of hire. Findings include: On 09/16/2025, at 11:15 AM, Surveyors reviewed Caregiver C's record. Caregiver C was hired on 01/27/2017. Caregiver C's record did not contain evidence of a completed background check. On 09/16/2025, at 2:20 PM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A reported Caregiver C had previously worked for another provider in which Licensee A was related to. Licensee A reported s/he thought s/he could use the background information disclosure (BID) from the other facility. Licensee A confirmed the background check was conducted 12/04/2015, which was over a year prior to when Caregiver C started employment with Licensee A.	M 114		

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M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the licensing agency, within 24 hours, a significant change in 1 of 1 resident's (Resident 1) status. Resident 1 eloped from the facility. Findings include: The facility was licensed as an ambulatory adult family home (AFH), serving up to 4 residents in client groups traumatic brain injury, emotionally disturbed/mental illness, physically disabled, and developmentally disabled. On 09/16/2025, at 11:45 AM, Surveyors reviewed Resident 1's record. Resident 1 was admitted on 11/28/2024 with diagnoses including bipolar disorder, intellectual disabilities, type 2 diabetes and pedophilia. Resident 1's individual service plan (ISP), undated, indicated Resident 1 required 24-hour supervision due to exit-seeking. 1's ISP indicated, "Wandering risk, requires supervision and redirection from staff to prevent	M 134		

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M 134	Continued From page 3 elopement episodes. Exit-seeking and requires checks throughout day/night. As of 5/20/2025 [Resident 1] [sic] care team with community care and myself had made elopement part of [Resident 1's] [behavior support plan] (BSP). Due to recent incident with [Resident 1] taking off from the facility out of anger and frustration without [her/his] walker. Surveyors reviewed a police report, dated 06/19/2025, at 9:45 AM which indicated Resident 1 "left on foot 10 [minutes] ago ...owner told the [staff] not to follow ...". Resident 1 was returned to the group home by police at 10:04 AM. On 09/16/2025, at 2:20 PM, Surveyors interviewed Licensee A. Licensee A confirmed Resident 1 had eloped from the facility in May . Surveyors inquired about the incident in June, which Licensee A confirmed. Licensee A reported s/he was unaware of the reporting requirements. On 09/16/2025, Surveyors reviewed the Department's electronic file for the facility and did not locate a self-report for Resident 1's elopement on 06/19/2025.	M 134		
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 observation, record review, and interviews, the provider did not ensure the home, and its operation complied with this chapter and	M 216		

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M 216	Continued From page 4	M 216		

all other laws governing the home and its operations potentially affecting 4 of 4 residents. The provider has been unable to maintain compliance with Chapter 88 of the Department of Health Services-Licensed Adult Family Home regulations.

This is being cited for a third time. See Statement of Deficiency (SOD) 15D712, dated 06/03/2024, and 15D711, dated 08/02/2023.

Findings include:

On 09/17/2025, Surveyors completed a verification visit at Excel R3. As a result of the survey, 1 previous citation was corrected, 1 complaint was substantiated, and the provider was issued 19 deficiencies. Two of 19 were repeat deficiencies, and 1 citation was cited for the third time. The following deficiencies were identified:

M0114 88.03(b) - Criminal Records Check
M0134 88.03(5)(e)1 - Significant Change to The Resident
M0216 88.04(2)(a) - Responsibilities - This is being cited for the third time
M0232 88.04(2)(g)(1) - Health Screening for Staff
M0244 88.04(5)(a) - Training - 15 hours within 6 Months
M0246 88.04(5)(b) - Training -8 Hours Annually
M0262 88.05(2)(a) - Difficulty Walking
M0276 88.05(3)(a) - Homelike Environment
M0332 88.05(4)(a) - Fire Safety-Fire Extinguishers
M0334 88.05(4)(b)(1) - Fire Safety-Smoke Detectors - This is a repeat cite
M0348 88.05(4)(d)2.c Semi-Annual Fire Drills
M0380 88.06(2)(a) - Admission Health Exam
M0424 88.06(3)(f) - Review of ISP - This is a

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M 216	Continued From page 5 repeat cite M0458 88.07(3)(a) - Prescription Medications M0470 88.07(4)(a) - Nutrition M0482 88.09(1)(a) - Resident Records M0570 88.10(3)(l) - Safe Physical Environment M0582 88.10(3)(q) - Medications Y0019 50.065(6)(am) - Four Year Caregiver Background Requirement On 09/16/2025, at 2:20 PM, Surveyors interviewed Licensee A. Surveyors relayed concerns regarding number of citations identified during current survey. Licensee A acknowledged Surveyors concerns. Licensee A reported s/he had assistance from other staff to ensure compliance with codes and s/he would conduct retraining to ensure facility would be in substantial compliance for next verification visit.	M 216		
M 232	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation indicating 2	M 232		

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M 232	Continued From page 6 of 2 staff (Caregiver B and Caregiver C) been screened for communicable diseases, including tuberculosis (TB), by a physician, a registered nurse or a physician's assistant, within 90 days before the start of providing service. Caregiver B and Caregiver C were not screened for communicable diseases including TB prior to providing cares. Findings include: On 09/16/2025, at 11:15 AM, Surveyors reviewed employee records and identified the following: - Caregiver B was hired on 11/07/2020. Caregiver B's record contained: Communicable disease screening, dated 12/15/2015, which was 1,789 days prior to starting service. TB test, dated 12/11/2015, which was 1,793 days prior to providing service. Communicable disease screening, dated 04/16/2025, which was 1,621 days after starting to provide service. - Caregiver C was hired on 01/27/2017. Caregiver C's record contained: Communicable disease screening dated 12/04/2015, which was 420 days prior to the start of providing service. Communicable disease screening dated 10/29/2018, which was 640 days after the start of providing service. TB test dated 10/31/2018, which was 642 days after the start of providing service.	M 232		

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M 232	Continued From page 7 On 09/16/2025, at 2:20 PM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A reported s/he was unaware the communicable disease screening and TB test had to be completed within 90 days prior to the start of working with residents. Licensee A reported Caregiver B's TB screening was completed before the start of providing service at the facility but was unable to locate the documentation. Licensee A reported Caregiver C's TB screening was completed while working at a different facility and believed it was transferable.	M 232		
M 244	88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS The licensee and each service provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 staff (Caregiver B) received 15 hours of training related to health, safety and welfare, resident rights, first aid and fire safety, and treatment appropriate to residents prior to or within 6 months of starting to provide cares. Caregiver B did not receive any training related to resident rights training.	M 244		

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M 244	Continued From page 8 Findings include: On 09/16/2025, at 11:15 AM, Surveyors reviewed Caregiver B's record. Caregiver B was hired on 11/07/2020. Caregiver B's record indicated s/he received training in first aid, fire safety and medication administration. Caregiver B's record did not contain evidence of training in resident rights. On 09/16/2025, at 2:20 PM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A reported s/he must have missed resident rights training.	M 244		
M 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 service provider received 8 hours of annual training for 1 of 2 years reviewed. Caregiver B did not receive annual training in 2024. Findings include:	M 246		

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M 246	Continued From page 9 On 09/16/2025, at 11:15 AM, Surveyors reviewed Caregiver B's record. Caregiver B was hired on 11/07/2020. Caregiver B's record did not contain evidence of annual training in 2024. On 09/16/2025, at 2:20 PM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A reported they switched over to a new system for continuing education towards the end of 2024, so Caregiver B might have been one of the staff who did not get the trainings completed.	M 246		
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 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.	M 262		

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M 262	Continued From page 10 This Rule is not met as evidenced by: Based on observation, and interview, the provider did not ensure 2 of 2 exits from the home were ramped to grade with a hard surfaced pathway with handrails for residents who walked only with difficulty, or only with the assistance of crutches, a cane, or a walker, or were unable to easily negotiate stairs without assistance. Resident 1 utilized a walker for ambulation. Findings include: On 11/27/2017, the adult family home was licensed as an ambulatory facility to serve up to 4 residents in the client groups of: developmentally disabled, physically disabled, emotionally disturbed/mental illness, and traumatic brain injury. On 09/16/2025, at 09:45 AM, Surveyors toured the home and observed the following: The front door identified as an emergency exit. There was a ramp from the front porch to the side of the house. From the base of the ramp to the driveway, there was approximately a 1-inch rise from driveway to ramp. The rear door was located off the kitchen which was identified as an emergency exit. Once the interior door was opened, it led to a rear foyer type of room. There were 2 exits from the area. The south exit had 5 stairs going down to the outside door, which led to the driveway. The east rear exit, led to a wooden deck. There was approximately a 1-inch rise from the interior floor of the home to the threshold of the door. From the threshold of the door, there was approximately a 2.25-inch drop to the wooden	M 262		

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M 262	Continued From page 11 deck. There were 4 steps to exit the wooden deck to the back yard. There was no ramp which led off the deck. Surveyor observed Resident 1 utilize a walker during the survey. On 09/16/2025 at 11:45 AM, Surveyors interviewed Licensee A. Surveyors inquired if Licensee A applied for a waiver for Resident 1's walker. Licensee A reported s/he believed the facility was licensed as semi-ambulatory. Licensee A confirmed her/his license was for ambulatory only. Licensee A confirmed Resident 1's pre-admission assessment identified Resident 1 as being unsteady when ambulating and she/he utilized a walker prior to admission. Licensee A reported s/he was not aware both exits needed to be ramped. Licensee A confirmed Resident 1 did not meet criteria for facility based on license type.	M 262		
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 home was well-maintained, clean, and a homelike environment for 4 of 4 residents. The kitchen, living room, dining room,	M 276		

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M 276	Continued From page 12 bathroom and 3 resident rooms required cleaning and maintenance. This is a repeat deficiency. See Statement of Deficiency (SOD) 38CK11, dated 11/08/2021. Findings include: On 09/16/2024, at 9:40 AM, Surveyor toured the facility and observed the following: Kitchen - Front two stove burners contained a buildup of black burnt substances, consistent with burnt food. - There was brownish staining on the ceiling located above kitchen cabinets consistent with food splatter. - There was a thick, sticky, blackish substance on the lower corners of 11 upper cabinets, and the upper corners of 8 lower cabinets. Surveyor was able to scratch the substance off with her/his fingernail. - A buildup of gray matter, similar to dust along floor baseboards. - The ceiling fan was missing 2 light bulbs and the fan blades. - There was a missing drawer, which caused an opening to the lower cabinet. The drawer next the missing one was screwed shut. Surveyors found the missing drawer in the lower cabinet. The 'missing drawer' was missing a faceplate, which caused screws to be exposed. - There was grayish web like matter hanging from the ceiling, consistent with dust and spiderwebs. Resident 1's Room -Door handle was broken, and door latch of door was broken.	M 276		

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M 276	Continued From page 13 Dining Room - A buildup of gray matter, similar to dust along windowsills. - Doorway which led to Resident 3's and Resident 2's room from dining room was missing a threshold which allowed Surveyors to see into the room with the door closed. - The light fixture did not contain a covering, only bare lightbulbs. Living Room - On the wall, next to Resident 4's door, was a brownish staining, with pieces of thicker brown material, which resembled feces. - A buildup of gray matter, similar to dust along the trim work which led from the living room to the dining room. - The ceiling fan was missing 2 bulbs. Bathroom - The bathroom did not contain hand towels or paper towels for handwashing. - The base of the shower contained a black mold-like substance. - Two light bulbs were missing above the bathroom sink. On 09/16/2025, at 2:40PM, Surveyors interviewed Licensee A. Surveyors relayed concerns of the condition of the home. Licensee A acknowledged Surveyors concerns. Licensee A reported the home was due for some remodeling and upgrading.	M 276		
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS Fire extinguishers. Every adult family home shall be equipped with one	M 332		

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M 332	Continued From page 14 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. The fire extinguishers were last inspected in July of 2023. Findings include: On 09/16/2025, at 9:45 AM, Surveyors toured the home. Surveyors observed 1 fire extinguisher in the kitchen, 1 fire extinguisher at the top of the stairs, and 1 fire extinguisher in the basement. All fire extinguishers were last inspected in July of 2023. On 09/16/2025, at 2:20 PM, Surveyors interviewed Licensee A. Licensee A confirmed the	M 332		

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M 332	Continued From page 15 code requirement. Licensee A reported an outside company inspects the fire extinguishers. Licensee A reported s/he was unaware the last inspection was completed in 2023.	M 332		
{M 334}	88.05(4)(b)1 FIRE SAFETY-SMOKE DETECTORS Every adult family home shall be equipped with one or more single station battery operated, electrically interconnected or radio signal emitting smoke detectors on each floor level. Required smoke detectors shall be located in each habitable room except the kitchen and bathroom and specifically in the following locations: at the head of each open stairway, at the door leading to every enclosed stairway, on the ceiling of the living room or family room, on the ceiling of each sleeping room and in the basement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure smoke detectors were in 1 of 8 required locations. The head of the open stairway leading to the basement did not contain a smoke detector. This deficiency is being cited for a third time. See Statement of Deficiency (SOD) 38CK13, dated 02/13/2025, and SOD 38CK12, dated 11/20/2023. Findings include:	{M 334}		

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{M 334}	Continued From page 16 On 09/16/2025, at 9:45 AM, Surveyors toured the facility. The open stairway which led to the basement was missing a smoke detector. The base was attached to the ceiling. On 09/16/2025, at 2:40 PM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A reported s/he was unsure why the smoke detector was missing and would ensure maintenance replaced the missing smoke detector.	{M 334}		
M 348	88.05(4)(d)2.c SEMI-ANNUAL FIRE DRILLS The licensee shall conduct semi-annual fire drills with all household members with written documentation of the date and the evacuation time for each drill maintained by the home. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the semi-annual fire drills documented the date and the evacuation time for each drill for 2 of 2 years. There was no documentation of fire drills being conducted in 2023, 2024 and to date in 2025. Findings include: On 09/16/2025, at 11:00 AM, Surveyor reviewed the facility safety files. There was no evidence of fire drill being conducted in 2023, 2024 and to date in 2025. On 09/16/2025, at 2:20 PM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A reported either Maintenance D or Caregiver C complete the fire	M 348		

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M 348	Continued From page 17 drills. Licensee A reported the fire drills were completed, but they did not have the documentation at the home. Licensee A reported s/he thought Caregiver C gave us the binder.	M 348		
M 380	88.06(2)(a) ADMISSION-HEALTH EXAM Except as provided in subd. 2., the licensee shall ensure that a new resident of an adult family home receives a health examination by a physician to identify health problems and is screened for communicable disease, including tuberculosis. Screening for communicable disease may be provided by a physician, a registered nurse or a physician assistant. The health examination and screening shall take place within 90 days prior to admission to the home or within 7 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 residents (Resident 1, Resident 2, and Resident 3) were screened for communicable diseases including tuberculosis (TB) 90 prior to or 7 days after admission. Resident 1, Resident 2, and Resident 3 were not screened for communicable diseases, including TB. Findings include: On 09/16/2025, at 11:30 AM, Surveyors reviewed resident records and identified the following: Resident 1 was admitted to the facility on	M 380		

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M 380	Continued From page 18 11/28/2024.Resident 1's record did not contain evidence of a TB test or a communicable disease screening. Resident 2 was admitted to the facility on 10/14/2018. Resident 2's record did not contain evidence of a TB test or a communicable disease screening. Resident 3 was admitted to the facility on 06/01/2019, with diagnoses including down syndrome and attention-deficit hyperactivity disorder. Resident 1's record did not contain evidence of a TB test or a communicable disease screening. On 09/16/2025, at 2:20 PM, Surveyors interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A reported Resident 1, Resident 2, and Resident 3 were screened for TB and communicable diseases prior to admission and s/he had emails from the case worker but was unable to locate the paperwork.	M 380		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months 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	M 424		

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M 424	Continued From page 19 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 resident's individual service plan (ISP) was reviewed every 6 months and with changes for 2 of 3 residents (Resident 2, and Resident 3). In addition, 3 of 3 residents (Resident 1's, Resident 2's, and Resident 3's) ISP were not signed by all parties involved in the review. This is a repeat deficiency. See Statement of Deficiency 38CK11, dated 11/08/2021. Findings include: On 09/16/2025, at 11:30 AM, Surveyors reviewed resident records and identified the following: - Resident 1 was admitted to the facility on 11/28/2024, with diagnoses including bipolar disorder, type 2 diabetes mellitus, post-traumatic stress disorder (PTSD), and unspecified intellectual disabilities. Resident 1 was her/his own decision maker. Resident 1's record contained an ISP labeled "current ongoing care plan". Resident 1's ISP was updated on 05/2025. Surveyors did not review evidence Resident 1's ISP was signed by the provider or her/his managed care organization (MCO). - Resident 2 was admitted to the facility on 10/14/2018, with diagnoses including intellectual	M 424		

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M 424	Continued From page 20 disability, pervasive developmental disorder, attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder, and rage attacks. Resident 2's record contained an ISP labeled "current ongoing care plan" dated 09/16/2025. Resident 2's current ISP was not signed by her/his guardian, the provider, or the MCO. Resident 2's ISP was due for review on 05/2024, 11/2024, and 05/2025. - Resident 3 was admitted to the facility on 06/01/2019, with diagnoses including down syndrome and ADHD. Resident 3 was her/his own person. Resident 3's record contained an ISP labeled "current ongoing care plan" dated 09/16/2025. Resident 3's ISP was not signed by the provider or her/his MCO. Resident 3's ISP was due for review on 05/2024, 11/2024, and 05/2025. On 09/16/2025, at 2:40 PM, Surveyors interviewed Licensee A. Licensee A reported s/he worked with MCOs and nurses after admission to complete resident ISPs. Licensee A reported ISP reviews were completed for residents at regular 6-month intervals with MCOs. Licensee A reported s/he does not always attend ISP reviews with MCOs and residents . Licensee reported staff would attend ISP reviews in her/his place.	M 424		
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		

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M 458	Continued From page 21	M 458		

This Rule is not met as evidenced by:
Based on observation and interview the provider did not ensure all prescription medications were stored as specified by the pharmacist or the manufacturer for 2 of 3 residents (Resident 1 and Resident 2), and did not ensure medications were destroyed when expired for 1 of 3 residents (Resident 3). Resident 1's and Resident 2's in-use insulin pens were stored in the refrigerator and not labeled with an open date. Expired medication for Resident 3's was located on a shelf in a locked medication cabinet.

Findings include:

On 09/16/2025, at 9:45 AM, Surveyors toured the facility and observed the following:

Example 1

A locked mini fridge located on the kitchen counter which contained:
Resident 1:
-Lispro KWICKPEN 100/milliliter (ML)insulin pens - 1 box which contained 1 insulin pen. A label on the box stated, "Refrigerate unopened cartridges or pens. Once in use, do not refrigerate. Store the cartridge or pen in use at room temperature. Discard unused portion after 28 days"

- Humalog 100u/mL KWIK PEN - 1 box containing 5 insulin pens.

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M 458	Continued From page 22 Surveyors did not observe a date on any of the insulin pens, indicating when the pens were opened or a date of when the pen should be discarded. Resident 2: - Lantus SoloStar 100 units/mL - 1 box containing 4 insulin pens. A label on the box stated, "Refrigerate unopened cartridges or pens. Once in use, do not refrigerate. Store the cartridge or pen in use at room temperature. Discard unused portion after 28 days." Surveyors did not observe a date on any of the insulin pens, indicating when the pens were opened or a date of when the pen should be discarded. On 09/16/2025, At 10:43 AM. Surveyors interviewed Caregiver B. Caregiver B confirmed in use insulin pens were placed back in secured refrigerator with unused pens after use. Example 2 Medication closet: - Resident 3' s medication was located on a shelf in the medication cabinet. Resident 3's shelf contained the following expired medications: 1 bottle of triamcinolone 0.1% lotion, expiration date 03/19/2025, and 1 bottle of triamcinolone 0.1% lotion, expiration date 08/22/2024. On 09/16/2025, at 2:40 PM, Surveyors interviewed Licensee A and Administrator B. Licensee A reported s/he was unaware unused insulin pens were required to be stored at room temperature. Licensee A reported s/he	M 458		

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M 458	Continued From page 23 reorganized the medication cabinet 2 weeks ago and removed expired medications. When Surveyor inquired about the expired medication still in the medication cabinet, Licensee A reported s/he must have missed the expired medications still located in the cabinet. Administrator B reported s/he would ensure the expired medications were disposed of and staff would be retrained on medications.	M 458		
M 470	88.07(4)(a) NUTRITION A licensee shall provide each resident with a quantity and variety of foods sufficient to meet the resident's nutritional needs and preferences and to maintain the resident's health. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure each resident received a variety of food which met their individual preferences and maintained resident health for 4 of 4 residents. There was a limited amount of food readily available in the refrigerator, freezer, and cabinets. Findings include: On 09/03/2025, the department received a complaint with concerns regarding food availability for the residents. On 09/16/2025, at 9:45 AM, Surveyors observed breakfast being served. Breakfast consisted of scrambled eggs and bacon. Surveyors did not observe any drinks served for breakfast.	M 470		

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M 470	Continued From page 24 Surveyors toured the kitchen. Surveyors observed in the refrigerator 2 containers of margarine, a container with potato salad, an open package of bacon, and assorted condiments. The freezer contained a package of ground turkey, package of beef patties, a box of sausage patties, 1 pound of hamburger and an open bag of shrimp. The cupboards contained 3 boxes of noodles, cans of vegetables, cans of cream soups, 2 cans of tuna and a jar of peanut butter. Surveyors did not observe any fresh fruits, fresh vegetables, bread, dairy or drinks in the home. At approximately 11:50, Surveyors observed lunch served, which consisted of 2 hotdogs with a half of piece of cheese, ketchup, mustard and some potato salad. At 11:55, Surveyors interviewed Resident 4. Resident 4 reported yesterday for breakfast, they had oatmeal and coffee for breakfast, and half a sandwich and some chips for lunch. Resident 4 reported s/he was unable to remember what they had for dinner. "Key Recommendations: Consume a healthy eating pattern that accounts for all foods and beverages within an appropriate calorie level. A healthy eating pattern includes: A variety of vegetables from all of the subgroups-dark green, red and orange, legumes (beans and peas), starchy, and other, fruits, especially whole fruits, grains, at least half of which are whole grains, fat-free or low-fat dairy, including milk, yogurt, cheese, and/or fortified soy beverages. A variety of protein foods, including seafood, lean meats and poultry, eggs, legumes (beans and peas), and nuts, seeds, and soy products. Oils" (Source: US Department of Health and Human Services	M 470		

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M 470	Continued From page 25 website, Dietary Guidelines For Americans 2015-2020 Eighth Edition, August 24, 2021, https://health.gov/sites/default/files/2019-09/2015-2020_Dietary_Guidelines.pdf (retrieval date - September 18, 2025).) On 09/16/2025, at 2:20 PM, Surveyors interviewed Licensee A. Licensee A reported s/he did the grocery shopping. Licensee A reported s/he did not make menus. When Surveyors relayed concerns of the food in the home, Licensee A reported s/he was unsure of what Surveyors meant by nutritious food. Surveyors relayed the importance of ensuring residents were maintaining a healthy diet by including all the food groups.	M 470		
M 482	88.09(1)(a) RESIDENT RECORDS The licensee shall maintain a record for each resident. Resident records shall be maintained in a secure location within the home to prevent unauthorized access. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 4 of 4 residents' (Resident 1, Resident 2, Resident 3, and Resident 4) records contained all required information and were maintained in a secure location within the home. Findings include: Interviews	M 482		

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M 482	Continued From page 26 On 09/16/2025, at 9:45 AM, Surveyors interviewed Licensee A. Licensee A reported all resident files were kept at the office. When Surveyors inquired why resident files were kept at the office and not within the home, Licensee A reported s/he did not want staff to access resident personal information. Surveyors inquired if Licensee A was aware of the code requirement. Licensee A reported s/he just learned about it at another survey with another provider who was related to her/him in which resident files were to be kept in the home, but s/he did not feel comfortable. Licensee A left the home to go to the office and retrieve the resident files for Surveyors to review. On 09/16/2025, at 2:40 PM, Surveyors interviewed Licensee A. Licensee A confirmed s/he needed to ensure all resident documents were kept in resident files and at the facility. Record Review On 09/16/2025, at 11:45 AM, Surveyors reviewed resident records and identified the following: -Resident 1 was admitted to the facility on 11/28/2024. Resident 1's record did not contain the following documents: Admission health exam Communicable disease screening and TB test Admission Evacuation Evaluation Medication Written Order Annual health exams - Resident 2 was admitted on 10/14/2018. Resident 2's record did not contain the following documents: Admission health exam	M 482		

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M 482	Continued From page 27 Communicable disease screening and TB test Service/Admit Agreement Admission Evacuation Evaluation Medication Written Order Annual health exams -Resident 3 was admitted on 06/01/2019. Resident 3's record did not contain the following documents: Admission health exam Medication Written Order Communicable disease screening and TB test	M 482		
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. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure water temperatures were kept at a safe temperature for 1 of 1 bathroom. The hot water temperature in the resident bathroom was 152.1° Fahrenheit (F). Findings include:	M 570		

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M 570	Continued From page 28 The facility was licensed as an ambulatory adult family home (AFH), serving up to 4 residents in client groups traumatic brain injury, emotionally disturbed/mental illness, physically disabled, and developmentally disabled. On 09/16/2025, at 10:09 AM, Surveyors tested the water temperature in bathroom 1's sink faucet. The water temperature was 152.1°F. "Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents 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-01942, Hot Water Temperatures in Adult Family Homes, August 2017) On 09/16/2025, at 2:40 PM, Surveyors interviewed Licensee A. Licensee A confirmed the water temperature should not exceed 115°F. Licensee A reported Caregiver C tested water temperature monthly. Licensee A reported she would ensure the water temperature was rechecked after it was drained and refilled.	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	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016698	A. BUILDING: _____ B. WING _____	R-C 09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL R3	2019 GREEN ST LOWER RACINE, WI 53402

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M 582	Continued From page 29	M 582		

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 interview and record review, the provider did not ensure 1 of 1 resident received prescribed medications in the dosage and at the intervals prescribed by the resident's physician. Resident 1 did not receive the prescribed insulin in the correct dosage as prescribed by her/his physician.

Findings include:

On 09/16/2025, at 11:30 AM, Surveyors reviewed resident records and identified the following:

- Resident 1 was admitted to the facility on 11/28/2024, with diagnoses including bipolar disorder, type 2 diabetes mellitus, post-traumatic stress disorder (PTSD), and unspecified intellectual disabilities. Resident 1's record contained a medication administration record's (MAR) for 08/01/2025 - 09/30/2025. Resident 1's MAR indicated Resident 1 was prescribed Lispro KWICKPEN 100/milliliter (ML) insulin pens "inject 4 units subcutaneously every evening with dinner and give sliding scale (SS) with all meals: >150: 0units(U), 150-200: 2U, 201-250: 4U, 251-300: 6U, 301-350: 8U, 351-400: 10U, Greater than 400: CALL MD (medical doctor)." Resident 1's file contained a form labeled "Diabetic Med Sheet" with insulin administrations from 08/29/2025 -

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M 582	Continued From page 30 09/14/2025. The "Diabetic Med Sheet" reported the following: - 09/14/2025 at 8:00 PM, BS 312, Units of Insulin 6 Resident 1's "Diabetic Med Sheet" did not indicate if Resident 1 received her/his base dose of 4 units every evening with dinner along with her/his SS dose. Resident 1 should have received 10U of his/her insulin according to his/her order. On 09/16/2025 at 2:40 PM, Surveyors interviewed Licensee A. Licensee A reported caregivers assisted Resident 1 with her/his insulin administration. Surveyors relayed concerns related to Resident 1 not receiving the correct dose of insulin on 09/14/2025 based on her/his sliding scale. Licensee A confirmed Resident 1 did not receive her/his required dose of insulin on 09/14/2025. Surveyors also relayed concerns related to Resident 1's "Diabetic Med Sheet" not indicating if s/he received the ordered base dose of insulin with evening meals. Licensee A reported s/he would have staff retrained on interpreting a SS and on proper documentation for insulin administration .	M 582		
Z 019	50.065(6)(am) Four Year Caregiver Background Requirement Every 4 years an entity shall require its caregivers and nonclient residents to complete a background information form that is provided to the entity by the Department.	Z 019		

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Z 019	Continued From page 31	Z 019		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure caregiver background checks were completed every 4 years for 2 of 2 caregivers reviewed. Caregiver C and Caregiver B did not have a background check completed at least every 4 years.

Findings include:

On 09/16/2025, at 11:15 AM, Surveyors reviewed employee records and identified the following:

- Caregiver C was hired on 01/27/2017. Caregiver C's record did not have a completed background check upon hire. Caregiver C's record contained a background information disclosure (BID), dated 02/07/2023. Caregiver C's record did not contain a Department of Justice check (DOJ) or a caregiver background check (IBIS). Caregiver C's record also contained a BID, DOJ and IBIS, dated 07/28/2025.

Caregiver C's record should have contained a completed background check in 2021.

- Caregiver B was hired on 11/07/2020. Caregiver B's original BID was not in Caregiver B's record. Caregiver B's record did contain a DOJ and IBIS, dated 11/07/2020. Caregiver B's record did not contain evidence of a 4-year background check in 2024.

On 09/16/2025, at 2:20 PM, Surveyors

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Z 019	Continued From page 32 interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A reported s/he must have missed them at the time they were due.	Z 019		