STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018281	A. BUILDING: _____ B. WING _____	R-C 12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR LIVING LLC	10179 RANGER STATION ROAD HAYWARD, WI 54843

(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
{N 000}	Initial Comments On 12/18/2025, Surveyor began a verification visit and complaint investigation at Harbor Living LLC. Data was collected through 12/19/2025. Ten of 11 violations from Statement of Deficiency (SOD) QJT511 were corrected. One violation is a repeat deficiency. See SOD QJT511, dated 11/10/2024. The complaint was unsubstantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 15.	{N 000}		
{N 220}	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 4 caregivers sampled	{N 220}		

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

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{N 220}	Continued From page 1 were screened for communicable disease, including tuberculosis (TB), prior to working with residents. This is a repeat violation. See Statement of Deficiency (SOD) QJT511, dated 11/10/2024. Findings include: The provider is licensed to care for 16 residents in the client groups physically disabled, developmentally disabled, emotionally disturbed/mental illness, advanced aged, traumatic brain injury, irreversible dementia/Alzheimer's disease, and terminally ill. On 12/18/2025, Surveyor reviewed Caregiver A's, Caregiver B's, and Caregiver C's record. Caregiver A was hired on 03/11/2024. His/her file did not contain evidence s/he was screened for TB. Caregiver B was hired 06/25/2025. His/her file did not contain evidence s/he was screened for TB. Caregiver C was hired 05/05/2025. His/her file did not contain evidence s/he was screened for TB. At approximately 12:10 PM, Surveyor interviewed Administrator D who stated s/he would like to administer the TB test him/herself if s/he could find any to order. At approximately 12:15 PM, Surveyor requested Administrator D provide proof of TB testing by 12:00 PM on 12/19/2025. Administrator D stated s/he would have Caregiver A, Caregiver B, and Caregiver C reach out to their medical provider to see if there was a completed TB test.	{N 220}		

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{N 220}	Continued From page 2 On 12/19/2025 at 12:19 PM, Surveyor received a voice mail message from Administrator D that stated that s/he did not have proof Caregiver A, Caregiver B, or Caregiver C had completed TB tests. Administrator D stated s/he may have realized why the TB testing was never completed and that was due to not being able to get hold of anyone at the hospital.	{N 220}		