STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019576	A. BUILDING: _____ B. WING _____	C 06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCELCARE INC DBA HARRISON HOME	W72N675 HARRISON AVENUE CEDARBURG, WI 53012

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N 000	Initial Comments On 06/17/2026, Surveyor conducted one (1) complaint investigation and standard survey. Additional information was gathered through 06/24/2026. As a result of the survey, eight (8) deficiencies were identified, the complaint was unsubstantiated. Census: 14	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 1 of 2 caregivers reviewed was screened for clinically apparent communicable disease, including tuberculosis, within 90 days before the start of employment. Findings include: On 06/17/2026 at approximately 9:20 AM, Surveyor requested Caregiver D's employee	N 220		

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

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N 220	Continued From page 1 record from Manager B. Manager B stated s/he did not have access to the employee records and that Administrator A would be on his/her way. At approximately 10:30 AM, Administrator A arrived at the facility and provided Caregiver D's employee record. Caregiver D was hired on 04/28/2025. Caregiver D's record reflected Caregiver D had a tuberculosis test on 05/09/2025, and documentation s/he was screened for clinically apparent communicable disease on 12/07/2024. On 06/17/2026 at 1:00 PM, Surveyor interviewed Administrator A. Administrator A confirmed Caregiver D was not screened prior to starting employment for tuberculosis and that the free of communicable disease screening was completed over 90 days prior to starting employment. The provider did not ensure that caregivers reviewed were screened for clinically apparent communicable disease, within 90 days before the start of employment.	N 220		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid.	N 277		

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N 277	Continued From page 2 This Rule is not met as evidenced by: Based on record review and staff interviews, 1 of 1 employee record reviewed did not have the required continuing education training including reporting of abuse, neglect and misappropriation. Findings include: On 06/17/2026 at approximately 9:20 AM, Surveyor requested Caregiver C's employee record from Manager B. Manager B stated s/he did not have access to the employee records and that Administrator A would be on his/her way. At approximately 10:30 AM, Administrator A arrived at the facility and provided Caregiver C's employee record. Caregiver C was hired on 05/01/2024. Caregiver C's record did not contain evidence of continuing education training in reporting of abuse, neglect and misappropriation for 2025. On 06/17/2026 at 1:00 PM, Surveyor interviewed Administrator A. Administrator A stated s/he was unaware caregivers needed to have the 6 required continuing education requirements every calendar year. Surveyor reviewed the code requirement with Administrator A to include 15 hours of continuing education including training in standard precautions; client group; medications; resident rights; prevention and reporting of abuse, neglect and misappropriation; and fire safety and emergency procedures, including first aide. The provider did not ensure staff received required continuing education annually.	N 277		

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N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were screened within 90 days before or 7 days after admission by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse for clinically apparent communicable disease, including tuberculosis. Findings Include: On 06/17/2026, at approximately 9:20 AM, Surveyor requested Resident 1's resident record from Manager B. Resident 1 was admitted on 02/23/2026, there was no evidence in Resident 1's record s/he was screened for clinically apparent communicable disease, including tuberculosis.	N 302		

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N 302	Continued From page 4 On 06/17/2026 at approximately 1:00 PM, Surveyor interviewed Administrator A. Administrator A showed Surveyor a screening conducted 04/11/2025 prior to a skilled nursing stay. Administrator A confirmed s/he did not have a screening for clinically apparent communicable disease, including tuberculosis, within 90 days before or 7 days after admission for Resident 1. The provider did not ensure residents were screened within 90 days before or 7 days after admission for clinically apparent communicable disease, including tuberculosis.	N 302		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name,	N 406		

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N 406	Continued From page 5 strength and amount. This Rule is not met as evidenced by: Based on observation, staff interview and record review the provider did not establish an effective procedure for the proper destruction and disposal of unused, discontinued, or outdated medications. The medication cart contained opened insulin pens for Resident 1, 2 and 3, with no dates to determine the specific expiration date of the medication. Findings include: Division of Quality Assurance Insulin Storage Guide publication dated 11/2016 indicated, "...Insulin is available from the drug manufacturers in two basic packages-vials and pens. General insulin storage requirements are as follows: ...5. Check Storage guideline specific to the insulin formulation. This is usually in the product package insert...The following tables address specific expiration or beyond-use dating guidelines that apply to insulin products...Pens...Lantus Pen: label expiration date 28 days when seal is punctured..." Review of the Lantus Solostar Pen Manufacturer's Insert revised 07/22/2023 indicated, "An in-use Lantus Solostar Pen should be thrown away after 28 days, even if it still has insulin left in it." On 06/17/2026 at 12:05 PM, Surveyor and Administrator A observed the facility's medication cart. The med cart contained 3 opened Lantus Solostar Pens. Surveyor noted the following:	N 406		

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N 406	Continued From page 6 *Resident 1 had an opened Lantus Solostar Pen, with no dates to confirm when the pen was opened or expired. *Resident 2 had an opened Lantus Solostar Pen, with no dates to confirm when the pen was opened or expired. *Resident 3 had an opened Lantus Solostar Pen, with no dates to confirm when the pen was opened or expired. On 06/17/2026 at 12:20 PM, Administrator A verified the above insulin pens were open and being used for Resident 1, 2 and 3, with no dates to confirm when the pens were opened or when the pens would be expired.	N 406		
N 492	83.45(1)(a) Exterior areas. Exterior areas. The CBRF shall maintain the yard, any fences, sidewalks, driveways and parking areas of the CBRF in good repair and free of hazards. This Rule is not met as evidenced by: Based on observation and interview, the CBRF did not maintain the yard and sidewalks in good repair and free of hazards. Findings include: The provider is licensed to serve up to 8 semi-ambulatory residents. On 06/17/2026 at 10:00 AM, Surveyor observed the following: --The concrete sidewalk from 2 of 3 exits was in	N 492		

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N 492	Continued From page 7 disrepair. Multiple areas exhibited an elevation difference between slabs of concrete up to 2 inches. The condition of the sidewalk created a tripping hazard for residents. --A tree was overgrown on the sidewalk creating an obstruction from the patio to the front of the building. On 06/17/2026 at 1:00 PM, Surveyor interviewed Administrator A. Administrator A acknowledged the concerns with the sidewalk and the tree and stated s/he will have maintenance address the concerns.	N 492		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the	N 525		

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N 525	Continued From page 8 provider did not ensure quarterly fire drills were conducted with both employees and residents including holding one fire evacuation drill annually that simulates the conditions during usual sleeping hours in calendar years 2024 and 2025. Findings include: The provider is licensed to provide care and services to residents within the client groups of irreversible dementia/Alzheimer's, developmentally disabled, advanced age, traumatic brain injury, physically disabled, terminally ill and/or emotionally disturbed mental illness. On 06/17/2026 at approximately 9:20 AM, Surveyor requested the fire drills that had been completed for 2024 and 2025 from Manager B. Manager B provided Surveyor with the binder. Surveyor observed fire drills were completed in 2024 and 2025, but there was not a simulated night time drill completed for 2024 or 2025. Manager B confirmed the completed drills were done on 1st and 2nd shift, and that there had not been a simulated night time drill done in 2024 or 2025. On 06/17/2026 at 1:00 PM, Surveyor interviewed Administrator A. Administrator A stated she was unaware they needed to do the simulated night time drill annually. The provider did not ensure one night time simulated drill annually was conducted.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or	N 526		

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N 526	Continued From page 9 other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure evacuation drills, such as tornadoes, flooding or other emergency or disasters, were completed semi-annually for 2024 and 2025. Findings include: The provider is licensed to provide care and services to residents within the client groups of irreversible dementia/Alzheimer's, developmentally disabled, advanced age, traumatic brain injury, physically disabled, terminally ill and/or emotionally disturbed mental illness. On 06/17/2026 at approximately 9:20 AM, Surveyor requested the other drills that had been completed for 2024 and 2025 from Manager B. There was no documentation provided that other drills were conducted for the 2nd half of 2024 and 2025. On 06/17/2026 at 1:00 PM, Surveyor interviewed Administrator A. Administrator A stated they had completed tornado drills. Surveyor shared the requirement for there to be an other drill completed semi-annually. Administrator A confirmed they had not conducted an other drill in the second half of 2024 or 2025. The provider did not ensure evacuation drills, such as tornadoes, flooding or other emergency or disasters, were completed semi-annually for 2024 and 2025.	N 526		

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N 538	83.48(3)(a) Fire detection systems inspected annually. After the first year following installation, fire detection systems shall be inspected, cleaned and tested annually by certified or trained and qualified personnel in accordance with the specifications in NFPA 72 and the manufacturer ' s specifications and procedures. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the fire detection system (smoke and heat detectors) was tested annually by certified and qualified personnel in accordance with the specifications in NFPA 72 and the manufacture's specifications and procedures. Findings include: The provider is licensed to provide care and services to residents within the client groups of irreversible dementia/Alzheimer's, developmentally disabled, advanced age, traumatic brain injury, physically disabled, terminally ill and/or emotionally disturbed mental illness. On 06/17/2026 at approximately 9:20 AM, Surveyor requested the provider's annual smoke and heat detection inspection report from Manager B. Manager B stated Administrator A would have the records. On 06/17/2026 at 10:30 AM, Administrator A arrived at the facility. Administrator A stated s/he needed to reach out to the company to obtain the records. Administrator A stated Ahern had completed the smoke and heat detector test for	N 538		

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N 538	Continued From page 11 2024 and 2025. The reports from Ahern reflected there were 2 heat detectors. Surveyor shared the requirement for locations of heat detectors. Administrator A stated s/he was unaware of the locations. On 06/18/2026 at 11:36 AM, Surveyor interviewed Staff E with Action Fire Alarm. Staff E stated s/he hasn't been at the facility since 2024 when they conducted emergency lighting testing. Staff E confirmed the last inspection completed there were 3 heat detectors in the facility. Staff E stated they had provided the facility with a quote to fix deficiencies identified during their last inspection, but the facility never replied to the quote. Staff F confirmed the smoke detectors were smoke detectors only and were not heat detectors. On 06/18/2026 at 12:07 PM, Surveyor spoke with Staff F at Ahern. Staff F provided fire inspections for 2024 and 2025. * 12/02/2024 - The report identified 1 failed smoke in the basement, and 2 heat detectors, 1 in the garage and 1 in the kitchen * 12/10/2025 - The report identified 1 failed smoke in the basement, and 2 heat detectors, 1 in the garage and 1 in the kitchen. Staff F confirmed they did not have a return trip to correct the deficiency with the smoke detector identified in the basement on the 2024 or 2025 report. On 06/23/2026 at 9:00 AM, Surveyor reviewed the facility folder for inspections provided at licensing. Surveyor observed a report from Action Fire Alarm dated 12/05/2022. The report identified 3 heat detectors located in the garage and 2 in the attic.	N 538		

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N 538	Continued From page 12 On 06/24/2026 at 11:05 AM, Surveyor interviewed Administrator A. Administrator A stated s/he had Action Alarm at the facility on 06/22/2026 or 06/23/2026. Administrator A acknowledged the basement smoke remained deficient and that Action Alarm was sending him/her a quote to fix. Administrator A confirmed s/he did not have anything scheduled to fix the smoke in the basement. Administrator A stated s/he shared the code requirement with Action Alarm on where the smoke/heat detectors were to be located. The provider did not ensure the fire detection system (smoke and heat detectors) was tested annually by certified and qualified personnel in accordance with the specifications in NFPA 72 and the manufacture's specifications and procedures, and that deficiencies identified were corrected.	N 538		