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(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 06/04/2026, the bureau of assisted living southern regional office conducted 3 complaints investigations, 2 verifications visits and a self-report review at Vitacare Assisted Living a CBRF located in Cross Plains, WI. As a result of the survey, 7 violations of DHS Chapter 83 were issued. Two of 3 complaints were substantiated. Seven of the 8 violations identified in previous statement of deficiency (SOD) 8OI011 dated 01/07/2026 were substantially corrected. Four of the 7 violations identified in previous SOD W10512 dated 11/18/2025 were substantially corrected. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 17	{N 000}		
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 observation, record review and interview, the provider did not ensure Resident 1 received his/her medication in the dosage and at	N 352		

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

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intervals prescribed by a practitioner.

From 05/22/2026 to 05/31/2026, Resident 1 did not receive 14 doses of medication as prescribed.

This is a repeat violation of statement of deficiency WI0512 dated 11/18/2025 and W10511 dated 07/15/2025.

FINDINGS INCLUDE:

On 06/01/2026, the Department received a complaint regarding medication administration services at facility.

On 06/04/2026, Surveyors arrived at facility for a complaint investigation.

OBSERVATION:

On 06/04/2026 at 12:50 PM, Surveyor initiated a medication cart audit with Nurse A. Nurse A explained staff were expected to administer a pill from the slot labeled with the number matching the date (EX: 06/01/2026 = slot 1). Surveyor reviewed resident blister packs and observed the pharmacy label indicated many blister packs were filled with the "Cycle Fill Order," with a dispension date on 05/13/2026. Nurse A acknowledged that blister packs dispensed on 05/13/2026 started to be administered from on 05/21/2026 (slot 21). Surveyor reviewed Resident 1's blister pack of his/her evening scheduled acetaminophen (Tylenol) 325mg tablets dispensed on 05/13/2026, and found tablets remained in the #22 to #29 slots (Picture 1). Surveyor reviewed Resident 1's blister pack of his/her evening dose of Tamsulosin 0.4mg capsules dispensed on 05/13/2026, and found tablets remained in the #22 to #28 and #31 slots. Nurse A acknowledged

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N 352	Continued From page 2 Resident 1's AM and PM blister packs dispensed on 05/13/2026 were punched out from slots #21 to #31 (Picture 2). Nurse A acknowledged it was strange that pills remained in the #22 to #31 slots for his/her evening medications. RECORD REVIEW: On 06/04/2026, Surveyor reviewed Resident 1's facility record. Resident 1 was admitted to the facility on 06/02/2025. Resident 1 had an activated power of attorney. Resident 1 received hospice services. On 06/04/2026, Surveyor reviewed Resident 1's May 2026 medication administration record (MAR). The following was documented: 1.) On 05/21/2026 at 5:00 PM, Tamsulosin Cap 0.4mg - waiting on pharmacy 2.) On 05/22/2026 at 4:00 PM, Tylenol 325mg tablet - waiting pharmacy 3.) On 05/22/2026 at 5:00 PM, Tamsulosin Cap 0.4mg - waiting on pharmacy 4.) On 05/23/2026 at 4:00 PM, Tylenol 325mg tablet - not in cart 5.) On 05/23/2026 at 5:00 PM, Tamsulosin Cap 0.4mg - waiting on pharmacy 6.) On 05/24/2026 at 4:00 PM, Tylenol 325mg tablet - not in stock 7.) On 05/24/2026 at 5:00 PM, Tamsulosin Cap 0.4mg - not in stock 8.) On 05/25/2026 at 5:00 PM, Tamsulosin Cap 0.4mg - not in cart 9.) On 05/27/2026 at 4:00 PM, Tylenol 325mg tablet - waiting on pharmacy 10.) On 05/27/2026 at 5:00 PM, Tamsulosin Cap 0.4mg - waiting on pharmacy 11.) On 05/28/2026 at 5:00 PM, Tamsulosin Cap 0.4mg - not in stock 12.) On 05/29/2026 at 4:00 PM, Tylenol 325mg	N 352		

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N 352	Continued From page 3 tablet - waiting on pharmacy 13.) On 05/ 29/2026 at 5:00 PM, Tamsulosin Cap 0.4mg - waiting on pharmacy 14.) On 05/30/2026 at 4:00 PM, Tylenol 325mg tablet - waiting on pharmacy INTERVIEW: On 06/04/2026 at 3:00 PM, Surveyors discussed the above concerns with Nurse A, Administrator B and Director C. Nurse A acknowledged that Resident 1's evening does from the most recent cycle fill had pills remaining in the #22 to #31 slots. Nurse A stated s/he believed that if staff documented that they were waiting on pharmacy then the medication wasn't available for administration. Nurse A stated s/he would email Surveyor the pharmacy delivery slip for Resident 1's Tylenol and Tamsulosin. Nurse A acknowledged that Resident 1 was at the facility from 05/22/2026 to 05/31/2026 and capable of taking his/her pills. Nurse A acknowledged if Resident 1's evening pills were available they should have been administered by staff. Nurse A explained staff are instructed to let him/her know if medication was missing from the cart, and staff hadn't notified him/her of Resident 1 missing Tylenol or Tamsulosin at the end of May. On 06/04/2026 at 3:29 PM, Nurse A emailed surveyor the pharmacy delivery slip for Resident 1's Tylenol 25 mg tablet and Tamsulosin 0.4mg capsules blister packs. The delivery slip was signed by facility on 05/18/2026.	N 352		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient	N 396		

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numbers on a 24-hour basis to meet the needs of the residents.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure a sufficient number of employees were provided on a 24-hour basis to meet the needs of residents.

On 03/16/2026 at approximately 11:00 AM, Police Chief E witnessed Caregiver D working alone in the facility. Caregiver D reported feeling overwhelmed because s/he hadn't been able to prepare breakfast for all of the residents. Additionally, s/he was behind on administering resident morning medications.

On 06/04/2026, Surveyor reviewed the staff schedule and found Caregiver D was the only staff member from 11:00 PM on 03/15/2026 to 11:30 AM on 03/16/2026.

FINDINGS INCLUDE:

On 03/16/2026, the Department received a complaint regarding staffing to resident ratios.

On 06/04/2026, Surveyors arrived at facility for a complaint investigation.

On 06/04/2026, Surveyor reviewed police report incident number 26-113819. Police Chief E documented the following on 03/16/2026 at 11:15 AM, "On Monday, March 16, 2026, at approximately 11:15 am, while at [Name Of Facility] Area EMS with an unrelated medical emergency, I learned that [Caregiver D] was caring for all the resident by [herself/himself]. [Caregiver D] also told me [s/he] was behind providing the required medications to the

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residents. [Caregiver D] also told me [s/he] had to have residents make breakfast for themselves and other residents because [s/he] was so far behind. I contacted [Administrator B] and informed [him/her] of the situation at [Name Of Facility]. [Administrator B] informed me that [s/he] would look into the matter and thanked me for reporting the situation to [him/her] ..."

On 06/04/2026 at 11:00 AM, Surveyor discussed the above police report with Nurse A, Administrator B and Director C. Administrator B stated the usual staffing ratio for morning shift was 2-3 caregivers with an administrator or nurse. Administrator B reported there was a bad snow storm the morning of 03/16/2026 and so the morning staff called in because they physically couldn't get to the facility. Administrator B stated staff called-in as they were trying to leave their homes around 7:00 AM. Administrator B stated the plan was for Director C to come in and help the nightshift staff member who stayed until staff could travel. Director C reported s/he had many issues traveling to the facility that morning and that was why Police Chief E witnessed Caregiver D working alone at 11:00 AM. Director C reported that a second caregiver was able to make it to the facility right after the police left. Nurse A, Administrator B nor Director C recalled residents being required to make their own meals that morning, or medications being administered late.

On 06/04/2026 at 11:30 AM, Surveyor reviewed the staff schedule from 03/15/2026 to 03/21/2026 with Nurse A. On 03/15/2026 the night shift med tech was scheduled from 11:00 PM to 12:30 PM, with 13.5 hours documented as worked. Nurse A identified the night shift med tech as Caregiver D from the police report. On 03/16/2026, Caregiver D was the sole staff scheduled to start his/her

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shift, s/he started his/her shift at 11:30 AM and ended at 3:00 PM. Nurse A acknowledged that Caregiver D was the only staff documented on the schedule from 03/15/2026 at 11:00 PM until 03/16/2026 at 11:30 AM. Nurse A acknowledged all AM shifts besides 03/16/2026 had 2-3 caregivers scheduled.

EXAMPLE 1: Resident 2

On 06/04/2026, Surveyor reviewed Resident 2's facility record. Resident 2 was admitted to the facility on 04/07/2025. Resident 2 had a guardian. Resident 2 was diagnosed with the following but not limited to: essential hypertension, depression, anxiety, edema, chronic pain, gastroesophageal reflux disease w/o esophagitis, alcoholism, anxiety and chronic obstructive pulmonary disease (COPD).

On 06/04/2026, Surveyor reviewed Resident 1's March 2026 medication administration record (MAR). On 03/16/2026 the following medications prescribed for 8:00 AM were administered after 10:00 AM:
1.) Acetaminophen 1,000 mg for pain - 10:31AM
2.) Bupropion 300 mg for anxiety - 10:33 AM
3.) Duloxetine 60mg - 10:33 AM
4.) Finasteride 5mg for enlarged prostate - 10:33 AM
5.) Fluticasone 50mcg nasal spray for allergies - 10:34 AM
6.) Pregabalin 150mg - 10:36 AM
7.) Tamsulosin 0.4 mg - 10:37 AM
8.) Trelegy Ellipta 200-62.5-25mcg inhaler for COPD- 10:37 AM

EXAMPLE 2: Resident 3

On 06/04/2026, Surveyor reviewed Resident 3's

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facility record. Resident 3 was admitted to the facility on 12/05/2025. Resident 3 had a guardian. Resident 3 was diagnosed with history of heart attack, aortic regurgitation and history of aneurysm. The following was documented on the facesheet, " ...high risk for elopement, history of elopement ...".

On 06/04/2026, Surveyor Resident 3's March 2026 MAR. On 03/16/2026 the following medication prescribed for 8:00 AM were administered after 11:00 AM.
1.) Amlodipine 5 mg - 11:15 AM
2.) Duloxetine 30 mg for anxiety - 11:16 AM
3.) Duloxetine 60 mg for anxiety - 11:17 AM
4.) Ferrous Gluconate 324 mg - 11:18 AM
5.) Pantoprazole 40 mg - 11:18 AM
6.) Quetiapine 25 mg for dementia related behaviors - 11:19 AM

INTERVIEW:

On 06/04/2026 at 3:00 PM, Surveyor discussed the above concerns with Nurse A, Administrator B and Director C. Nurse A, Administrator B and Director C acknowledged the morning of 03/16/2026, there was one employee (Caregiver D) to provide services to residents. Nurse A, Administrator B and Director C acknowledged Caregiver D reported not being able to serve residents breakfast or administer resident medications on time to Police Chief E. Nurse A, Administrator B and Director C acknowledged Resident 2 nor Resident 3 morning medications were administered within the prescribed interval the morning on 03/16/2026. Nurse A, Administrator B and Director C acknowledged the staffing issues had been reported at approximately 7:00 AM and a second staff member didn't start until 11:30 AM.

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{N 444}	83.40 Oxygen storage. Oxygen storage. Oxygen storage shall be in an area that is well ventilated and safe from environmental hazards, tampering, or the chance of accidental damage to the valve stem. If oxygen cylinders are in use, oxygen cylinders shall be secured in an upright position. If stored upright, cylinders must be secured. If stored horizontally, cylinders shall be on a level surface where they will remain stationary. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not store oxygen cylinders in a way that ensured they were safe from environmental hazards, tampering or the chance of accidental damage to the valve. Surveyor observed 2 cylinders of oxygen not properly stored. This is a repeat violation from previous Statement of Deficiency (SOD) 8OI011 dated 01/07/2026. Findings include: On 06/04/2026, at approximately 09:40 AM, Surveyor toured the facility and observed in Resident 2's room, an oxygen tank was on floor unsecured near the door. On 06/04/2026, at approximately 10:30 AM, Surveyor observed an oxygen tank on floor unsecured in the supply closet. The overhead light was burned out making it hard to see and Surveyor almost knocked the oxygen tank over. On 06/04/2026, Surveyor reviewed Resident 2's record. Resident 2 admitted to the facility, 02/26/2025, with diagnosis including chronic	{N 444}		

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{N 444}	Continued From page 9 obstructive pulmonary disease (COPD). Resident 2's oxygen management documentation, dated 08/21/2025, documented: "Ensure portable tanks are being stored properly." On 06/04/2026 at 12:30 PM, Surveyor interviewed Nurse A. Nurse A acknowledged that oxygen tanks must be securely stored for safety of everyone in the building. Nurse A acknowledged that 2 oxygen cylinders were unsecured and, "They will be properly stored immediately."	{N 444}		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by:	N 452		

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N 452	Continued From page 10 Based on observation and interview, the provider did not ensure that food was stored in safe, sanitary conditions. There were several food items in the refrigerator that were not labeled. Findings include: On 06/04/2026 at 10:30 AM, Surveyor observed the kitchen. There was a bowl of vegetables covered with aluminum foil that was not tabled. There was a bowl of meat covered in aluminum foil that was not labeled. There was a bowl of potatoes covered in aluminum foil that was not labeled. The cabinet door was missing on a floor cabinet next to the stove that contained seasonings. Five containers of seasoning were open making the seasonings prone to contamination from food spilling from stove. On 06/04/2026 at 1:30 PM, Surveyor interviewed Nurse A. Nurse A acknowledged that all food items not in original packaging must be labeled with what the item is and the date. Nurse A acknowledged that there were 3 food items in the common refrigerator that were not labeled.	N 452		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the	N 481		

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N 481	Continued From page 11 intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a safe, clean, comfortable and homelike environment appropriate for residents. There were broken cabinets in the kitchen, dishwasher was not operating, numerous damage to walls and doors from wheelchairs. This is a repeat violation from previous Statement of Deficiency (SOD) W10512 dated 11/18/2025. Findings include: On 06/04/2026 at 10:00 AM, Surveyor toured the physical environment OBSERVATIONS: In the kitchen, there as a bracket and open vent where an above range microwave used to be. Facility now uses a tabletop microwave. In the kitchen, a cabinet door was missing that enclosed seasonings, making them open to contamination. In the kitchen, the dishwasher was not operable. The door was not able to stay closed and was held to the unit by tape. The light was burned out in the supply closet making it very difficult to see. Surveyor almost knocked over an unsecured oxygen tank that was on the floor. The door handle to the medication room fell off	N 481		

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N 481	Continued From page 12 the door 6 times during the course of the survey when caregivers entered/exited the room. There was a large stain (1.5 feet x 1.5 feet) in the carpet in the common hallway leading to the dining room. There was damage to the lower part of the entry/exit door of the facility from being struck by resident wheelchairs. The wall in a common hallway (7 feet x 3 feet) was 2 different colors from attempting to match paint colors. The wall in a common hallway (5 feet x 3 feet) was 2 different colors from attempting to match paint colors. There was an outlet cover missing in Resident 2's bedroom. On 06/04/2026 at 1:40 PM, Surveyor interviewed Nurse A. Nurse A acknowledged that there were several environmental concerns. Nurse A stated, "Looks like we have some work to do cleaning things up around here."	N 481		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that cleaning compounds and toxic	N 499		

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N 499	Continued From page 13 substances were stored in a secure area. This is a repeat violation from previous Statement of Deficiency (SOD) W10512 dated 11/18/2025. Findings include: The provider is licensed to provide cares for up to 19 residents in the client groups irreversible dementia/Alzheimer's, advanced aged, and physically disabled On 06/04/2026, at approximately 10:30 AM, Surveyor toured the facility and observed the unlocked laundry room, located off of the kitchen, that contained the following cleaning compounds: -105 count container of dishwasher pacs -Gallon jug of disinfectant (laundry and air freshener) -32 fluid ounce bottle of multi-surface cleaner and bleach -Gallon jug of ammonia -18 ounce spray can of flying insect killer - outdoor fresh scent -32 fluid ounce bottle of multi-surface disinfectant cleaner -32 fluid ounce bottle of jug of disinfectant (laundry and air freshener) -(2) Gallon jug of bleach -80 fluid ounce bottle of multi-surface cleaner - 2x more concentrated On ,06/04/2026 at 1:40 PM, Surveyor interviewed Nurse A. Nurse A stated the laundry room was supposed to be locked due to the storage of cleaning compounds in the room. Surveyor advised that the door was not locked and Surveyor was able to enter the room without a key or code to the lock. Nurse A acknowledged that cleaning compounds must be secured.	N 499		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019196	A. BUILDING: _____ B. WING _____	R-C 06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 499	Continued From page 14 Nurse A stated that the door to the laundry room would be locked and staff notified and trained on the importance of securing toxic chemicals.	N 499		
N 650	83.59(4)(b) Delayed egress: locking device sign posted Delayed egress door locks are permitted with department approval only in facilities with a supervised automatic fire sprinkler system and a supervised interconnected automatic fire detection system and shall comply with all of the following: A sign shall be posted adjacent to the locking device indicating how the door may be opened. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that a sign was posted adjacent to locking device of a delayed egress door on 2 of 4 doors. There was no sign indicating how delayed egress door may be opened on 2 of 4 delayed egress doors. Findings include: On 06/04/2026 at 9:45 AM, Surveyor toured the physical environment. Surveyor observed a delayed egress door in the back of the facility that did not have a sign indicating how the door may be opened. Surveyor observed a delayed egress door in the front of the facility that did not have a sign indicating how the door may be opened.	N 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 650	Continued From page 15 On 06/04/2026, at 1:40 PM, Surveyor interviewed Nurse A. Nurse A acknowledged that exits from the facility are delayed egress for safety of residents. Nurse A stated s/he was not aware that signs were missing from 2 delayed egress doors and that signs would be posted as soon as possible.	N 650		