

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018756	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/03/2026
NAME OF PROVIDER OR SUPPLIER VITACARE LIVING - MENOMONIE I		STREET ADDRESS, CITY, STATE, ZIP CODE 1916 TALEN STREET MENOMONIE, WI 54751		
(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 08/26/2026, Surveyors completed 2 complaint investigations and a standard licensure survey at Vitacare Living- Menomonie I. Data collected through 09/03/2026. One of 2 complaints were substantiated. Eighteen deficiencies were identified. Ten of 18 were repeat deficiencies. See Statement of Deficiency (SOD) 949Y11, dated 06/22/2022; SOD EL5R11, dated 11/08/2022; SOD O2Q311, dated 05/17/2023; SOD O2Q313, dated 03/19/2025; SOD O2Q314, dated 09/15/2025; SOD O2Q315, dated 03/09/2026. Census: 14	N 000		
N 163	83.12(4)(a) Reporting when resident's whereabouts unknown A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time a resident 's whereabouts are unknown, except those instances when a resident who is competent chooses not to disclose his or her whereabouts or location to the CBRF, the CBRF shall notify the local law enforcement authority immediately upon discovering that a resident is missing. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies or persons recovering from substance abuse. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the department within 3 working days after Resident	N 163		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N 163	Continued From page 1 1's whereabouts were unknown on 07/13/2026 and 08/17/2026. This is a repeat deficiency. See Statement of Deficiency (SOD) 949Y11, dated 06/22/2022. Findings include: The Department received a complaint regarding supervision concerns. On 08/26/2026 at approximately 12:19 PM, Surveyor requested Resident 1's record from Regional Director (RD) G. At 4:59 PM, Surveyor received Resident 1's record via e-mail from RD G. On 08/27/2026 at approximately 9:00 AM, Surveyor reviewed Resident 1's notes. A note entered on 07/13/2026 at 10:55 PM read in part, "Per update from residents guardian ... resident was scheduled for a 1:20 PM appointment with [medical doctor] ... transportation had been arranged through [transportation company]; however, resident left the facility prior to the scheduled transportation arrival with [friend] without completing the facility sign-out process. Facility staff attempted to contact [friend] and notified [Guardian I]." A note entered on 08/17/2026 at 1:35 PM read in part, "This writer received a call ... regarding [Resident 1] and whether [s/he] should be alone while out in the community. This writer informed [him/her] that [Resident 1] should not be alone when leaving the facility ...[Resident 1] was found alone at City Hall".	N 163			

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N 163	Continued From page 2 At approximately 9:20 AM, Surveyor reviewed Resident 1's incident reports. There was no incident report regarding Resident 1 leaving the facility on 07/13/2026 without approval or facility staff aware. An incident report dated 08/17/2026 at 8:00 PM, noted that Resident 1 was seen by a staff member getting onto a bus on the side of the road at 9:30 AM that morning. Resident 1 was returned to the facility between 4:30 and 5:00 PM. The incident report noted that it was a reportable incident to the State. At 9:30 AM, Surveyor reviewed the Departments e-file to review if self-reports were submitted for the 07/13/2026 and the 08/17/2026 incident. Surveyor did not find evidence of a self-report for the 07/13/2026 incident. The 08/17/2026 self-report was submitted to the Department on 08/24/2026 at 5:49 PM by Director B, more than 3 working days after the incident. On 09/01/2026 at approximately 2:08 PM, Surveyor interviewed Guardian I. Guardian I stated that s/he was frustrated because Resident 1 was not allowed to have unsupervised time in the community and on 2 different occasions Resident 1 left the facility and staff were unaware. Guardian I stated the first time Resident 1 left with a friend, which resulted in Resident 1 missing an important appointment. Guardian I noted the second time Resident 1 left the facility s/he was gone a long time before staff noticed. On 09/03/2026 at approximately 3:47 PM, Surveyors interviewed Director A and Registered Nurse (RN) E. Director A stated a self-report should have been submitted for the 07/13/2026 incident when Resident 1 left the facility without	N 163			

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N 163	Continued From page 3 staff approval. Director A stated self-reports should be submitted within 3 days and noted that s/he completed his/her self-reports the same day.	N 163		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: As a result of this 2-complaint and licensure survey, a total of 18 violations were issued and 1 of the 2 complaints were substantiated. This was a repeat deficiency. See Statement of Deficiency (SOD)O2Q311, dated 05/17/2023; SOD O2Q314, dated 09/15/2025; SOD O2Q315, dated 03/09/2026. Findings include: On 09/03/2026, Surveyor reviewed department records for Vitacare Menomonie I, licensed on 03/01/2022. Since initial licensure on 03/01/2022, the facility has had 8 substantiated complaints and 74 deficiencies. The provider was issued a No New Admit Order on 10/06/2025. Extended on 04/07/2026. Lifted on 06/03/2026. The following information was reviewed: SOD 949Y11 issued on 09/28/2022. Two deficiencies were identified: 1. 83.12(4)(a) Reporting When Residents Whereabouts Unknown 2. 83.38(1)(b) Supervision	N 196		

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N 196	Continued From page 4 SOD EL5R11 was issued on 12/14/2022. Twenty deficiencies were identified: 83.13(3)(a) Posting License, Deficiencies, Revocations 83.15(3)(a) Administrator Shall Supervise Daily Operation 83.17(1) Licensee Conduct Caregiver Background Check 83.19 Orientation 83.21 (2)(a)-(d) Department-Approved Training Course 83.21(1)-(3) All Employee Training 83.22(1)-(4) Task Specific Training 83.32(3)(b) Rights of Residents: Confidentiality 83.32(3)(d) Rights of Residents: Free of Mistreatment 83.32(3)(h) Rights of Residents: To Receive Medication 83.37(1)(i) PRN Psychotropic Medication 83.37(1)(j) Proof-of-Use Record 83.37(3)(c) Medication Storage: Locked Cabinet 83.38(1)(b) Supervision 83.39(3) Hand Washing 83.45(1)(f) Furnishings Clean, Safe, and Maintained. 83.45(3) Toxic Substances 83.45(5) Garbage and Refuse 83.46(1)(f) Combustibles 83.48(1)(b) Smoke and Heat Detectors Per NFPA 72 SOD 949Y12 was issued on 01/05/2023. One deficiency was identified: 83.39(1) Infection Control Program SOD ELR12 was issued on 02/14/2023. One deficiency was identified:	N 196		

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N 196	Continued From page 5 1. 50.065(2)(bm) Out of State Background Checks SOD O2Q311 was issued on 07/16/2023. Nine deficiencies were identified. 1. 83.14(2)(a) Licensee Ensures Facility Complies with Laws 2. 83.32(3)(h) Rights of Residents: To Receive Medication 3. 83.32(3)(i) Rights of Residents: Prompt and Adequate Treatment 4. 83.35 (1)(b) Sources Used For Assessment Information 5. 83.35(3)(a) Comprehensive Individualized Service Plan 6. 83.36(1)(a) Adequate Staff to Meet Resident Needs 7. 83.37(3)(c) Medication Storage: Locked Cabinet 8. 83.38(1)(b) Supervision 9. 83.45(1)(f) Furnishings Clean, Safe, and Maintained. SOD O2Q312 was issued on 10/18/2024. Five deficiencies were identified. 1. 83.17(2)(a) Employees Screened For Communicable Disease 2. 83.19 Orientation 3. 83.20(2)(a)-(d) Department-Approved Training Course 4. 83.21(1)-(3) All Employee Training 5. 83.44(2)(c) Interior Floors, Walls and Ceilings SOD O2Q313 was issued on 05/15/2025. Three deficiencies were identified. 1. 83.17(2)(a) Employees Screened For Communicable Disease 2. 83.20(2)(a)-(d) Department-Approved Training Course 3. 83.36(1)(a) Adequate Staff to Meet Resident	N 196			

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N 196	Continued From page 6 Needs SOD KO5311 was issued on 09/05/2025. Two deficiencies were identified. 83.13(3)(a) Posting License, Deficiencies, and Revocations 83.36(2) Maintain Current Written Staffing Schedule SOD O2Q314 was issued on 10/07/2025. Five deficiencies were identified. 83.14(2)(a) Licensee Ensures Facility Complies With Laws 83.35(3)(b) Service Plan Development Parties Involved 83.35(3)(d) Service Plans Updated Annually Or On Changes 83.36(1)(a) Adequate Staff to Meet Resident Needs 83.39(3) Hand Washing On 10/07/2025, the provider was sent a notice and order letter for SOD #O2Q314 which contained an order not to admit new or additional residents and special orders. The orders read in part, "Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b)7., EFFECTIVE UPON RECEIPT OF THIS NOTICE AND ORDER, THE DEPARTMENT OF HEALTH SERVICES HEREBY ORDERS THAT VITACARE LIVING - MENOMONIE II NOT ADMIT ANY NEW OR ADDITIONAL RESIDENTS until all violations in SOD #O2Q314 are corrected, compliance is verified by the Department, and this Order is rescinded in writing. Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY	N 196			

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N 196	Continued From page 7 ORDERS that Vitacare Living - Menomonie I: 1. Pursuant to Wis. Stat. § 50.03(5g)(b)3. and (b)6., effective immediately, the licensee will comply with requirements specified by Wis. Admin. Code § DHS 83.36(1)(a) and shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. The facility will develop (or review/revise) written procedures to ensure: -Staffing patterns will be sufficient to meet the personal care needs of residents, to ensure needed supervision, to provide needed services (e.g., toileting, bathing, medication management, interventions to prevent falls, personal cares, meals), and to facilitate a safe evacuation of the building in the event of an emergency. -When a resident or residents (as a group) require the assistance of two or more staff members to address care and service needs, to provide supervision, or to evacuate the building in an emergency, the licensee will ensure sufficient, qualified staff members are on duty, present and available to assist residents at all times. -Written staff schedules will be current and shall include each employee's full name, job assignment and time worked. Records will be amended, as necessary, to ensure an accurate and complete record of time worked by all facility employees, and/or employees of contract agencies providing routine services to facility residents. Additionally: - All managers and resident care staff (as appropriate) will receive in-service training regarding the provider's written procedures required by Order #1. - Training will be documented in employee files and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. - A copy of the written procedures and all documentation as evidence of meeting the requirements in Order #1 will be made available to department representatives	N 196		

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N 196	Continued From page 8 upon request. 2. Pursuant to Wis. Stat. § 50.03(5g)(b)6., within 7 days of receipt of this notice, the CBRF will provide each resident's legal representative and case manager (if any), with a copy of Statement of Deficiency (SOD) O2Q314 and a copy of this Notice and Order letter. The licensee shall retain documentation, acceptable to the Department, to verify compliance with Order #2. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from each legal representative and case manager (if any). The documentation required by Order #2 will be available to department representatives upon request." The provider appealed SOD O2Q314. A stipulated settlement agreement was put into place on 12/19/2025. The settlement agreement reduced the forfeitures. In exchange the provider agreed to comply with the NNAO order, comply with special orders listed above, ensure all citations in O2Q314 were corrected, and pay the reduced forfeitures. On 10/09/2025, the Department issued the facility a warning letter that read in part, "This letter constitutes a warning regarding substantial noncompliance with: Wis. Admin Code, DHS Chapter 50, Uniform Licensure Wis. Admin Code, DHS Chapter 83, Community Based Residential Facilities Failure to correct this pattern of noncompliance will result in license revocation." SOD O2Q15 was issued on 04/07/2026. Seven deficiencies were identified. 83.14(2)(a) Licensee Ensures Facility Complies With Laws 83.34(3) More than \$200 Personal Funds	N 196		

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N 196	Continued From page 9 From Resident 3. 83.34(4) Provide Written Final Accounting 4. 83.35(3)(b) Service Plan Development Parties Involved 5. 83.35(3)(d) Service Plans Updated Annually Or On Changes 6. 83.38(1)(b) Supervision 7. 83.38(1)(c) Leisure Time Activities On 4/07/2026, the provider was sent a notice and order letter for SOD #O2Q315 which contained an order not to admit new or additional residents and special orders. The orders read in part, "Based on the results of the Department's investigation and pursuant to authority provided in Wis. Stat. § 50.03(5g)(b)7., the Department of Health Services HEREBY EXTENDS the ORDER issued on October 07, 2025 with SOD #O2Q314 that Vitacare Living - Menomonie I NOT ADMIT ANY NEW OR ADDITIONAL RESIDENTS until all violations in Statement of Deficiency (SOD) O2Q315 are corrected, compliance is verified by the Department, and this Order is rescinded in writing. Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Vitacare Living - Menomonie I: 1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., effective immediately, the licensee shall ensure all resident care staff provide the supervision necessary to ensure the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. WITHIN 45 DAYS of receipt of this notice, the licensee shall:	N 196		

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N 196	Continued From page 10 - Review the record for each resident with an identified behavioral pattern that is or may be harmful to the resident or others (e.g., physical aggression, wandering and elopement) and risk for falls. - Develop or revise, as necessary, the resident's individualized service plan to comprehensively document the level and frequency of services needed to ensure the resident's safety, including the level of supervision required in the home and community. - Ensure the resident and the resident's legal representative, as appropriate, sign the plan acknowledging their involvement in, understanding of and agreement with the plan. - Ensure all staff responsible for providing services to residents review the resident's individualized service plan and will provide services in accordance with the plan." On 05/28/2026, a letter was sent to the provider with an Order Lifting No New Admissions. On 08/26/2026 at approximately 9:00 AM, Surveyor interviewed Caregiver J. Surveyor asked to speak with the person in charge. Caregiver J reported that Director B quit a few days ago. S/he stated Director A was overseeing, but s/he was on vacation. Caregiver J stated that the team leads were going to help run things until a new director was hired. Caregiver J stated Director A was going to train the team leads on what needed to be done, but they had not yet received training. Caregiver J stated they had limited access to records and were unable to print. Another caregiver, Caregiver K, was able to reach Regional Director (RD) H by phone on the day of survey. Caregiver K reported that RD H would not be coming on site, but s/he would pass along the record request to RD H who would be	N 196		

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N 196	Continued From page 11 able to e-mail Surveyor documents. On 09/02/2026 at approximately 11:30 AM, Surveyors interviewed Director A and Registered Nurse (RN) E. Director A stated s/he was the director of 3 other buildings but had started overseeing this building when Director B left. Surveyor asked who was overseeing the day-to-day operations of the facility. Director A stated s/he was responsible for the daily oversight and that Regional Nurse (RN) F was the administrator. RN E stated that s/he had been in casual status (working limited hours) but had returned full time as of 09/01/2026. RN F was overseeing the nurse responsibilities while RN E was casual. Director A stated that the team leads would be helping RN E with the day-to-day once they were trained. Director A stated s/he had not yet trained the team leads. Throughout the survey, Director A and RN E had difficulties locating some of the required documentation. It was noted that Director B might have deleted e-mails or did not complete his/her job duties. On 09/03/2026, at approximately 2:55 PM, Surveyors interviewed Director A and Registered Nurse (RN) E. Director A noted that there had been some performance concerns related to Director B. Surveyor asked who was overseeing Director B during his/her employment. Director A noted that Regional Nurse (RN) F was overseeing Director B. Director A noted that Director B would report that s/he was completing all required tasks, but during the survey process it was noted that multiple things were in fact not completed.	N 196		

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N 196	Continued From page 12 At approximately 4 PM, Director A stated s/he worked hard to clean up and keep things running smooth at his/her 3 locations. Director A stated that s/he was disappointed with how the survey went. S/he noted s/he had a lot to clean up, but s/he would start working on things right away. During the survey, 18 deficiencies were identified. Ten of 18 deficiencies identified during this survey were repeat deficiencies. The survey was prompted by a standard licensing survey and 2 complaints related to resident care and supervision. One of 2 complaints were substantiated, and the following concerns were identified. Concerns identified with an asterisk (*) were concerns identified during previous surveys (i.e. repeat violations): -*Resident whereabouts were not reported to the department. -Continuing education hours were not completed. -Residents were not free from restraints. -*Residents did not receive all medications at prescribed. -Long term care Ombudsman posters were not posted. -*Residents did not have comprehensive service plans. -*Service plans were not signed by all parties involved. -*Staffing was not adequate to meet resident needs. -Medication errors were not reported. -*Residents were not adequately supervised. -*Activities were not completed. -Diets were not followed. -There was not adequate pest control. -The furnace was not inspected. -*Combustibles were within 3 feet of the furnace.	N 196		

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NAME OF PROVIDER OR SUPPLIER VITACARE LIVING - MENOMONIE I		STREET ADDRESS, CITY, STATE, ZIP CODE 1916 TALEN STREET MENOMONIE, WI 54751		
(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 196	Continued From page 13 -*Smoke detector checks were not completed every other month. -Water temperatures exceeded 115 degrees. Cross reference: N0163 DHS 83.12(4)(a) Reporting When Resident's Whereabouts Unknown N0277 DHS 83.25 Continuing Education N0351 DHS 83.32(3)(g) Rights of Residents: Physical Restraints N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0365 DHS 83.33 (4) Posting Of Long Term Care Ombudsman Program N0386 DHS 83.35 (3)(a) Comprehensive Individualized Service Plan N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved N0396 DHS 83.36(1)(a) Adequate Staff To Meet Resident Needs N0410 DHS 83.37(1)(k) Medication Error Or Adverse Reaction N0426 DHS 83.38(1)(b) Supervision N0427 DHS 83.38(1)(c) Leisure Time Activities. N0448 DHS 83.41(2)(a) Nutrition: Diet N0500 DHS 83.45 (4) Pest Control N0504 DHS 83.46 (1)(c) Heating System Maintenance N0507 DHS 83.46 (1) (f) Combustibles N0535 DHS 83.48 (1) (b) Smoke and Heat Detectors Per Nfpa 72 N0617 DHS 83.55(6)(b) Bath and Toilet Areas: Water Temperature	N 196		
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	N 277		

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N 277	Continued From page 14 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. This Rule is not met as evidenced by: Based on record review and interview, Caregiver C did not receive at least 15 hours per calendar year of continuing education. Findings include: On 08/26/2026 at approximately 2:00 PM, Surveyor requested staff records for Caregiver C. Caregiver C had a hire date of 04/01/2023. Surveyor reviewed Caregiver C's 2025 continuing education. Caregiver C completed 13.75 hours of continuing education in 2025. On 09/03/2026 at approximately 3:20 PM, Surveyors interviewed Director A and Registered Nurse (RN) E. Director A stated they assign 15 hours in EduCare, but it was possible s/he didn't pass a test. Director A stated if they don't pass a course, they must repeat it for the hours to count. Director A stated it was the director's responsibility to audit the continuing education to ensure it was done. Director A stated s/he would start auditing the continuing education for these buildings moving forward to ensure training was completed.	N 277		

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N 351	Continued From page 15	N 351			
N 351	83.32(3)(g) Rights of Residents: Physical restraints In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from physical restraints. Be free from physical restraints except upon prior review and approval by the department upon written authorization from the resident ' s primary physician or advanced practice nurse prescriber as defined in s. N 8.02(2). The department may place conditions on the use of a restraint to protect the health, safety, welfare and rights of the resident. This Rule is not met as evidenced by: Based on record review, interview, and observation, the provider did not ensure Resident 3 was free from restraints. Findings include: On 08/26/2026 at approximately 12:00 PM, Surveyor interviewed Resident 3. While in Resident 3's room, Surveyor noticed that Resident 3 had a hospital bed with bedrails. At 12:10 PM, Surveyor interviewed Caregiver C about Resident 3's bedrails. Caregiver C stated that most days Resident 3 was weak and unable to get up and out of bed him/herself or move around the bedrails. On 08/27/2026 at approximately 10:50 AM, Surveyor reviewed Resident 3's most recent	N 351			

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N 351	Continued From page 16 assessment. The assessment was dated 06/20/2026 and read in part: "Mobility - Bed Needs assistance with bed mobility, specify: [Resident 3] needs assistance getting in and out of bed. Has a hard time moving in bed as [s/he] becomes weaker. Needs assistance with turning and repositioning, specify: That is why [s/he] has bed rails to assist." On 09/03/2026 at 3:16 PM, Surveyor interviewed Director A and Registered Nurse (RN) E. Director A stated to his/her understanding, the bedrail was present when Resident 3 moved into the facility. Director A stated if the bed rail was a restraint, the facility would need to submit a waiver or reevaluate the situation. Director A questioned how Resident 3 would be able to exit the bed if Resident 3 was unable to maneuver around the bedrail. Surveyor asked what the process or policy was used to evaluate bed rail safety. Director A stated that a service plan would be implemented regarding the bedrail to ensure that its use was monitored monthly by the director. Surveyor asked if this process had been completed for Resident 3. Director A stated not that s/he could find. Director A stated that s/he would personally enter Resident 3's room and observe if the resident was able to exit the bed. Director A stated that staff had not informed him/her that Resident 3 had become weaker. S/he stated that staff may have told Director B about Resident 3's change. Director A also noted that when a resident experienced a change in condition, the resident's needs should be reevaluated.	N 351			

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N 352	Continued From page 17	N 352		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received his/her medications as ordered by his/her physician. This is a repeat deficiency. See Statement of Deficiency (SOD) SOD O2Q311, dated 05/17/2023, SOD EL5R11, dated 11/08/2022. Findings include: The provider is licensed to care for 16 residents in the client groups terminally ill, irreversible dementia/Alzheimer's disease, and advanced aged. On 08/27/2026 at approximately 10:00 AM, Surveyor reviewed Resident 1's medication administration record (MAR). Resident 1 was admitted to the facility on 06/16/2026. Resident 1 had diagnoses that included: stroke, anxiety, chronic diastolic congestive heart failure, cognitive defects, dementia with behavioral disturbance, hypertensive heart disease, and mood disorder. Surveyor reviewed Resident 1's June 2026, July	N 352		

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N 352	Continued From page 18 2026, and August 2026 MARs. Resident 1 did not receive the following medications on the noted days because they were unavailable or out of stock. June 2026 -Clonidine Dis 0.1/24hr (Wed)Place 1 patch one the skin once weekly. Missed doses on the 17th and 24th. -Nicotine Td Dis 7mg/24hr (Daily) Apply 1 patch on the skin once daily. Missed doses on the 17th through 29th. July 2026 -Fish Oil 1,000 mg softgel (Daily) Give 1 capsule by mouth once a day. Missed doses on the 22nd through 31st. -Vitamin C (Daily)Give 1 capsule by mouth once a day. Missed doses on the 22nd through 31st. -Vitamin D3 (Cholecalciferol) 50mcg (2000 units) (Daily) Give 1 Tab (tablet) by mouth once a day. Missed doses on the 22nd through 31st. -Nicotine Td Dis 7mg/24hr (Daily) Apply 1 patch on the skin once daily. Missed doses on the 1st, 2nd, 8th through 12th, 14th through 16th, and 20th through 31st. August 2026 -Fish Oil 1,000 mg softgel (Daily) Give 1 capsule by mouth once a day. Missed doses on the 1st through 10th, 12th through 14th, 16th through 19th, and 21st through 26th. -Vitamin C (Daily)Give 1 capsule by mouth once a day. Missed doses on the 1st through 10th, 12th through 14th, 16th through 19th, 21st through 23rd, 25th, and 26th. -Vitamin D3 (Cholecalciferol) 50mcg (2000 units) (Daily) Give 1 Tab (tablet) by mouth once a day. Missed doses on the 1st through 10th, 12th	N 352		

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N 352	Continued From page 19 through 14th, 16th through 19th, 21st through 23rd, 25th, and 26th. -Olanzapine Tab 5mg Odt (Daily) Take 1 tablet by mouth twice. Missed morning doses on the 5th through 9th, 12th through 17th, and 24th. Missed evening doses on the 5th through 16th, and 25th. On 09/01/2026 at approximately 2:00 PM, Surveyor interviewed Guardian I. Guardian I stated the provider had not notified him/her that Resident 1's medications were unavailable at any time since admission. On 09/03/2026 at approximately 3:10 PM, Surveyors interviewed Director A and Registered Nurse (RN) E. Surveyor and Director A looked at Resident 1's MAR's together and noted the number of times Resident 1's medications were unavailable. Director A stated this did not meet their expectations. RN E stated s/he had followed up with pharmacy when his/her employment started back on 09/01/2026 and pharmacy stated they needed new orders from the provider. Director A stated the provider should be reaching out to the pharmacy and PCP (primary care physician) right away when it was noted medications were not being filled.	N 352		
N 365	83.33(4) Posting of long term care ombudsman program The CBRF shall post in a conspicuous location in the CBRF a poster provided by the board on aging and long term care ombudsman program, concerning the long-term care ombudsman program under s. 16.009 (2)(b), Stats. The poster shall include the name, address and telephone number of the ombudsman 's office. This requirement does not apply to those facilities	N 365		

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N 365	Continued From page 20 exclusively licensed to serve clients under the jurisdiction of a government correctional agency. This Rule is not met as evidenced by: Based on observation and interview, the provider did not post in a conspicuous location a poster provided by the Board on Aging and Long Term Care Ombudsman Program, concerning the long-term care ombudsman program. Findings include: On 08/26/2026 at approximately 11:39 AM, Surveyor observed a Citizenship and Immigration Services Ombudsman poster from Homeland Security. Surveyor did not observe any Ombudsman poster for the Board on Aging and Long Term Care. On 09/03/2026 at approximately 3:27 PM, Surveyors interviewed Director A and Registered Nurse (RN) E. Director A stated s/he would get that changed right away.	N 365			
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is	N 386			

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N 386	Continued From page 21 responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure within 30 days after admission, a comprehensive individual service plan (ISP) was developed for Resident 1. This is a repeat deficiency. See Statement of Deficiency (SOD) SOD EL5R11, dated 11/08/2022. Findings include: On 08/26/2026 at approximately 12:19 PM, Surveyor requested Resident 1's record from Regional Director (RD) G. At 4:59 PM, Surveyor received Resident 1's record via e-mail from RD G. Resident 1's record did not contain an ISP. Resident 1 was admitted to the facility on 06/16/2026. Resident 1 had diagnoses that included: stroke, anxiety, chronic diastolic congestive heart failure, cognitive defects, dementia with behavioral disturbance, hypertensive heart disease, and mood disorder. On 08/31/2026 at approximately 4:20 PM, Surveyor interviewed RD G. RD G stated they were unable to locate an ISP for Resident 1. RD G stated the "planned services" document was what the facility referred to as each residents' ISP. RD G stated Resident 1 did not have a planned services document completed. Surveyor	N 386		

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N 386	Continued From page 22 asked if Resident 1 had any other documents that reflected the needs and services the resident was receiving. RD G stated s/he would send Resident 1's master care plan. At 4:40 PM, Surveyor reviewed the master care plan that RD G e-mailed. The master care plan for Resident 1 was dated 08/31/2026, 5 days after the survey had started. On 09/02/2026 at 11:46 AM, Surveyor interviewed Director A and Registered Nurse (RN) E. Director A stated they were unable to find Resident 1's ISP. Director A stated that RN E sent out the finished ISP and documents to Resident 1's guardian for signature yesterday, 9/1/2026. Surveyor requested those documents be e-mailed to him/her by end of day. At 4:41 PM, Surveyor received an e-mail from Director A. The e-mail had 2 documents and noted that it was what the Resident 1's guardian was sent. On 09/03/2026 at 8:00 AM, Surveyor reviewed the documents Director A sent with Resident 1's ISP. The planned services document was dated 09/02/2026. The document laid out different services required for Resident 1, however the outcome, desired outcome, or support instructions were left blank. The e-mail also included the master care plan dated 08/31/2026. At 3:40 PM, Surveyor interviewed Director A and RN E. Surveyor noted that the documents sent to Resident 1's guardian were left blank in multiple spots. Director A stated s/he already had added Resident 1's ISP to his/her to do list. The provider did not complete a comprehensive	N 386		

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N 386	Continued From page 23 ISP for Resident 1 until 9/2/2026, and the 9/2/2026 ISP was still incomplete.	N 386			
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 4 residents reviewed (Resident 1, Resident 3, and Resident 4) or legal representatives were involved in the development of their individual service plans (ISPs). Resident 3 did not sign his/her ISP to acknowledge their involvement in and agreement with the plan. Resident 1's and Resident 4's legal representatives did not sign their ISP to acknowledge their involvement in and agreement with the plan.	N 387			

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N 387	Continued From page 24 This is a repeat deficiency. See Statement of Deficiency (SOD) SOD O2Q315, dated 03/09/2026, SOD O2Q314, dated 09/15/2025. Findings include: On 08/27/2026, Surveyor reviewed resident records. Resident 1 was admitted to the facility on 06/16/2026. Resident 1's record indicated s/he had a guardian. Resident 1's record did not include evidence of ISP or evidence of a signed ISP. Resident 3 was admitted to the facility on 10/27/2022. Resident 3's record did not indicate s/he had a designated representative. Resident 3's Planned Services document and Master Care Plan (MCP), dated 05/21/2026 did not include evidence that it was reviewed or signed by Resident 3. Resident 4 was admitted to the facility on 02/02/2017. Resident 4's record indicated s/he had a guardian or power of attorney. Resident 4's Planned Services document and MCP, dated 05/21/2026 did not include evidence that it was reviewed or signed by Resident 4's guardian or power of attorney. On 08/31/2026 at approximately 4:20 PM, Surveyor interviewed Regional Director (RD) G. RD G stated that the Planned Services document was what they considered the ISP for Residents. RD G stated in addition the residents would have a MCP. RD G stated they send both documents for guardians to review. On 09/03/2026 at approximately 3:40 PM,	N 387			

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N 387	Continued From page 25 Surveyors interviewed Director A and Registered Nurse (RN) E. Director A stated they had sent Resident 1's updated ISP on 09/02/2026 to the guardian for signature. Director A stated they could not find signed ISPs for Resident 3 or Resident 4 in Director B's e-mail. Director A acknowledged the need for ISPs to be signed by the resident or resident's legal representatives.	N 387		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: The provider did not provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This is a repeat deficiency. See Statement of Deficiency (SOD) SOD O2Q313, dated 03/19/2025, SOD O2Q311, dated 05/17/2023. Findings include: On 08/26/2026 at approximately 10:40 AM, Surveyor asked Caregiver C about staffing. Caregiver C stated they staff 2 people on dayshift (6:00 AM until 2:00 PM), 2 people on evening shift (2:00 PM until 10:00 PM), and 1 person on night shift (10:00 PM until 6:00 AM). Surveyor asked Caregiver C if they had any residents that required assistance of 2 staff members. Caregiver C stated that Resident 2 was a 2-assist. Caregiver C also stated that Resident 3 and Resident 5 may require 2-assist depending on the day.	N 396		

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NAME OF PROVIDER OR SUPPLIER VITACARE LIVING - MENOMONIE I		STREET ADDRESS, CITY, STATE, ZIP CODE 1916 TALEN STREET MENOMONIE, WI 54751		
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N 396	Continued From page 26 At 12:19 PM, Surveyor requested resident records. At 12:30 PM, Surveyor asked Caregiver J and Caregiver K for the June 2026, July 2026, and August 2026 staff schedule. Caregiver K provided Surveyor with the August 2026 schedule. Caregiver K stated Caregiver C would have the June 2026 and July 2026 schedule. At 1:30 PM, Surveyor asked Caregiver C for June 2026 and July 2026 schedule. Caregiver C provided Surveyor with the June 2026 schedule and stated that someone disposed of the July 2026 schedule. Surveyor asked Caregiver C about staffing. Caregiver C stated the previous director, Director B, put 1 staff on NOC (night) shift because there was "not much to do." Caregiver C stated staffing decreased to 1 over NOC shift when they were under NNAO (no new admit order) and it was never increased. Caregiver C stated complaints had been brought forward regarding staffing on NOC shift. Surveyor asked Caregiver C what staff do overnight when the 2-assist residents need help. Caregiver C stated that Resident 2 was a 2-assist, but staff would transfer him with 1-assist overnight. S/he stated s/he was unsure how they would transfer Resident 3 overnight with 1 staff. At 5:34 PM, Surveyor requested July 2026 schedule from Regional Director (RD) G and RD H. On 08/27/2026 at 11:00 AM, Surveyor reviewed Resident 2's Assessment dated, 06/11/2026. Under the mobility section of his/her assessment it read in part, "Mobility- Transfer. Needs an assistive device to transfer: Sit-to-stand lift 2	N 396		

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N 396	Continued From page 27 person assist sit to stand. Wheelchair." At 12:45 PM, Surveyor reviewed the staff schedules provided for June 2026, July 2026, and August 2026. The June 2026 schedule indicated that only 1 person worked the night shift (10:00 PM until 6:00 AM) for the whole month of June. The July 2026 schedule indicated that only 1 person worked the night shift (10:00 PM until 6:00 AM) for the whole month of July except for July 6th when a second staff was noted to be training on night shift. The August 2026 schedule indicated that only 1 person worked the night shift (10:00 PM until 6:00 AM) for the whole month of August except for August 7th, August 8th, and August 10th, when a second staff was noted to be training on night shift. On 09/02/2026 at approximately 12:25 PM, Surveyor interviewed Director A and Registered Nurse (RN) E. RN E stated that Resident 2 was a 2-person assist. Surveyor asked if the expectation would be that 2 staff were scheduled on all shifts. Director A stated yes that Director B was told by Regional Nurse (RN) F that s/he needed to schedule 2 staff on all shifts. Surveyor asked when Director B was told s/he needed to make that change. Director A stated that RN F stated, "It was a long time ago." At 3:33 PM, Surveyor received an e-mail from Director A. The email stated that RN F told Director B sometime in June that it was supposed to be 2 staff on every shift.	N 396		

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N 410	Continued From page 28	N 410		
N 410	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident 's record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after Resident 1 refused a medication for 2 consecutive days multiple times during June 2026, July 2026, and August 2026. Findings include: On 08/26/2026 at approximately 12:19 PM, Surveyor requested Resident 1's record from Regional Director (RD) G. On 08/27/2026 at approximately 10:00 AM, Surveyor reviewed Resident 1's medication administration record (MAR). Resident 1 was admitted to the facility on	N 410		

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N 410	Continued From page 29 06/16/2026. Resident 1 had diagnoses that included: stroke, anxiety, chronic diastolic congestive heart failure, cognitive defects, dementia with behavioral disturbance, hypertensive heart disease, and mood disorder. Surveyor reviewed Resident 1's June 2026, July 2026, and August 2026 MARs. Resident 1 refused the following medications on the following days: June 2026 MAR -Certavite/Antioxidants Tab (Daily) take one tablet by mouth daily at 8:00 AM; refused the 22nd through 24th, and 26th through 28th. -Buspirone Tab 5mg (Daily) take 1 tablet by mouth twice daily at 8:00 AM and 8:00 PM. Refused the 8:00 AM dose the 18th through the 24th and the 26th through 28th. Refused the 8:00 PM dose the 17th through 26th and 28th through 30th. July 2026 -Fish Oil 1,000 mg softgel (Daily) take 1 capsule by mouth once a day; refused on the 15th and 16th. -Vitamin C (Daily) take 1 capsule by mouth once a day; refused on the 15th and 16th. -Vitamin D3 (Cholecalciferol) 50mcg (2000 units) (Daily) take 1 tab by mouth once a day; refused on the 15th and 16th. -Aspirin CHW 81mg (Daily) take 1 tablet by mouth once daily; refused on the 15th and 16th. -Certavite/Antioxidants Tab (Daily) take one tablet by mouth daily at 8:00 AM; refused on the 10th through 12th, 15th, 16th, 24th through 26th, and 29th through 30th. -Buspirone Tab 5mg (Daily) take 1 tablet by mouth twice daily. Refused the 8:00 AM dose on	N 410		

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N 410	Continued From page 30 the 1st through 5th, 8th through 17th, 22nd, 24th through the 26th, 29th, and 30th. Refused the 8:00PM dose on the 2nd through 31st. -Ezetimibe Tab 10mg (Daily) take 1 tablet by mouth once daily; refused on the 15th and 16th. -Amlodipine Tab 5mg (Daily) take 1 tablet by mouth daily at bedtime; refused on the 15th, 16th, 24th, and 25th. August 2026 -Certavite/Antioxidants Tab (Daily) take one tablet by mouth daily at 8:00 AM; refused on the 2nd through 4th, 7th through 9th, 12th, 13th, 17th, 21st through 23rd, and 26th. -Buspirone Tab 5mg (Daily) take 1 tablet by mouth twice daily at 8:00 AM and 8:00 PM. Refused the 8:00 AM dose on the 2nd through 4th. Refused the 8:00PM dose on the 1st and 2nd. -Clonidine Dis 0.1/24hr (Re)place 1 patch on the skin once weekly at 8:00 AM; refused on the 5th, 12th, 19th, 26th. -Nicotine Td Dis 7mg/24hr (Daily) apply 1 patch on the skin once daily at 8:00 AM; refused on the 21st and 22nd. -Candesartan Tab 16mg (Daily) take 1 tablet by mouth once daily check blood pressure before taking medication, and retake blood pressure 2 hours after taking medication. Refused the 7th through 26th. -Amlodipine Tab 5mg (Daily) take 1 tablet by mouth daily at bedtime; refused on the 1st and 2nd. On 09/01/2026 at 8:40 AM, Surveyor requested physician or guardian notification for Resident 1. Surveyor did not receive any documentation with notification to Resident 1's physician regarding his/her consecutive refusal of medication for June 2026, July 2026, and August 2026.	N 410		

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N 410	Continued From page 31 On 09/02/2026 at approximately 12:00 PM, Surveyors interviewed Director A and Registered Nurse (RN) E. Surveyor asked if all physician or guardian notifications were sent. RN E stated "yes;" s/he sent all the ones s/he was able to find. RN E stated s/he did not have access to Director B's email notifications to physicians or guardians. Director C stated they would try to get into Director B's email and send any additional documentation by end of day. Surveyor did not receive any physician notification documentation by end of day on 09/02/2026. On 09/03/2026 at approximately 3:00 PM, Surveyors interviewed Director A and Registered Nurse (RN) E. Director A confirmed they could not find any notification regarding medication refusals for Resident 1. Director A stated it would have been Director B's responsibility to ensure that was done.	N 410		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs.	N 426		

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N 426	Continued From page 32 This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide supervision appropriate to Resident 1's needs when s/he eloped and was gone for 6 hours without staff noticing. This is a repeat deficiency. See Statement of Deficiency (SOD) O2Q315, dated 03/09/2026, SOD O2Q311, dated 05/17/2023, SOD EL5R11, dated 11/08/2022, and SOD 949Y11, dated 06/22/2022. Findings include: The Department received a complaint related to supervision concerns. On 08/26/2026 at approximately 10:45 AM, Surveyors interviewed Caregiver C about any elopement risks. Caregiver C stated that Resident 1 was an elopement risk. Caregiver C stated that Resident 1 eloped last week. Caregiver C stated that Resident 1 was now on checks, but unsure how frequently they were. Caregiver C stated that Resident 1 was not allowed unsupervised community time. On 08/26/2026 at approximately 12:19 PM, Surveyor requested Resident 1's record from Regional Director (RD) G. At 4:59 PM, Surveyor received Resident 1's record via e-mail from RD G. Resident 1 was admitted to the facility on 06/16/2026. Resident 1 had diagnoses that included: stroke, anxiety, chronic diastolic congestive heart failure, cognitive defects, dementia with behavioral disturbance, hypertensive heart disease, and mood disorder.	N 426		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018756	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/03/2026
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N 426	Continued From page 33 Resident 1 had a guardian. Resident 1 was placed under protective placement on 06/16/2026. On 08/27/2026 at 6:00 AM, Surveyor reviewed Resident 1's record. Resident 1's record did not contain an individual service plan (ISP). Resident 1's record did contain an assessment, dated 06/20/2026. Resident 1's assessment did not include anything about supervision or that Resident 1 was under protective placement. At 9:20 AM, an incident report dated 08/17/2026 at 8:00 PM, stated that Resident 1 was last seen by 2 staff members around 9:00 AM. It noted that another staff member saw Resident 1 around 9:30 AM getting onto a bus on the side of the road. This caregiver did not notify any other staff when they saw Resident 1 leave. At 3:38 PM, Director B received a phone call from Fire Chief J who informed him/her that Resident 1 was at the City Hall. Director B talked with the staff on shift and neither staff member was aware that Resident 1 had left the building. Resident 1 returned to the facility between approximately 4:30-5:00 PM. On 08/31/2026 at approximately 4:20 PM, Surveyor interviewed RD F. RD F stated they were unable to locate an ISP for Resident 1. RD F stated the "planned services" document was what the facility referred to as each residents ISP. RD F stated Resident 1 did not have a planned services document completed. Surveyor asked if Resident 1 had any other documents that reflected the needs and services the resident was receiving. RD F stated s/he would send Resident 1's master care plan.	N 426			

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N 426	Continued From page 34 At 4:40 PM, Surveyor reviewed the master care plan that was e-mailed from RD F. The master care plan (MCP) for Resident 1 was dated 08/31/2026, 5 days after the survey had started. Resident 1's MCP, dated 08/31/2026 read in part, "Elopement Risk - Is not at risk of elopement- Note: Able to leave and return at will." On 09/01/2026 at 12:43 PM, Surveyor received an e-mail from APS (Adult Protective Services) M. APS M stated that Resident 1 was under guardianship and protective placement. APS M stated that Resident 1 should not be leaving the facility unattended as s/he required 24-hour care and supervision which was why the protective placement was ordered. At approximately 2:00 PM, Surveyor interviewed Guardian I. Guardian I stated s/he was notified by Director B that Resident 1 was missing, but Guardian I was under the impression that Resident 1 had only been missing for 20-30 minutes. When Guardian I received the incident report regarding the elopement. Guardian I was baffled that Resident 1 was missing for approximately 6 hours and no staff noticed. Guardian I was concerned that staff were not educated that Resident 1 was under protective placement and not allowed to leave the facility. Guardian I stated s/he did not understand why if a staff saw him/her leave, they did not stop him. On 09/03/2026 at approximately 3:00 PM, Surveyors interviewed Director A and Registered Nurse (RN) E. Surveyor noted that Resident 1 had no ISP, and his MCP dated 08/31/2026, completed after date of survey and after the date of elopement was not updated to reflect his/her supervision needs. Director A stated s/he already had Resident 1's ISP on his/her list of things to do	N 426		

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N 426	Continued From page 35 and would update it accordingly. The provider did not ensure the supervision needs of Resident 1 were met, when s/he eloped for 6 hours without staff noticing and the ISP was not updated to reflect interventions or supervision needs.	N 426			
N 427	83.38(1)(c) Leisure time activities. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation and interview, the provider did not provide a daily activity program to meet the interests and capabilities of the residents. The provider did not develop and post the activity schedule in an area available to residents. This is a repeat deficiency. See Statement of Deficiency (SOD) O2Q315, dated 03/09/2026. Findings include:	N 427			

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N 427	Continued From page 36 On 08/26/2026 at 10:35 AM, Surveyors entered the building and noted that no activity schedule was posted. Surveyors were on site until about 3:30 PM and did not observe any activities take place. At 11:15 AM, Surveyor interviewed Caregiver D about activities. Caregiver D stated they do not have an activity schedule. S/he stated we do things randomly. S/he stated about once a week they do something organized as a group. Caregiver D stated they do not have an activity coordinator. At approximately 12:50 PM, Surveyor interviewed Resident 6 about activities. Resident 6 stated they have bingo on Fridays and that is it. At approximately 1:00 PM, Surveyor interviewed Caregiver J. Caregiver J stated that s/he used to do activities for both buildings. S/he stated, recently, activities were hard to complete due to low staff numbers. Caregiver J stated that they do provide bingo on Fridays for residents. At approximately 1:05 PM, Surveyor interviewed Resident 5 about activities. Resident 5 stated they do bingo on Fridays, but nothing outside of bingo. At approximately 1:10 PM, Surveyor interviewed Resident 7 about activities. Resident 7 stated they have bingo on Fridays. On 09/03/2026 at approximately 3:30 PM, Director A stated activities would get addressed as soon as possible. S/he stated s/he would start scheduling tasks in the computer. Director A stated s/he would keep track to make sure activities were completed. Surveyor asked about	N 427		

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N 427	Continued From page 37 no posted activity calendar for the month of August. Director A stated s/he did not know why it was not completed.	N 427		
N 448	83.41(2)(a) Nutrition: diet. Diets. 1. The CBRF shall provide each resident with palatable food that meets the recommended dietary allowance based on current dietary guidelines for Americans and any special dietary needs of each resident. 2. The CBRF shall provide a therapeutic diet as ordered by a resident ' s physician. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide a therapeutic diet as ordered by Resident 1's physician. Findings include: On 08/26/2026 at approximately 12:19 PM, Surveyor requested Resident 1's record from Regional Director (RD) H. Resident 1 was admitted to the facility on 06/16/2026. Resident 1 had diagnoses that included: stroke, anxiety, chronic diastolic congestive heart failure, cognitive defects, dementia with behavioral disturbance, hypertensive heart disease, and mood disorder. At 4:59 PM, Surveyor received Resident 1's record via e-mail from RD H. RD H's email read in part, "[S/he] is on a mechanical soft diet."	N 448		

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N 448	Continued From page 38 On 08/27/2026 at 6:30 AM, Surveyor reviewed Resident 1's assessment dated, 06/20/2026. Resident 1's assessment indicated that s/he was on a mechanical soft diet, and the diet texture dysphagia advanced (soft and bite sized). On 08/26/2026 at approximately 12:30 PM, Surveyor interviewed Caregiver C. Caregiver C stated that the rounding physician wanted Resident 1 on a soft mechanical diet. S/he stated that Resident 1 preferred staff to cut his/her food up really small. At 12:54 PM Surveyor interviewed Resident 1. Resident 1 stated s/he had not eaten yet, but s/he was kind of hungry. At 12:56 PM, Caregiver D brought Resident 1 a lunch plate to the outside patio where Resident 1 was sitting. The hot dog was cut in 1/2" slices, round, and not cut into quarters; potato chips; and 1-inch chunks of watermelon (Photo 1). At 1:12 PM, Surveyor observed Resident 1 choke on a chip. Resident 1 proceeded to cough. No staff were supervising or near Resident 1 at the time. Resident 1 was outside on the patio eating alone. On 09/03/2026 at approximately 3:45 PM, Surveyor interviewed Director A and Registered Nurse (RN) B. Surveyor asked Director A if s/he knew what a mechanical soft diet was. Director A stated that mechanical soft should be basically ground up. Director A stated what Resident 1 got for lunch was not mechanical soft. Director A stated that s/he would be doing re-training with staff regarding diets.	N 448		

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N 500	Continued From page 39	N 500		
N 500	83.45(4) Pest control. Pest control. The CBRF shall implement safe, effective procedures for control and extermination of insects, rodents and vermin. This Rule is not met as evidenced by: Based on observation and interview, the provider did not implement safe and effective procedures for control of flies throughout the building. Findings include: On 08/26/2026 from approximately 10:35 AM until 3:30 PM, Surveyors were on site at the facility. Throughout the day, Surveyors noticed a large amount of flies throughout the building. At approximately 11:20 AM, Surveyor interviewed Resident 2. Surveyor observed many flies in Resident 2's room. Resident 2 stated there had been a lot of flies in his/her room for at least a week now because of the opening in his/her window. Surveyor observed Resident 2's window open. The screen did not fit the window properly leaving about a 1-inch gap, wide open to the outside. At approximately 11:25 AM, Surveyor interviewed Caregiver C. Caregiver C stated that s/he noticed the window issue in Resident 2's room a few days ago. Caregiver C stated s/he told Director B. Caregiver C stated they used to have a maintenance book to note concerns, but s/he was unaware of where it was at. At approximately 12:40 PM, Surveyor observed multiple dead bugs and flies throughout the windowsills in the common areas of the building.	N 500		

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N 500	Continued From page 40 On 09/03/2026 at approximately 3:30 PM, Surveyors interviewed Director A and Registered Nurse (RN) B. Director A stated there was a maintenance book that staff should be writing in. Director A also stated that pest control needed to be sent out and s/he would work on that.	N 500		
N 504	83.46(1)(c) Heating system maintenance. Heating. The CBRF shall maintain the heating system in a safe and properly functioning condition. The CBRF shall ensure that a heating contractor or local utility company completes all of the following maintenance and makes available to the facility documentation of the maintenance performed: 1. An oil furnace shall be serviced at least once each year. 2. A gas furnace shall be serviced at least once every 3 years. 3. The CBRF shall have a chimney inspected at intervals corresponding with the heating system service under subd. 1. or 2. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that a heating contractor or local utility company completed maintenance and had documentation of the maintenance performed. On 08/26/2026, Surveyor reviewed the inspection book and noted the last completed furnace inspection to be 05/25/2023. On 08/31/2026 at 4:20 PM, Surveyor interviewed Regional Director (RD) G. RD G stated s/he	N 504		

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N 504	Continued From page 41 would send what they found regarding the furnace. S/he stated the document s/he found was completed in 2024, so that would be within the 3 years for gas furnace inspection. RD G stated s/he was not sure if this counted as the furnace inspection but was going to e-mail it over. At 5:00 PM, Surveyor reviewed the document RD G sent over. The document was dated 03/07/2024. The letter was from a heating company but appeared to be a service call. The letter indicated there were multiple issues that needed to be fixed, and did not indicate those issues were fixed. On 09/02/2026 at 11:39 PM, Surveyor interviewed Director A and Registered Nurse (RN) B. Director A stated that all s/he was able to locate was the same document that RD G sent. Surveyor asked if those issues identified on the invoice were fixed. Director A stated s/he would reach out to the heating company and send updates by end of day. At 3:33 PM, Surveyor received an e-mail from Director A. The email, from Director A read, "Update - A furnace inspection does need to be done, the company did say they inspected it but it wasn't the one for state. So, I am getting that on the books."	N 504			
N 507	83.46(1)(f) Combustibles. Combustible materials shall not be placed within 3 feet of any furnace, boiler, water heater, fireplace or other similar equipment. This Rule is not met as evidenced by: Based on observation and interview, the provider	N 507			

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N 507	Continued From page 42 did not ensure that combustible materials were not placed within 3 feet of the furnace. This is a repeat deficiency. See Statement of Deficiency (SOD) EL5R11, dated 11/08/2022. Findings include: On 08/26/2026 at approximately 11:38 AM, Surveyor observed the furnace room and noticed multiple cardboard boxes within 3 feet of the furnace. Surveyor noted an area marked off with red tape. The red taped area contained large boxes of cardboard and a walker. The red taped area was within 3 feet of the furnace. On 09/03/2026 at approximately 3:25 PM, Surveyors interviewed Director A and Registered Nurse (RN) E. Director A stated usually the red tape was to block off an area where combustibles should not be placed. Director A stated s/he would look into it and remove the combustibles.	N 507			
N 535	83.48(1)(b) Smoke and heat detectors per NFPA 72. Smoke and heat detectors shall be installed and maintained in accordance with NFPA 72 National Fire Alarm Code and the manufacturer ' s recommendation. Smoke detectors powered by the CBRF ' s electrical system shall be tested by CBRF personnel according to manufacturer ' s recommendation, but not less than once every other month. CBRFs shall maintain documentation of tests and maintenance of the detection system. This Rule is not met as evidenced by:	N 535			

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N 535	Continued From page 43 Based on record review and interview, the provider did not ensure that smoke detectors were tested every other month. This is a repeat deficiency. See Statement of Deficiency (SOD) EL5R11, dated 11/08/2022. Findings include: On 08/26/2026, Surveyor reviewed the inspection book and did not locate any evidence of smoke detector tests being completed every other month. On 08/31/2026 at 4:20 PM, Surveyor interviewed Regional Director (RD) G. RD G stated the smoke detectors were not externally monitored. S/he stated they were unable to find evidence of smoke detector checks, but s/he stated Director A was back from vacation and was going to attempt to locate them on site. On 09/02/2026 at 11:37 AM, Surveyor interviewed Director A and Registered Nurse (RN) B. Director A stated they had not yet located them, but s/he was having Caregiver C look in the maintenance binder. At 4:06 PM, Director A emailed stating s/he was unable to find the smoke detector checks. Director A stated s/he printed some logs out to use moving forward.	N 535			
N 617	83.55(6)(b) Bath and toilet areas: water temperature The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least	N 617			

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N 617	Continued From page 44 140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency. This Rule is not met as evidenced by: Based on record review, interview, and observation, the provider did not ensure that the temperature of water at fixtures used by residents did not exceed 115 degrees F when the shared bathroom at the back of the building exceeded a temperature of 120 degrees F. Findings include: On 08/26/2026 at 12:43 PM, Surveyor requested a staff member to assist him/her in checking the water temperature in a shared resident bathroom. Caregiver D stated, "It gets hot!" Caregiver C accompanied Surveyor to the bathroom. Caregiver C turned on the water and immediately put a bowl underneath the water, filled it up, and took the temperature from the bowl of water. Caregiver C noted the temperature to be 110 degrees. Caregiver C stated Director B turned the water heater to setting "B". Caregiver C noted the "B" setting to be 140 to 145 degrees F. Caregiver C stated that the water temperature was turned up in May or June sometime. Surveyor took the water temperature and got a reading of 120 degrees with the provider's thermometer. Both Surveyor and Caregiver C felt the water and noted it to feel warmer than 120 degrees. Caregiver C stated s/he thought the thermostat was inaccurate. Surveyor asked if	N 617		

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N 617	Continued From page 45 s/he ever calibrated the thermometer and Caregiver C stated s/he did not know how. On 09/03/2026 at approximately 3:26 PM, Surveyors interviewed Director A and Registered Nurse (RN) B. Director A stated that was not how s/he taught his/her staff how to take water temperatures. S/he stated s/he would provide education to staff and get a new thermometer.	N 617			