STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017717	A. BUILDING: _____ B. WING _____	C 04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCELCARE ADULT HOME INC EXCELCARE 3	12051 N BRIARHILL RD MEQUON, WI 53097

(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 04/06/2026, Surveyor conducted one (1) complaint and abbreviated survey at Excelcare Adult Home Inc Excelcare 3. Additional information gathered through 04/08/2026. As a result of the survey, the complaint was unsubstantiated, and the abbreviated survey resulted in 1 deficiency. Census: 4	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 the residence was a homelike environment for 4 of 4 residents, Resident 1, Resident 2, Resident 3 and Resident 4. Findings Include: The provider is licensed for client groups emotionally disturbed/mental illness, developmentally disabled, traumatic brain injury, advanced age, physically disabled and/or irreversible dementia/Alzheimer's. On 04/06/2026, at 11:30 AM, Surveyor toured the home with Caregiver B. Surveyor observed:	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
	0017717	A. BUILDING: _____ B. WING _____	C 04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCELCARE ADULT HOME INC EXCELCARE 3	12051 N BRIARHILL RD MEQUON, WI 53097

(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 * kitchen cabinet contained food items like pasta and jiffy corn muffin mix open and not sealed * potatoes and onions stored on floor in box and onions were sprouting * 2 hallway lights missing the light cover * Resident 1's bedroom missing light fixture cover * Basement ceiling tiles missing * Bathroom holes in walls and walls scraped with paint missing * Resident 1's pillow on bed without pillow protector and pillow case; multiple stains on the pillow * Thermostat in living room dirty with tape over the buttons so temperature can not be adjusted * Chair in living room with approximate 10" diameter stain and fabric fraying on edge of chair * Both entrance/exit doors had deadbolts approximately 4" above the door handle On 04/06/2026 at approximately 1:15 PM, Surveyor interviewed Licensee A. Licensee A acknowledged the potatoes/onions sprouting should be tossed and stated s/he would work with staff to put the potatoes and onions on a shelf, not the floor. Licensee A observed the light fixtures missing the light covers. Licensee A stated s/he was unaware the ceiling tiles were missing in the basement but would ensure they are replaced. Licensee A acknowledged the chair in the living room should be tossed. Licensee A stated Resident 1 does not like a pillowcase on pillow, s/he would replace the pillow and ensure the pillow is clean and laundered as needed. Licensee A stated s/he would have the exit doors corrected to ensure the doors can be opened with the door lever. Licensee A acknowledged 3 of 4 residents were wheelchair bound and that residents needed assistance. Surveyor shared concerns with the home like environment and Licensee A stated s/he would work on the	M 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017717	A. BUILDING: _____ B. WING _____	C 04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCELCARE ADULT HOME INC EXCELCARE 3	**12051 N BRIARHILL RD MEQUON, WI 53097**

(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 2 concerns identified.	M 276		