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 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 06/17/2026, Surveyor completed a verification visit at Excel R3. As a result, 5 previous deficiencies were corrected, and 3 deficiencies were recited. Two of 3 deficiencies are being cited a third time. One deficiency is being cited a fifth time. Census: 3	{M 000}		
{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 all other laws governing the home and its operations potentially affecting 3 of 3 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 fifth time. See Statement of Deficiency (SOD) 38CK15, dated 02/11/2026, SOD 38CK14, dated 09/17/2025, SOD 15D712, dated 06/03/2024, and 15D711, dated 08/02/2023. Findings include: On 06/10/2026, Surveyors reviewed the Departments files and identified the following:	{M 216}		

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

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{M 216}	Continued From page 1 On 04/09/2026, the Department issued SOD 38CK15 and Notice and Order Letter notifying the provider of the results of the verification visit at Excel R3. As a result of the survey, the provider was issued 8 deficiencies. Six of 8 were repeat deficiencies with 1 deficiency being cited for a third time and 1 deficiency being cited for a fourth time. The following deficiencies identified: M0216 88.04(2)(a) - Responsibilities - This is being cited for the fourth time M0262 88.05(2)(a) - Difficulty Walking - This is a repeat cite M0424 88.06(3)(f) - Review of ISP - This is being cited for a third time M0458 88.07(3)(a) - Prescription Medications - This is a repeat cite M0482 88.09(1)(a) - Resident Records - This is a repeat cite M0570 88.10(3)(l) - Safe Physical Environment- This is a repeat cite M0582 88.10(3)(q) - Medications- This is a repeat cite Y0019 50.065(6)(am) - Four Year Caregiver Background Requirement- This is a repeat cite The Special Orders from the Notice and Order Letter included the following: " ... CONSULTANT REQUIRED 1. Pursuant to Wis. Admin. Code §§ DHS 88.03(6)(g)2.b. and 2.e., effective immediately, the licensee shall comply with the requirements specified by Wis. Admin. Code § DHS 88.04(2)(a) and ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. That is, the licensee shall develop and implement corrective measures in consultation with a registered nurse	{M 216}		

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{M 216}	Continued From page 2 (RN) not currently affiliated with the licensee. The RN will have knowledge of assisted living regulations (e.g., Wis. Admin. Code ch. 88, Wis. Stat. ch. 50) and knowledge of the client groups served by Excel R3. The licensee will provide the consultant with a copy of the SOD 38CK15, along with this Notice and Order letter prior to providing consultation services ... ... WITHIN 7 DAYS of receipt of this notice, the licensee shall provide the legal representative and case manager (if any) for each current resident with a copy of Statement of Deficiency 38CK15 and a copy of this Notice and Order letter. The licensee shall retain evidence, acceptable to the department, to verify compliance with this Order. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from each legal representative and case manager. Required evidence will be made available to the department representatives upon request...." On 06/10/2026, Surveyor completed a verification visit at Excel R3. As a result of the survey, the provider was issued 3 deficiencies. Two of 3 deficiencies are being cited a third time. One deficiency is being cited a fifth time. The following deficiencies identified: M0216 88.04(2)(a) - Responsibilities - This is being cited for the fifth time. M0458 88.07(3)(a) - Prescription Medications - This is being cited for the third time. M0582 88.10(3)(q) - Medications- This is being cited for the third time. On 06/10/2026, at 12:40 PM, Surveyor reviewed emails sent from RN Consultant D to Resident 2's, Resident 3's and Resident 4's managed care organization (MCO). The emails were sent on	{M 216}		

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{M 216}	Continued From page 3 04/20/2026 and contained the SOD and Notice and Order letter. The emails to the MCOs contained a chain from a prior email from RN Consultant D regarding the prior survey at Excel R3, which was dated 11/25/2025. On 06/10/2026, at 1:20 PM, Surveyor interviewed Licensee A. Licensee A acknowledged Surveyor's concerns regarding resident's medications. Licensee A reported attempted to get a bridge order after speaking with RN Consultant D. Licensee A reported s/he was unaware the emails were sent to the MCOs after the 7-day requirement. On 06/17/2026 at 2:15 PM, Surveyor interviewed Licensee A. Licensee A reported s/he did not start to employ RN Consultant D until after the SOD came out. Licensee A did report RN Consultant D was assisting at another facility, and Licensee A inquired about how to send out the notifications to the MCOs. Licensee A reported RN Consultant D wrote up the emails for the MCO notifications. Summary: The licensee did not ensure the MCO's received the SOD and Notice and Order Letter within 7 days of receiving the SOD as indicated in the Special Orders. The licensee did not ensure s/he hired a RN Consultant who was not currently affiliated with the licensee as indicated in the Special Orders.	{M 216}		
{M 458}	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from	{M 458}		

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{M 458}	Continued From page 4 the pharmacy and be stored as specified by the pharmacist. 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 1 of 3 residents (Resident 2). Resident 2's in-use insulin pens were stored in the refrigerator which was not secured and was not able to keep the insulin pens at a proper temperature. This deficiency is being cited for a third time. See Statement of Deficiency (SOD) 38CK15, dated 02/11/2026 and SOD 38CK14, dated 09/17/2025. 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 06/10/2026, at 12:48 PM, Surveyor observed a mini fridge located on the kitchen counter. The mini fridge did not contain a locking mechanism. Surveyor observed 2 boxes of Lantus Solostar 100 units/milliliters (mL). The label on the insulin	{M 458}		

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{M 458}	Continued From page 5	{M 458}		

boxes indicated the insulin was prescribed to Resident 2. 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." Surveyor felt the insulin pens. The insulin pens were warm to the touch. Surveyor took a temperature inside the mini fridge, which was 62.6° Fahrenheit (F). One box was labeled with a date from pharmacy of 11/10/2025, the second box was labeled with a date from pharmacy of 02/10/2026.

" ...It is recommended that insulin be stored in a refrigerator at approximately 36°F to 46°F. Unopened and stored in this manner, these products maintain potency until the expiration date on the package. Insulin products contained in vials or cartridges supplied by the manufacturers (opened or unopened) may be left unrefrigerated at a temperature between 59°F and 86°F for up to 28 days and continue to work ...Insulin loses some effectiveness when exposed to extreme temperatures. The longer the exposure to extreme temperatures, the less effective the insulin becomes. This can result in loss of blood glucose control over time." (Source: Food & Drug Administration Website, Information Regarding Insulin Storage and Switching between Products in an Emergency, September 19. 2017, https://www.fda.gov/drugs/emergency-preparedness-drugs/information-regarding-insulin-storage-and-switching-between-products-emergency (retrieval date June 11, 2026).)

On 06/10/2026, at 1:20 PM, Surveyor interviewed Licensee A. Licensee A reported s/he had purchased a new mini fridge since the previous survey and was unaware it was not working properly. Licensee A confirmed the code

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{M 458}	Continued From page 6 requirement to keep medications locked. Licensee A reported s/he would purchase a lock box to start storing insulin in the common 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), 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 2 of 2 residents (Resident 2 and Resident 3) received prescribed medications in the dosage and at the intervals prescribed by the resident's physician. Resident 2 missed 55 doses of prescription medications in June 2026. Resident 3 missed 36 doses of prescription medications in June 2026. This deficiency is being cited for a third time. See Statement of Deficiency (SOD) 38CK15, dated 02/11/2026 and SOD 38CK14, dated 09/17/2025. Findings include: On 06/10/2026, at 12:44 PM, Surveyor reviewed resident records and identified the following:	{M 582}		

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{M 582}	Continued From page 7 Resident 2 was admitted to the facility on 10/14/2018, with diagnoses including intellectual disability. Resident 2's record contained a medication administration records (MAR) for June 2026. Resident 2's MAR indicated Resident 2 was prescribed lamotrigine 150 milligrams (mg) once a day, Biktarvy once a day, benztropine 0.5 mg twice a day, and haloperidol 5 mg 3 times a day. Resident 2's MAR for June 2026 indicated Resident 2 was not administered the following medications: lamotrigine 150 mg at 8:00 AM: 06/01/2026 - 06/09/2026 (9 doses) Biktarvy at 8:00 AM: 06/01/2026 - 06/04/2026 (4 doses) benztropine 0.5 mg at 8:00 AM: 06/01/2026 - 06/09/2026 (9 doses) benztropine 0.5 mg at 8:00 PM: 06/01/2026 - 06/08/2026 (8 doses) haloperidol 5 mg at 8:00 AM: 06/01/2026 - 06/09/2026 (9 doses) haloperidol 5 mg at 4:00 PM: 06/01/2026 - 06/08/2026 (8 doses) haloperidol 5 mg at 8:00 PM: 06/01/2026 - 06/08/2026 (8 doses) Resident 3 was admitted to the facility on 06/01/2019, with diagnoses including Down syndrome. Resident 3's record contained a MAR for June 2026. Resident 3's MAR indicated Resident 3 was prescribed atomoxetine 40 mg once a day, bisoprolol 10-6.25 mg once a day, fluoxetine 20 mg once a day, levocetirizine 5 mg	{M 582}		

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{M 582}	Continued From page 8 once a day, pantoprazole sodium 20 mg once a day, risperidone 1 mg twice a day, vitamin D3 50 mg once a day. Resident 3's MAR for June 2026 indicated Resident 3 was not administered the following medications: atomoxetine 40 mg at 8:00 AM: 06/01/2026 - 06/09/2026 (9 doses) fluoxetine 20 mg at 8:00 AM: 06/01/2026 - 06/09/2026 (9 doses) risperidone 1 mg at 8:00 AM: 06/01/2026 - 06/09/2026 (9 doses) risperidone 1 mg at 4:00 PM: 06/01/2026 - 06/09/2026 (9 doses) On 06/10/2026, at 1:00 PM, Surveyor interviewed Licensee A. Licensee A reported Resident 2 and Resident 3 had an appointment scheduled for 05/27/2026 to see their psychiatrist. Licensee A reported the day of the appointment, Resident 2 had a behavior which caused both Resident 2 and Resident 3 to miss the appointment. Licensee A reported the appointment was rescheduled to 06/08/2026 and the medication refills were reordered. Licensee A reported s/he attempted to get a bridge of medications to help with the gap and it was denied. Licensee A reported s/he tried to get Resident 2 and Resident 3 into their appointment sooner, but because of staffing issues at the doctor's office, they were unable to accommodate anything earlier than 06/08/2026.	{M 582}		