STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011173	A. BUILDING: _____ B. WING _____	R-C 09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HARBOR	**1600 OHIO ST RACINE, WI 53405**

(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
{U 000}	INITIAL COMMENTS On 09/25/2025, Surveyor completed a complaint investigation and a verification visit at Home Harbor. As a result, 2 of the previous 2 deficiencies were re-cited, and 2 new deficiencies were identified; therefore 4 total deficiencies were identified. One complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 86	{U 000}		
U 118	89.23(2)(a)2.c SERVICES SUFFICIENT SERVICES. Minimum required services. A residential care apartment complex shall have the capacity to provide all of the following services to all tenants, either directly or under contract: c. Nursing services: health monitoring, medication administration and medication management. This Rule is not met as evidenced by: Based on observation and record review, the provider did not ensure nursing services were provided to all tenants for medication administration and medication management. This	U 118		

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
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U 118	Continued From page 1 had the potential to affect 86 of 86 tenants. Findings include: Wis. Admin. Code ch. 89 defines medication management as the following: means oversight by a nurse, pharmacist or other healthcare professional to minimize risks associated with use of medications. Medication management includes proper storage of medications; preparation of a medication organization or reminder system; assessment of the effectiveness of medications; monitoring for side effects, negative reactions and drug interactions; and delegation and supervision of medication administration. On 09/16/2025, at approximately 1:20 PM, Surveyors observed and reviewed the 3 medication (med) carts at Home Harbor and the following expired medications were identified: Med Cart 1 - North Tenant 6: - 1 bottle of polymyxin B trimethoprim (tmp) eye drops; Filled: 07/03/2024 - Discard By: 07/03/2025. - A bubble pack of acetaminophen 500 milligram (mg) caplets (caps), 19/30 caps remaining; Filled: 07/03/2024 - Discard By: 07/03/2025. - A bubble pack of prednisone 10 mg tablets (tabs), 20/20 tabs remaining; Filled: 09/05/2024 - Discard By: 09/05/2025. Tenant 7: - 1 tube of hydrocortisone 1% cream; Filled: 09/09/2024 - Discard By: 09/09/2025. - 1 bottle of refresh liquigel 1% eye drops; Filled: 02/06/2024 - Discard By: 02/05/2025.	U 118		

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U 118	Continued From page 2 - A bubble pack of tizanidine 2 mg tabs, 25/30 tabs remaining; Filled: 05/23/2024 - Discard By: 05/23/2025. - A bubble pack of senna 8.6 mg tabs, 56/60 tabs remaining; Filled 02/06/2024 - Discard By: 02/05/2025. - A bubble pack of ondansetron hydrochloride (HCl) 4 mg tabs, 29/30 tabs remaining; Filled: 02/06/2024 - Discard By: 02/05/2025. - A bubble pack of furosemide 40 mg tabs, 30/30 tabs remaining; Filled: 02/06/2024 - Discard By: 02/05/2025. - A bubble pack of acetaminophen 325 mg tabs, 16/60 tabs remaining; Filled: 02/06/2024 - Discard By: 02/05/2025. Tenant 13: - A bubble pack of acetaminophen 325 mg tabs, 28/30 tabs remaining; Filled: 03/12/2024 - Discard By: 03/12/2025. - A bubble pack of tramadol HCl 50 mg tabs, 25/30 tabs remaining; Filled: 07/08/2024 - Discard By: 07/08/2025. Med Cart 2 - Main Tenant 8: - A bubble pack of acetaminophen 500 mg caps, 9/30 caps remaining; Filled 05/06/2024 - Discard By: 05/06/2025. - A bubble pack of baclofen 5 mg tabs, 22/30 tabs remaining; Filled: 04/09/2024 - Discard By: 04/09/2025. - A bubble pack of ondansetron HCl 4 mg tabs, 12/30 tabs remaining; Filled: 04/09/2024 - Discard By: 04/09/2025. Tenant 9: - A bubble pack of hyoscyamine 0.125 mg tabs sublingual (SL), 15/15 tabs remaining; Filled:	U 118		

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U 118	Continued From page 3 03/22/2024 - Discard By: 03/22/2025. - A bubble pack of ibuprofen 400 mg tabs, 23/30 tabs remaining; Filled: 04/01/2024 - Discard By: 04/01/2025. - A bubble pack of loperamide HCl 2 mg caps, 16/20 caps remaining; Filled: 05/06/2024 - Discard By: 05/06/2025. - A bubble pack of ondansetron HCl 4 mg tabs, 7/10 tabs remaining; Filled: 03/22/2024 - Discard By: 03/22/2025. - A bubble pack of simethicone 80 mg chew, 27/30 chews remaining; Filled: 04/18/2024 - Discard By: 04/18/2025. - A bubble pack of lorazepam 0.5 mg tabs, 9/15 tabs remaining; Filled: 04/27/2024 - Discard By: 04/27/2025. - A bubble pack of lorazepam 0.5 mg tabs, 12/15 tabs remaining; Filled: 03/22/2024 - Discard By: 03/22/2025. Tenant 10: - A bubble pack of benzonatate 200 mg caps, 10/10 caps remaining; Filled: 03/19/2024 - Discard By: 03/19/2025. Tenant 11: - A bubble pack of hydroxyzine HCl 10 mg tabs, 27/30 tabs remaining; Filled: 05/02/2024 - Discard By: 05/02/2025. Tenant 12: - A bubble pack of cyclobenzaprine HCl 5 mg tabs, 9/30 tabs remaining; Filled: 07/09/2024 - Discard By: 07/09/2025. Med Cart 3 - South Tenant 14: - 1 Novolog insulin pen, dated 01/13/2025 by the pharmacy; Date Opened: 06/13.	U 118		

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U 118	Continued From page 4 Tenant 15: - 1 inhaler, 204 puffs remaining; Filled:12/13/2024 - Discard By: 12/12/2024 Interviews On 09/16/2025, at 1:21 PM, Surveyors interviewed Care Staff Manager (CSM) J, and the following was reported: From May 2025 through 08/10/2025, Nurse N was overseeing nursing services at the residential community apartment complex (RCAC). On 08/11/2025 through the time the RCAC hires a full-time permanent nurse, agency nurses were utilized. Agency nurses came into the RCAC 2 times per week to provide resident cares. Surveyors inquired who was responsible for medication administration and medication management. CSM J reported s/he was unaware of anyone who was responsible for reviewing medications and checking the medication carts for expired and discontinued medications. CSM J reported s/he would have to add checking the medication carts to her/his list of responsibilities. CSM J was delegated by Former Facility Licensed Practical Nurse (LPN) D in May 2025. On 09/16/2025, at 3:06 PM, Surveyors interviewed Executive Director (ED) G, and the following was reported: As of 08/08/2025, Nurse N was no longer employed at the RCAC. Agency nurses were coming in periodically to help conduct initial assessments, assist in determining information to be included in service plans, and to check on resident cares. ED G reported the agency registered nurse (RN) had checked medication	U 118		

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U 118	Continued From page 5 carts on Wednesday and Friday the previous week. ED G did not offer any further information and deferred further questions about medications and nursing to Director of Resident Care (DRC) I. On 09/16/2025, at approximately 3:15 PM, DRC I joined Surveyors and ED G in the interview. The following was reported by DRC I: DRC I was responsible for clinical services and hiring a nurse and caregivers. S/He and CSM J dictated job duties to the nurses. Surveyor inquired who was responsible for ensuring medications were reviewed and checking the med carts for expired/discontinued meds. DRC I reported upper management had "split us up," and it was her/his job to manage the clinical department. DRC I did not offer information as to who was responsible for the med carts. S/He reported the oncoming nurse will need to make reviewing the medication passing her/his first task. On 09/25/2025, at 9:35 AM, Surveyors interviewed Interim Executive Director K, DRC I, RN M, and President of Home Harbor (PHH) S, and the following was reported: They were made aware of the medication issues following Surveyors onsite visit. They hired RN M the week of 09/22/2025. RN M had started working on a med handbook and a med checklist. Following our interview RN M was going to begin delegating all med passers. PHH S reported s/he was confident with the newly appointed team of staff and that they would make the corrections needed to be deficiency free. Cross Reference: U0129 89.23(4)(a)2 - Services	U 118		

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U 129	Continued From page 6	U 129		
U 129	89.23(4)(a)2. SERVICES PROVIDER QUALIFICATIONS. Service Providers. Nursing services and supervision of delegated nursing services shall be provided consistent with the standards contained in the Wisconsin nurse practice act. Medication administration and medication management shall be performed by or, as a delegated task, under the supervision of a nurse or pharmacist. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure medication administration and medication management were performed by or delegated under the supervision of a nurse or pharmacist. Staff who passed medications to tenants were not delegated to do so after 05/24/2025. Medications were being administered and managed without the supervision of a nurse or pharmacist from 05/24/2025 through the date of this survey. This had the potential to affect 86 of 86 tenants. Findings include: On 08/25/2025, the Department received a complaint alleging a tenant had not received medications for several days, and medications were missing and not available for administration. The complaint alleged the facility did not have a	U 129		

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U 129	Continued From page 7	U 129		

nurse on staff and had been operating without one for approximately 2 weeks.

On 09/16/2025, at 9:10 AM, Surveyors conducted an onsite survey at the facility, which included interviews of staff, and the following was identified:

Interview with Director of Resident Care (DRC) I -

At 9:55 AM, Surveyors interviewed DRC I and s/he reported the following:

The facility did not have an in-house nurse. A nurse that previously worked part-time for the facility was going to begin working on 09/29/2025. During the time the facility was without an in-house nurse, they had contracted with a contracted health agency. A registered nurse (RN) and a licensed practical nurse (LPN) came to the facility to conduct assessments when needed.

Interview with Care Staff Manager (CSM) J -

At 1:21 PM, Surveyors interviewed CSM J and s/he reported the following:

The facility had been utilizing agency nurses since 08/11/2025, up to twice per week. All of the current medication passers, including her/himself, were delegated for medication administration and management by previous facility nurses. CSM J believed s/he was delegated by LPN D, who was no longer working at the facility and had not been since May 2025. At the end of May 2025 through approximately 08/10/2025, Nurse N had been working at the facility. CSM J did not believe Nurse N had delegated any of the medication passers. RN M had been rehired and set to begin

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U 129	Continued From page 8 employment on 09/29/2025. Interview with Executive Director (ED) G - At 3:06 PM, Surveyors interviewed ED G and s/he reported the following: ED G began employment with the facility on 05/05/2025. LPN D was working as the in-house nurse at that time. LPN D ended employment on 05/24/2025. Nurse N was hired on 05/20/2025 and ended employment on 08/08/2025. Agency nurses were contracted to work at the facility. An RN came in to conduct initial assessments as needed, and an LPN came in to check on residents and provide cares. The agency RN was checking medication carts and had last checked them on 09/10/2025 and 09/12/2025. Interview with DRC I - At approximately 3:20 PM, Surveyors interviewed DRC I and s/he reported the following: S/He was responsible for managing the clinical department and was working on hiring a facility nurse. S/He provided oversight of CSM J, whose job duties included dictating job duties to the RN's. DRC I reported LPN D likely delegated the medication passers, prior to her/his resignation/termination in May 2025. DRC I reported the first action of the oncoming nurse will need to be reviewing medication passing. On 09/18/2025, at 4:48 PM, Surveyor received and reviewed the staff roster for the facility. Surveyor identified the facility had 11 staff listed as medication technicians (med tech(s)) who were under the supervision of the nursing department; CSM J managed the Nursing	U 129		

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U 129	Continued From page 9 Department and DRC I was listed under the Administration Department. None of the staff on the facility's roster, including CSM J and DRC I held credentials in nursing. The staff roster did not include a nurse. Interview with Interim Executive Director K - On 09/25/2025, at 9:30 AM, Surveyors interviewed Interim Executive Director K and s/he reported the following: S/He confirmed Caregiver L was the only staff who had been delegated in 2024 by a previous facility RN. The newly hired RN M would be delegating all facility med techs following the interview. On 09/25/2025, at 4:09 PM, DRC I sent Surveyor an email containing documentation of Former Facility LPN D's delegations to CSM J on 04/22/2025, Med Tech P on 03/12/2025, and Med Tech Q on 05/16/2025. DRC I confirmed these were the only documents the facility had of delegation of medication passers. DRC I confirmed delegations were not valid when the nurse/pharmacist who provided delegation was no longer employed at the facility. Cross Reference: U0118 89.23(2)(a)2c - Services	U 129		
{U 189}	89.28(1) Risk Agreement (1) REQUIREMENT As a protection for both the individual tenant and the residential care apartment complex, a residential care apartment complex shall enter into a signed, jointly	{U 189}		

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{U 189}	Continued From page 10 negotiated risk agreement with each tenant by the date of occupancy. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 4 tenants (Tenant 2, Tenant 3, Tenant 4, and Tenant 5) had signed, jointly negotiated risk agreements by the date of occupancy, or with additional risks identified. Tenant 3's, Tenant 4's, and Tenant 5's risk agreements were not completed by the date of occupancy. Tenant 2's risk agreement did not identify the resident's choice to receive 1 of her/his medications from a different pharmacy and have it delivered directly to the tenant to be turned over to the facility for administration. This resulted in missing medication and missed administrations. This is a repeat citation. See Statement of Deficiency (SOD) 64R311, dated 04/24/2025. Findings include: Wis. Admin. Code ch. 89 defines risk agreement as the following: means a binding stipulation identifying conditions or situations which could put the tenant at risk of harm or injury and the tenant's preference for how those conditions or situations are to be handled. On 09/16/2025, at 11:16 AM, Surveyors reviewed tenant files, and the following was identified: Tenant 3 was admitted to the facility on 08/01/2025. Tenant 3's risk agreement was signed and dated on 08/12/2025, 11 days after the date of admission. Tenant 4 was admitted to the facility on	{U 189}		

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{U 189}	Continued From page 11 08/01/2025. Tenant 4's risk agreement was signed and dated on 08/13/2025, 12 days after the date of admission. Tenant 5 was admitted to the facility on 07/01/2025. Tenant 5's risk agreement was signed and dated on 08/12/2025, 42 days after the date of admission. Tenant 2 was admitted to the facility on 07/27/2017. Tenant 2's risk agreement did not identify any risks specific to Tenant 2. Tenant 2 required medication administration from staff at the facility and had this as an added service as part of her/his service agreement. Tenant 2 received medications from 3 separate pharmacies, one of which delivered the medication directly to Tenant 2. On 09/16/2025, at 2:56 PM, Surveyors interviewed Executive Director (ED) G. ED G verified with Community Relations Administrator (CRA) R the risk agreements for Tenant 2, Tenant 3, Tenant 4, and Tenant 5, provided to Surveyors to review, were accurate. ED G confirmed risk agreements were to be completed by the date of occupancy. S/He was unsure of why that was not done for the above tenants. On 09/25/2025, at 9:35 AM, Surveyors interviewed Interim Executive Director K and Director of Resident Care I, and the following was reported: Director of Resident Care I confirmed Tenant 2 had a medication which had been delivered directly to her/him and Tenant 2 did not recall receiving the medication. There was confusion with Tenant 2's medications due to them coming from different pharmacies and not all being	{U 189}		

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{U 189}	Continued From page 12 delivered directly to the facility to place into the medication carts. Interim Executive Director K was unsure of why Tenant 2's medications had been setup that way, and stated, "That's a definite way for things to be lost." They reported they were unaware what should go into a risk agreement. Interim Executive Director K reported they would look through each tenants' file to review their risk agreements and make the necessary updates/corrections.	{U 189}		
{U 267}	89.34(16) TENANT RIGHTS Rights of tenants. A tenant of a residential care apartment complex shall have all the rights listed in this section. These rights in no way limit or restrict any other rights of the individual under the U.S. Constitution, civil rights legislation or any other applicable statute, rule or regulation. Tenant rights are all of the following: (16) MEDICATIONS. Except as provided for in the service agreement, to have the facility not interfere with the tenant's ability to manage his or her own medications or, when the facility is managing the medications, to receive all prescribed medications in the dosage and at the intervals prescribed by the tenant's physician and to refuse medication unless there is a court order. This Rule is not met as evidenced by:	{U 267}		

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{U 267}	Continued From page 13 Based on record review and interview, the provider did not ensure 1 of 1 resident (Tenant 2) received all medications as prescribed. Tenant 2 missed 59 doses of dalfampridine, 1 dose of buspirone, 1 dose of clonazepam, 1 dose of mybetriq, and 6 doses of teriflunomide, for a total of 68 doses within a 32-day period. This is a repeat citation. See Statement of Deficiency (SOD) 64R311, dated 04/24/2025. Findings include: On 08/25/2025, the Department received a complaint alleging a tenant had not received medications for several days, and medications were missing and not available for administration. On 09/16/2025, at approximately 11:15 AM, Surveyor reviewed Tenant 2's record. Tenant 2 was admitted to the facility on 07/27/2017. Tenant 2's service agreement included medication management. Tenant 2's medication orders included the following: - Buspirone hydrochloride (HCl) 15 milligram (mg) tablets (tabs), take 1 tab by mouth 2 times daily 8:00 AM/ 5:00 PM, scheduled on 04/30/2025 - no end date. - Clonazepam 0.5 mg tabs, take 1 tab by mouth 2 times daily 8:00 AM/ 5:00 PM, scheduled on 07/28/2025 - no end date. - Dalfampridine extended release (Er) 10 mg tablet taken every 12 hours (tb12), take 1 tab by mouth every 12 hours at 6:00 AM and 6:00 PM, scheduled on 05/06/2025 - no end date.	{U 267}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011173	A. BUILDING: _____ B. WING _____	R-C 09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HARBOR	1600 OHIO ST RACINE, WI 53405

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{U 267}	Continued From page 14 - Mybetriq Er 50 mg tab, take 1 tab by mouth once daily at 5:00 PM, scheduled on 02/12/2025 - no end date. - Teriflunomide 14 mg tabs, take 1 tab by mouth once daily, scheduled for 06/23/2025 - no end date. Tenant 2's August and September 2025 Medication Administration Records (MARs) documented Tenant 2 did not receive the following medications: From 08/01/2025 through 08/29/2025, Tenant 2 had physician orders to take dalfampridine Er 10 mg tab by mouth every 12 hours at 6:00 AM and 6:00 PM. Tenant 2's MAR documented grayed out boxes, indicating the medication had been discontinued and not administered. Tenant 2 missed her/his twice daily doses of dalfampridine from 08/01/2025 - 08/29/2025. On 08/06/2025, at 5:00 PM, the MAR had blank boxes for the following medications, which indicated the medication had not been passed: - Buspirone HCl 15 mg tab - Clonazepam 0.5 mg tab - Mybetriq Er 50 mg tab On 08/20/2025, at 8:00 AM, under teriflunomide 14 mg tab the MAR documented refusal (RF) and staff initials, indicating Tenant 2 refused the medication. The notes stated, "Med not in cart." On 08/21/2025, at 8:45 AM, under teriflunomide 14 mg tab the MAR documented other and staff initials. The notes stated, "On order." On 08/22/2025, at 8:19 AM, under teriflunomide 14 mg tab the MAR documented other and staff	{U 267}		

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{U 267}	Continued From page 15 initials. There were no notes to support why the medication had not been administered. On 08/24/2025, at 7:59 AM, under teriflunomide 14 mg tab the MAR documented other and staff initials. There were no notes to support why the medication had not been administered. On 08/25/2025, at 9:55 AM, under teriflunomide 14 mg tab the MAR documented other and staff initials. The notes stated, "Unavailable." On 08/26/2025, at 10:00 AM, under teriflunomide 14 mg tab the MAR documented RF and staff initials, indicating Tenant 2 refused the medication. On 09/01/2025, at 7:31 PM, under dalfampridine Er 10 mg Tb12 the MAR documented other and staff initials. The notes stated, "Sleeping." Interviews On 09/16/2025, at 1:21 PM, Surveyors interviewed Care Staff Manager (CSM) J and the following was reported: On 06/21/2025, CSM J received a text message from Nurse N, which stated Tenant 2's dalfampridine Er 10 mg Tb12 was discontinued, and it had been entered into her/his MAR as discontinued. Nurse N had made a mistake when s/he discontinued Tenant 2's medication. On 08/23/2025, CSM J reactivated Tenant 2's dalfampridine Er 10 mg Tb12 on her/his MAR, after learning of the mistake. CSM J called the pharmacy to discuss the discontinuation/reactivation, and the pharmacist stated the medication required new physician orders to be reactivated. CSM J deactivated the	{U 267}		

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{U 267}	Continued From page 16	{U 267}		

medication in the system, again, that same day. CSM J spoke with Power of Attorney of Health Care (POAHC) O. POAHC O provided the residential care apartment complex (RCAC) with Tenant 2's medication list and discussed it with the physician and pharmacy to get dalfampridine Er 10 mg Tb12 put back onto Tenant 2's scheduled medications. Tenant 2's medication was delivered directly to her/him at the RCAC, on 08/15/2025. Staff could not locate the medication, and it was reordered on 08/26/2025. Tenant 2 had not received dalfampridine Er 10 mg Tb12 since it had been discontinued in the system on 06/21/2025. CSM J confirmed all of the above documentation indicated Tenant 2 missed medications. The documented refusal on 08/26/2025, should not have been documented as a RF, and should have been documented as medication not available. CSM J reported the notation on 09/01/2025 that Tenant 2 was sleeping did not make sense. Tenant 2 was known to stay awake until s/he received her/his evening medications, and if s/he had been sleeping, CSM J reported the medication should have still been offered/passed.

On 09/16/2025, at approximately 3:10 PM, Surveyors interviewed Director of Resident Care (DRC) I, and the following was reported:

In June 2025, Nurse N told staff Tenant 2's dalfampridine Er 10 mg Tb12 was discontinued. Tenant 2 was on this medication for many years and POAHC O did not understand or agree the medication should have been discontinued. The medication was mistakenly discontinued, and Tenant 2 did not receive the medication while it was documented on the MAR as discontinued. DRC I stated, "If there was a nurse here, this would have been resolved more quickly."

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