

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018761	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/06/2026
NAME OF PROVIDER OR SUPPLIER VITACARE LIVING - RICE LAKE I		STREET ADDRESS, CITY, STATE, ZIP CODE 1631 KERN AVE RICE LAKE, WI 54868		
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N 000	Initial Comments On 07/09/2026, Surveyors began a standard licensure survey and complaint investigation at VitaCare Living - Rice Lake I. Data was collected through 08/06/2026. Four violations were identified. One of 3 complaints was substantiated. Census: 15	N 000		
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 ensure leisure time activities were arranged for residents and did not provide a daily activity program. Findings include: On 07/09/2026 at approximately 10:21 AM,	N 427		

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

TITLE

(X6) DATE

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N 427	Continued From page 1 Surveyor interviewed Caregiver A. Caregiver A stated staff was not able to do activities with residents. Caregiver A stated s/he had heard residents had things they would like to do, but that activities never got done. At approximately 10:30 AM, Surveyor observed that there was no activity program posted in an area available to residents. Surveyor observed a blank whiteboard calendar in the dining room. At approximately 11:00 AM, Surveyor interviewed Resident 1. Resident 1 stated there were no activities that s/he was aware of. Resident 1 stated it had been a while since the provider had arranged for activities for residents. During the duration of the survey, Surveyor did not observe any activities being offered to residents. The provider did not sure to provide an activities program for residents.	N 427		
N 479	83.42(2) Resident records safeguarded. The licensee shall ensure all resident records are adequately safeguarded against destruction, loss or unauthorized access or use. This Rule is not met as evidenced by: Based on observation, interview and record review, the licensee did not ensure all resident records were retained or adequately safeguarded against destruction or loss. Findings include: On 07/09/2026, Surveyor observed the electronic	N 479		

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N 479	Continued From page 2 monitoring system installed in resident rooms. The devices consisted of two hardware pieces each, with one piece mounted on the ceiling and one mounted on the wall. From 07/09/2026 to 08/05/2026, Surveyor reviewed facility and resident records. Facility records included a policy titled, "Company-Issued Cellular Device Policy for [electronic monitoring company brand name] AI [artificial intelligence] Resident Monitoring, dated 02/05/2026." The policy read, in part, "...Devices may access or transmit protected health information (PHI) only as required for resident monitoring...No resident data may be stored locally on the device unless required by the [company brand name] application..." On 07/22/2026, at approximately 9:52 AM, Surveyor interviewed Caregiver A about the electronic monitoring system. Caregiver A stated the system was used by staff to perform safety checks on residents and respond to falls. Caregiver A demonstrated to Surveyor how the handheld cellular device used by staff showed images and functions of the electronic monitoring system. Surveyor observed the following: - Once staff logged into the system, they were able to see a series of thumbnails corresponding to all the resident rooms. - The thumbnails were labeled with numbers indicating which room they corresponded to. - Staff were able to select past alerts, which included both recordings of resident falls and false events which were erroneously recorded by the system, reviewed by the system, then dismissed. - When viewing a recording of a resident fall, staff could see a timeline of events which showed when a resident, for example, was sitting in a chair, when they were sitting on the floor, and	N 479		

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N 479	Continued From page 3 when a staff member entered the room. The system additionally time-stamped when the fall recording was reviewed by a staff member. - Recorded footage could be viewed from as early as 06/10/2026. Caregiver A stated the system would only start to record if there was an event which was flagged as a fall by the system. On 07/09/2026, at approximately 10:15 AM, Surveyor interviewed Administrator B. Administrator B stated when a resident fell, s/he was sent an alert. Administrator B stated s/he would then review the fall, new information was entered into the AI system, and the system would adjust to any changes in the pattern. Administrator B stated once that was completed, the video clip was deleted. At approximately 2:43 PM, Surveyors interviewed Team Lead (TL) D. TL D stated Administrator B was the one who could access videos and settings. While Surveyor was reviewing records for the survey, Surveyor located a policy titled, "Company-Issued Cellular Device Policy for [system brand name] AI [artificial intelligence] Resident Monitoring" (see above). TL D stated s/he had never seen the policy. On 07/29/2026, at approximately 10:00 AM, Surveyors interviewed Administrator B, Regional Director (RD) E, RD F, Licensee G, and System Administrator (SA) H. During the interview, SA H stated the following: - The electronic monitoring system was a fall detection tool that provided alerts for anomalous events. - The system was installed around 02/25/2026. - The system would delete data if people other	N 479		

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N 479	Continued From page 4 than the resident were detected in the resident's room. - The system would delete data continually as it monitored. - The system could provide week-long insights for residents. For example, trends and meta-data could be requested from the system. - Data was deleted after being viewed. During the interview, RD E stated all resident data that was collected and used to train the system was deleted once a resident moved out. In summary, the provider installed an electronic monitoring system that was monitoring resident activities and used to document significant incidents-specifically to detect falls. The system was installed in every resident room. The system was installed around 02/25/2026 and saved video event footage of residents from as early as 06/10/2026. Resident records were deleted continually as the system monitored and would be deleted once reviewed, or once a resident moved out of the facility. The provider did not ensure all resident records were adequately safeguarded against destruction or, loss, and the provider did not retain those resident records for the period of time required under DHS 83.13(2).	N 479			
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 intended use of the room.	N 481			

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N 481	Continued From page 5 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the living environment was homelike. The provider had an electronic monitoring fall-detection system installed in all resident rooms, to include those who did not wish to use the electronic monitoring system. Findings include: On 05/05/2026, the Department received a complaint regarding resident rights. On 07/09/2026, Surveyor observed the electronic monitoring system installed in resident rooms. The devices consisted of two hardware pieces each, with one piece mounted on the ceiling and one mounted on the wall. At approximately 10:50 AM, Surveyor observed that Resident 1 had the electronic monitoring hardware installed in his/her room. Resident 1 expressed frustration at the way the hardware was installed on his/her wall. At approximately 4:10 PM, Surveyors interviewed Administrator B. Administrator B stated Resident 1 did not have the electronic system running. On 07/29/2026, at approximately 10:00 AM, Surveyors interviewed Administrator B, Regional Director (RD) E and System Administrator (SA) H. SA H stated the system had been installed in resident rooms around 02/25/2026 and were affixed to the walls and ceilings of resident rooms. RD E stated the devices could be turned off at any time and unplugged, but the provider did not	N 481		

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N 481	Continued From page 6 want them to be unplugged. Administrator B stated Resident 1 had not consented to having the system activated in his/her room. The provider did not ensure to provide a homelike environment for residents.	N 481		
Y3235	50.09(1)(f) Privacy (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (f) Physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including, but not limited to: This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure residents had the right to privacy. The provider utilized an electronic monitoring system as a fall detection system. The electronic monitoring system was not turned off after Resident 2 expressed that	Y3235		

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Y3235	Continued From page 7 s/he did not consent to recording it in his/her room anymore, and staff-who were still able to view live images of resident rooms-used the system for spot checks to see if Resident 3 was engaged in a sexual act before performing a physical check. While using the system, staff accidentally saw Resident 2 and Resident 3 engaging in sexual intercourse. Findings include: On 05/05/2026, the Department received a complaint regarding resident rights. On 07/09/2026, Surveyor observed the electronic monitoring system installed in resident rooms. The devices consisted of two hardware pieces each, with one piece mounted on the ceiling and one mounted on the wall. From 07/09/2026 to 08/05/2026, Surveyor reviewed facility and resident records. Facility records included the following: - A policy titled, "Company-Issued Cellular Device Policy for [electronic monitoring company brand name] AI [artificial intelligence] Resident Monitoring, dated 02/05/2026." The policy read, in part, "...All use must comply with...state privacy laws, and [facility name] privacy policies...Resident monitoring is conducted for safety and care purposes only..." - A document which provided information about the electronic monitoring system. The document read, in part, "Core Information... Mobility, Staff Presence, Respiration, Sleep, Walking Speed, Activities and Whereabouts..." Records for Resident 2, admitted on 12/11/2025 included the following:	Y3235		

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Y3235	Continued From page 8 - A consent declaration, signed by Resident 2 on 11/27/2026, which read, in part, "By signing this Consent Declaration, you consent to [system company name] processing your personal data as described above, and you...understand that you can withdraw your consent at any time..." The document did not indicate withdrawal of consent had to be in writing. On 07/22/2026, at approximately 9:52 AM, Surveyor interviewed Caregiver A about the electronic monitoring system. Caregiver A stated the system was used by staff to perform safety checks on residents and respond to falls. Caregiver A demonstrated to Surveyor how the handheld cellular device used by staff showed images and functions of the electronic monitoring system. Surveyor observed the following: - Upon log-in, staff were able to see a series of thumbnails corresponding to all the resident rooms. - Each thumbnail showed icons which indicated residents were engaged in various activities, such as sleeping, being in the bathroom, or if the system was disconnected/turned off. - The thumbnails were labeled with numbers indicating which room they corresponded to. - Staff were able to select past alerts, which included both recordings of resident falls and false events which were erroneously recorded by the system, reviewed by the system, then dismissed. - Recordings showed heat-sensitive images of resident rooms. The residents in the recordings were de-identified, with any identifying features reduced to an orange/red heat signature silhouette. - Recorded footage could be viewed from as early as 06/10/2026. - Resident rooms could be selected at any time to	Y3235		

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Y3235	Continued From page 9 perform a "spot check," which resulted in a still image display of the resident's room in real time. The system would then lock staff out of performing an additional spot check for an undetermined amount of time before they could check that same room again. - When viewing a recording of a resident fall, staff could see a timeline of events which showed when a resident, for example, was sitting in a chair, when they were sitting on the floor, and when a staff member entered the room. The system additionally time-stamped when the fall recording was reviewed by a staff member. [MT6.1] - Recorded footage of non-fall events, such as a visiting family and 2 residents being in a room together, were saved on the handheld device and could be viewed. Caregiver A stated the following regarding the electronic monitoring system: - The system did not work well, for example, the system would alert staff that a resident was in the bathroom, when the resident was actually outside the building. - S/he had received approximately 1 hour of training regarding the system. - The system would only start to record if there was an event which was flagged as a fall by the system. - Resident 2 and Resident 3 were a couple. Resident 2 was his/her own person, had originally consented to having the system active in his/her room, but did not like the system currently. Resident 2 and Resident 3 engage in sexual intercourse with one another. Resident 2 would come up to staff and inform them that s/he would be going into his/her room with Resident 3, which staff understood to mean that they would be engaging in sexual intercourse. Staff would then	Y3235		

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Y3235	Continued From page 10 refrain from conducting spot checks on Resident 2's room. However, while using the system device, staff had seen Resident 2's room accidentally while Resident 2 and Resident 3 were engaged in sexual acts, and it was apparent to staff that they were engaged in sexual activity. Resident 2 said s/he wanted the system turned off/taken out/unplugged. Caregiver A stated the system usually stayed on, as s/he had not been told what to do. - Resident 2 and Resident 3 were identifiable when they were together in a room due to the distinct shapes of their wheelchairs. - The system could be turned off, but s/he did not have the ability. S/he thought Administrator B had the ability to turn off the system. - Sleep pattern and respiration were recorded by the system, and could be checked by staff. At approximately 10:20 AM, Surveyor interviewed Caregiver C. Caregiver C stated s/he had not taken an official training course on the system. At approximately 10:31 AM, Surveyor interviewed Resident 2 and Resident 3. Resident 2 stated s/he and Resident 3 were a couple. Resident 2 stated s/he did not like the electronic monitoring system because s/he felt it showed when s/he and Resident 3 were "intimate." Resident 2 stated s/he had told staff that s/he did not like the system, but no one ever said they would shut it off or take it down. Resident 2 stated the company who had installed the system had told him/her that the system did not show anything, but that s/he did not believe it. Resident 2 stated s/he did not really know how the system worked. Resident 2 stated s/he changed his/her clothes in his/her closet because s/he was afraid the system could see him/her change. Resident 2 stated Resident 3 was "shy" when engaged in sexual	Y3235		

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Y3235	Continued From page 11 intercourse due to the system, and that s/he would look up at it during sexual intercourse. Resident 2 stated s/he thought the system could still view him/her and Resident 3 doing something, just without showing body parts. Resident 2 stated there had been no follow-up to see how s/he felt about the system. Resident 2 stated s/he would like the system taken out of his/her room[MT7.1]. Resident 2 stated s/he thought the system was illegal and an invasion of privacy. At 10:59 AM, Surveyor observed that there was no signage in the facility that indicated electronic monitoring was in use. At approximately 11:55 AM, Surveyor viewed the cellular handheld device for the electronic monitoring system with Caregiver C. Caregiver C showed Surveyor how the system would detect when a caregiver entered a resident room, and lock the handheld device user out of conducting spot checks as a result. Surveyor observed that the list of thumbnails showing resident rooms had an icon on the thumbnail for Resident 2's room and indicated a staff member (Caregiver A) was in the room with Resident 2. Surveyor selected Resident 2's room thumbnail, and the system would not allow the room to be viewed. Caregiver C stated this function of the system did not always work. Caregiver C stated the system would also detect other residents or visiting family members as staff at times and would lock staff out of the spot check as well. After a few minutes, Surveyor observed that the icon showing that Caregiver A was in Resident 2's room performing cares was no longer on Resident 2's room thumbnail. Surveyor selected Resident 2's room and a spot check was started. Surveyor could see a live still image of Caregiver A sitting on Resident	Y3235		

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Y3235	Continued From page 12 2's bed administering insulin to Resident 2. Surveyor observed that a previous spot check could be viewed by the user of the handheld device, as the still image of Caregiver A performing cares with Resident 2 was able to be viewed afterwards. At approximately 2:43 PM, Surveyors interviewed Team Lead (TL) D. TL D stated s/he did not like the system as it would alert to false alarms. TL D stated Administrator B was the one who could access videos and settings. TL D stated that Administrator B had relayed to staff that safety checks were supposed to be done physically by staff walking into resident rooms and not by using the handheld monitoring device. TL D stated staff had not received much training on the system. TL D stated the training had been provided by the electronic monitoring system company, not by the provider. While Surveyor was reviewing records for the survey, Surveyor located a policy titled, "Company-Issued Cellular Device Policy for [system brand name] AI [artificial intelligence] Resident Monitoring" (see above). TL D stated s/he had never seen the policy. TL D stated that shortly after the system had been installed, Resident 2 had expressed that s/he hated the system. TL D stated Administrator B had been notified that Resident 2 no longer wanted the system active in his/her room, but that Administrator B told staff just to give it a little more time. TL D stated staff would utilize the system to conduct spot checks on Resident 3's room before knocking and entering, because s/he would masturbate. TL D stated staff would check before entering so they could see if Resident 3 was decent, as staff were able to tell what s/he was doing when s/he was engaged in sexual acts. For example, TL D stated staff could see Resident 3's blanket moving up and down.	Y3235		

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Y3235	Continued From page 13 On 07/29/2026, at approximately 10:00 AM, Surveyors interviewed Administrator B, Regional Director (RD) E, RD F, Licensee G, and System Administrator (SA) H. During the interview, SA H stated the following: - The electronic monitoring system was a fall detection tool that provided alerts for anomalous events. - The system was installed around 02/25/2026. - The system did not use resident names and was pseudonymized. - In each room, the system studied behaviors specific to the resident such as movements, respirations, gait, and sleeping patterns to determine a baseline. This baseline period was 30 days long, and was used by the system to determine what would be an alertable event. The system got reset for a new resident once a resident moved out. - The system could detect when staff were in a resident's room. - The system would delete data if people other than the resident were detected in the resident's room. - The system would delete data continually as it monitored. - The system could be disabled upon request by the resident when a visitor was in the room with them. The handheld cellular device used by staff could be used to disable the device when a resident asked. The electronic monitoring system company had educated staff on how to shut off and disabled the system from the handheld device. - S/he believed the system was working as intended. - The system could provide week-long insights for residents. For example, trends and meta-data could be requested from the system.	Y3235		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018761	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/06/2026
NAME OF PROVIDER OR SUPPLIER VITACARE LIVING - RICE LAKE I		STREET ADDRESS, CITY, STATE, ZIP CODE 1631 KERN AVE RICE LAKE, WI 54868		
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Y3235	Continued From page 14 - Access to the device was locked to the staff on-site. Remote access was only tied to the administrator working with the site. - Data was deleted after being viewed. - Staff were unable to provide live spot checks. When Surveyor informed SA H that Surveyors had observed staff performing live spot checks while on site, SA H stated that they should not be able to. SA H stated spot checks should only be able to be conducted while in maintenance mode. During the interview, RD E stated the following: - The system did not allow staff to conduct checks while a staff member was in the room with a resident. The handheld cellular device could be detected and recognized by the hardware in the room. - S/he believed the system was working as intended. - All resident data that was collected and used to train the system was deleted once a resident moved out. - The system could only be viewed on-site. Only staff specific to the facility could review data. - Residents had to let the provider know if they revoked their consent. The system could be turned off with the click of a button and could be unplugged. S/he did not want residents to unplug the system. - A presentation was given to residents and a pamphlet was handed out prior to the system's implementation. During the interview, Administrator B stated the following: - There had been a meeting between residents, resident families, and resident managed care organizations (MCOs) on 12/11/2025 informing them of the electronic monitoring system. - On-site staff training had been held over 3 days,	Y3235		

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Y3235	Continued From page 15 on 02/25/2026, 02/26/2026, and 02/27/2026. Representatives from the system company had met with each shift. - There was no signage at the facility which notified those in the building that there was electronic monitoring. - Staff were still learning the system. S/he would like staff to contact administration staff before disabling the system. - For staff who had been hired after the initial training in February 2026, training on the system is provided during that staff's orientation period. During the interview, Administrator B stated s/he was on site and confirmed s/he could view both buildings through the handheld device. During the interview, Licensee G stated the following: - The provider had chosen to use the particular system due to its anonymity. - There was measurable data which indicated the system was doing better than expected. - Alerts could be customized to each resident according to each resident's personalized challenges. In summary, the provider installed an electronic monitoring system that was monitoring resident activities. The system was installed in every resident room. The provider included a written consent to monitoring form which expressly stated that a resident could withdraw consent at any time. Resident 2 and Resident 3 expressed discomfort with the system. Resident 2 expressed to staff that s/he did not want the system active in his/her room multiple times, but the device remained active. Staff were able to identify residents based on distinctions not erased by the de-identifying technology. Staff were able to view	Y3235		

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Y3235	Continued From page 16 and identify when Resident 2 and Resident 3 were sexually active. The system could be viewed from the other facility licensed by the provider. Data was saved on the handheld cellular device after having been reviewed. The system's ability to identify other individuals (other residents, staff, and visitors) and lock the user out of conducting spot checks was not consistent. Staff performing cares on residents could be viewed live, and video footage of more than 1 resident and/or family members could be viewed on the handheld devices. The provider did not ensure all residents had the right to privacy.	Y3235			