STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015290	A. BUILDING: _____ B. WING _____	R-C 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCELCARE ADULT HOME INC	3611 N 38TH STREET MILWAUKEE, WI 53216

(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 02/26/2025, Surveyors completed a standard survey, verification visit, and complaint investigation. As a result, 3 of the previous 7 deficiencies were corrected, 4 deficiencies were recited, and 4 new deficiencies were identified for a total of 8 deficiencies issues. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 4	{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 record review and interview, the provider did not ensure the home, and its operation complied with all laws governing the home and its operation affecting 2 of 2 residents. Licensee A was the health care power of attorney for a Resident 3 in the adult family home. Licensee A admitted 2 residents who required wheelchairs (Resident 2 and Resident 3) into a shared bedroom which did not have enough square footage to accommodate needs. Licensee A provided Resident 2 with a 30-day notice, but did not enforce the need for the resident to move out of the shared bedroom and to another facility. Findings include: On 01/31/2025, the Department received a	M 216		

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

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M 216	Continued From page 1	M 216		

complaint alleging the licensee was power of attorney for a resident.

Example 1

On 02/18/2025, at 9:32 AM, Surveyors reviewed Resident 3's record. Resident 3 was admitted on 01/02/2019, with diagnoses including multiple sclerosis, anxiety, abnormalities of gait and mobility, and insomnia. Resident 3's health care power of attorney (POA) was activated on 04/02/2024. Licensee A was listed at Resident 3's health care POA.

According to Wis. Stat. § 155.05(3), No health care provider for an individual, employee of that health care provider or employee of a health care facility in which an individual is a patient or resides, or a spouse of any of those providers or employees, may be designated by the individual as a health care agent unless the health care provider, employee or spouse of the provider or employee is a relative of the individual.

On 02/18/2025, at 11:55 AM, Surveyors interviewed Licensee A. Licensee A reported s/he was not related to Resident 3. Licensee A reported s/he was not aware s/he could not be Resident 3's health care POA. Licensee A reported the hospital staff did not say s/he could not be Resident 3's health care POA. Licensee A reported Resident 3 did not have anyone else, as her/his child had not spoken to Resident 3 since 2016.

Example 2

On 02/18/2025, Surveyors reviewed the department's electronic file for the facility. The provider submitted a waiver to waive the square

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M 216	Continued From page 2	M 216		

footage of the bedroom so 2 nonambulatory residents could share a bedroom measuring 130 square feet. The waiver was denied on 06/20/2022 due to a significant fire safety risk in the event an evacuation was needed.

On 02/18/2025, at 9:25 AM, Surveyors toured the facility and observed Resident 2, and Resident 3 shared a bedroom. Resident 2 and Resident 3 both utilized wheelchairs for mobility and a mechanical lift for transfers.

On 02/18/2025, at approximately 10:10 AM, Surveyors measured the shared bedroom, and the room measured 126 square feet. The space requirement for a resident using a wheelchair was 100 square feet per person. The bedroom did not meet the minimum requirement of 200 square feet.

On 02/18/2025, at 11:50 AM, Surveyors interviewed Licensee A. Licensee A reported s/he issued Resident 2 a discharge notice after the previous survey. Licensee A reported Resident 2's managed care organization (MCO) will not move Resident 2 due to her/him being on hospice and s/he had a tracheostomy. Licensee A reported Resident 2's Power of Attorney (POA) E refused to move Resident 2. Licensee A reported s/he had issued numerous discharge notices, but Resident 2's MCO had not moved Resident 2. Licensee A reported s/he thought about issuing Resident 2 an eviction notice.

On 02/18/2025, at 3:55 PM, Surveyors sent an email to Resident 2's MCO inquiring about Resident 2's discharge from Excelcare Adult Home.

On 02/19/2025, at 2:10 PM, Surveyors received

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M 216	Continued From page 3 an email from Program Supervisor F. Program Supervisor F reported placements have been challenging due to Resident 2's complex medical needs. Program Supervisor reported POA E had declined all placements and Licensee A had consistently communicated to POA E Resident 2 can remain in the facility. Program Supervisor F reported when Resident 2 had been hospitalized, the MCO reached out to the social worker for assistance, but the social worker reported Excelcare Adult Home continued to "assert their willingness to readmit".	M 216		
M 235	88.04(2)(h) COMPLY WITH OSHA The licensee and all service providers involved in the operation of the adult family home shall comply with the universal precautions contained in the U.S. Occupational Safety and Health Administration Standard 29 CFR 1910.1030 for the control of blood-borne pathogens. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 caregivers received training in standard precautions annually, as required in the U.S. Occupational Safety and Health Administration (OSHA) Standard 29 CFR 1910.1030 for the control of blood-borne pathogens. Caregiver B and Caregiver F did not receive annual training in standard precautions in 2023. The OSHA standard requires the employer train each employee with occupational exposure, "At	M 235		

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M 235	Continued From page 4 the time of initial assignment to tasks where occupational exposure may take place" per 1910.1030(g) (2)(ii)(A); and "At least annually thereafter," per 1910.1030(g)(2)(ii) (B). Findings include: On 02/18/2025, at 11:30 AM, Surveyor reviewed Caregiver C's file. Caregiver C was hired on 12/02/2023. Caregiver C received training in standard precautions on 05/10/2024. On 02/18/2025, at 11:55 AM, Surveyor interviewed Licensee A. Licensee A confirmed the code requirement. Licensee A confirmed Caregiver C worked on the floor prior to receiving standard precaution training. Licensee A reported s/he did not know why Caregiver C's training was late.	M 235		
M 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each service provider received 8 hours of annual training for 1 of 2	M 246		

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M 246	Continued From page 5 years reviewed. Caregiver D only received 6 hours of training in 2024. Findings include: On 02/18/2025, at 11:30 AM, Surveyors reviewed Caregiver D's file. Caregiver D was hired on 01/03/2021. Caregiver D's record indicated s/he received 4 hours of first aid and choking training on 07/03/2024 and 2 hours of training in caregiver misconduct training on 05/15/2024. Caregiver D's record did not contain evidence of any other training in 2024. On 02/18/2025, at 11:55 AM, Surveyors interviewed Licensee A. Licensee A confirmed staff were to have 8 hours of training annually. Licensee A reported staff complete training and receive certificates for their files. Licensee A was unable to locate any further training for 2024. Licensee A did not offer a reason Caregiver D's trainings were not in her/his file.	M 246		
{M 310}	88.05(3)(h)5 SPACE IN BEDROOMS A resident bedroom may accommodate no more than 2 persons. A resident bedroom shall have a floor area of at least 60 square feet per resident in shared bedrooms and 80 square feet in single occupancy rooms. For a person requiring a wheelchair, the bedroom space shall be 100 square feet for that resident. This Rule is not met as evidenced by: Based on observation, and interview, the provider	{M 310}		

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{M 310}	Continued From page 6	{M 310}		

did not ensure 1 of 1 shared bedroom had enough square footage for 2 residents who resided in the room. Resident 2 and Resident 3 utilized wheelchairs for mobility. The space requirement for a resident using a wheelchair is 100 square feet of bedroom space per resident. The shared bedroom did not provide a combined space of 200 square feet as required. The shared room measured 126 square feet.

This is a repeat deficiency. See Statement of Deficiency (SOD) RR6111, dated 05/06/2022.

Findings include:

On 02/18/2025, at 9:25 AM, Surveyors toured the facility and observed Resident 2, and Resident 3 shared a bedroom. Resident 2 and Resident 3 both utilized wheelchairs for mobility and a mechanical lift for transfers.

On 02/18/2025, at approximately 10:10 AM, Surveyors measured the shared bedroom, and the room measured 126 square feet. The space requirement for a resident using a wheelchair was 100 square feet per person. The bedroom did not meet the minimum requirement of 200 square feet.

On 02/18/2025, at 11:50 AM, Surveyors interviewed Licensee A. Licensee A confirmed the shared bedroom measured 126 square feet. Licensee A reported s/he issued a discharge notice to Resident 2 after the previous survey; however, they had not been able to find new placement.

On 02/26/2025, at 12:22 PM, Surveyors interviewed Licensee A. Surveyors inquired why Resident 2 received the discharge notice and not

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{M 310}	Continued From page 7 Resident 3. Licensee A reported because of Resident 2's medical needs, the staff receive special training, and s/he would not be able to afford the caregivers to ensure Resident 2's medical needs were met.	{M 310}		
{M 346}	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated annually for evacuation time, using the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not complete an annual evacuation assessment review for 2 of 2 residents who resided in the facility beyond one year. Resident 3 was not assessed annually for evacuation in 2025. Resident 5 was not assessed annually for evacuation in 2024. This is a repeat deficiency. See Statement of Deficiency (SOD) RR6111, dated 05/06/2022. Findings include: On 02/18/2025, at 9:32 AM, Surveyors reviewed resident records and identified the following: Resident 3 was admitted on 01/02/2019, with diagnoses including multiple sclerosis, anxiety, abnormalities of gait and mobility, and insomnia. Resident 3's annual evacuation assessment was	{M 346}		

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{M 346}	Continued From page 8 completed on 01/02/2024. Resident 3's record did not contain evidence indicating an annual evaluation evacuation assessment was completed in January 2025. Resident 5 was admitted on 11/13/2023, with diagnoses including paranoid schizophrenia, insomnia, bipolar disorder and dementia. Resident 5's initial evacuation assessment was completed on 11/13/2023. Resident 5's record did not contain evidence indicating an annual evaluation evacuation assessment was completed in November 2024. On 02/18/2025, at 11:50 AM, Surveyors interviewed Licensee A regarding the annual evacuation evaluation. Licensee A confirmed the evaluation evacuation assessments were to be completed annually. Licensee A reported s/he thought they were all completed. Licensee A reported they must have been missed.	{M 346}		
{M 424}	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences	{M 424}		

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{M 424}	Continued From page 9 change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 4 residents' (Resident 2's, Resident 3's, and Resident 4's) individual service plans (ISPs) were reviewed every 6 months. Resident 2's ISP was not updated when s/he started hospice services. Resident 3's ISP was not updated to reflect when Resident 3 experienced a change of condition. Resident 4's ISP was not reviewed every 6 months. This is a repeat deficiency. See Statement of Deficiency (SOD) RR6111, dated 05/06/2022. Findings include: On 02/18/2025, at 9:32 AM, Surveyor reviewed resident records and identified the following: Resident 2 was admitted on 02/22/2016 with diagnoses including multiple sclerosis, aspiration pneumonia, diabetes, chronic back and neck pain, esophagitis, and mucus plugs with acute respiratory distress. Resident 2's record contained an ISP, dated 05/16/2023. Resident 2 was hospitalized in April 2024. Resident 2's power of attorney was activated on 04/02/2024. Resident 2 started hospice services in April 2024. Resident 3 was admitted on 01/02/2019, with diagnoses including multiple sclerosis, anxiety, abnormalities of gait and mobility, and insomnia. Resident 3's record contained an ISP, dated	{M 424}		

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{M 424}	Continued From page 10 01/09/2023. Resident 3 was admitted to the hospital on the following dates: 04/11/2023 - 04/14/2023 for sepsis due to a urinary tract infection (UTI) and chronic hypoxic respiratory failure 01/20/2024 - 01/31/2024 for sepsis due to a UTI and right middle lobe pseudomonas infection 06/17/2024 - 06/24/2024 for pseudomonas pneumonia 12/15/2024 - 12/27/2024 for acute gastrointestinal (GI) bleed, acute chronic hypoxic respiratory failure, UTI, and acute anemia. 01/18/2025 - 02/01/2025 for hypotension secondary to GI bleed, aspiration pneumonia, acute blood loss anemia, and chronic hypoxic respiratory failure. Resident 3's record did not contain evidence of Resident 3's ISP being reviewed after Resident 3 experienced a change of condition. Resident 4 was admitted on 09/14/2020, with diagnoses including schizophrenia, bipolar with manic psychosis, high blood pressure, asthma, acid reflux, depression, polysubstance abuse with forced remission, type 2 diabetes, hyperactivity, explosive personality disorder, anxiety disorder, herpes simplex and psychosis unspecified. Resident 4's record contained an ISP, dated 11/08/2022. Resident 4's ISP was due to be reviewed in 05/2023, 11/2023, 05/2024, and 11/2024. Resident 4's record did not contain any evidence of Resident 4's ISP being reviewed. On 02/18/2025, at 10:50 AM, Surveyor	{M 424}		

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{M 424}	Continued From page 11 interviewed Licensee A. Licensee A reported all ISPs were just completed and updated. Licensee A reviewed resident files and was unable to find the current ISPs for Resident 2, Resident 3 and Resident 4. Licensee A reported s/he was unsure where the current ISPs were.	{M 424}		
M 504	88.09(1)(d)8 RESIDENT RECORD-ISP The individual service plan required under s. HSS 88.06(3). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 4 residents' (Resident 2's, Resident 3's, and Resident 4's) records contained current individual service plans (ISPs). Findings include: On 02/18/2025, at 9:32 AM, Surveyor reviewed resident records and identified the following: Resident 2 was admitted on 02/22/2016 with diagnoses including multiple sclerosis, aspiration pneumonia, diabetes, chronic back and neck pain, esophagitis, and mucus plugs with acute respiratory distress. Resident 2's record contained an ISP, dated 05/16/2023. Resident 2's record did not contain evidence of a current ISP. Resident 3 was admitted on 01/02/2019, with diagnoses including multiple sclerosis, anxiety, abnormalities of gait and mobility, and insomnia. Resident 3's record contained an ISP, dated 01/09/2023. Resident 3's record did not contain evidence of a current ISP.	M 504		

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M 504	Continued From page 12 Resident 4 was admitted on 09/14/2020, with diagnoses including schizophrenia, bipolar with manic psychosis, high blood pressure, asthma, acid reflux, depression, polysubstance abuse with forced remission, type 2 diabetes, hyperactivity, explosive personality disorder, anxiety disorder, herpes simplex and psychosis unspecified. Resident 4's record contained an ISP, dated 11/08/2022. Resident 4's record did not contain evidence of a current ISP. On 02/18/2025, at 10:50 AM, Surveyor interviewed Licensee A. Licensee A reported all ISPs were just completed and updated. Licensee A reviewed resident files and was unable to find the current ISPs for Resident 2, Resident 3 and Resident 4. Licensee A reported s/he was unsure where the current ISPs were.	M 504		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider	M 570		

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M 570	Continued From page 13 did not ensure a safe physical environment by ensuring water temperatures were kept at a safe temperature for 2 of 2 resident bathrooms. The hot water temperature in the first-floor resident bathroom was 149° Fahrenheit (F). The hot water temperature in the second-floor resident bathroom was 151° F. Findings include: On 02/18/2025, at 10:55 AM, Surveyors tested the water temperature in the first-floor resident's bathroom sink faucet. The water temperature was 149° F. The water temperature in the second-floor resident's bathroom sink faucet was 151° F. "Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding, e.g. second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability." (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017) On 02/18/2025, at 11:50 AM, Surveyors interviewed Licensee A. Licensee A reported the water was tested monthly. Licensee A reported s/he was unaware the water temperature was too high. Licensee A reported the water heater would be turned down.	M 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015290	A. BUILDING: _____ B. WING _____	R-C 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L 103	Continued From page 14	L 103		
L 103	441.301(c)(4)(iii) Ensures Right to Privacy, Respect, Freedom Ensures an individual ' s rights of privacy, dignity and respect, and freedom from coercion and restraint. All staff (paid and unpaid) need initial and annual training on resident rights. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 staff reviewed (Caregiver D) received training in resident rights. Caregiver D did not receive resident rights training in 2023 and 2024. Findings include: On 02/18/2025, at 11:30 AM, Surveyors reviewed Caregiver D's file. Caregiver D was hired on 01/03/2021. Caregiver D's record did not contain evidence of resident rights training in 2023 and 2024. On 02/18/2025, at 11:55 AM, Surveyors interviewed Licensee A. Licensee A confirmed staff were to be training in resident rights annually. Licensee A reported staff complete training and receive certificates for their files. Licensee A was unable to locate any further training for 2024.	L 103		