STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018759	A. BUILDING: _____ B. WING _____	R-C 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - ABBOTSFORD I	100 S 4TH AVE ABBOTSFORD, WI 54405

(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 06/23/2026, Surveyor conducted 3 complaint investigations and a verification visit at Vitacare Living - Abbotsford I. Data was collected through 06/25/2026. Three of 3 complaints were unsubstantiated. Five deficiencies were identified. Five of the 5 deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) EHFE11, dated 11/16/2022 and SOD G7KO12, dated 11/26/2025. Census: 15 Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed.	{N 000}		
{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: Based on record review and interview, the licensee did not ensure the community-based residential facility (CBRF) and its operation complied with all laws governing the CBRF. The licensee did not comply with Special Orders contained in a Notice and Order letter, dated 02/04/2026. This is a repeat deficiency. See Statement of Deficiency (SOD) G7KO12, dated 11/26/2025.	{N 196}		

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

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{N 196}	Continued From page 1 Findings include: The provider is licensed to care for up to 16 residents in the client groups of: physically disabled, advanced age, irreversible dementia/Alzheimer's disease, and terminally ill. On 02/04/2026, the licensee was issued a Notice and Order letter along with SOD G7KO12, which contained 21 violations of Wis. Admin. Code ch. DHS 83. The Notice and Order letter contained Special Orders, which read, in part: "WITHIN 7 DAYS of receipt of this notice, the licensee shall provide the legal representative and case manager (if any) for each resident with a copy of Statement of Deficiency (SOD) G7KO12 and a copy of this Notice and Order letter. The licensee shall retain evidence, acceptable to the department, to verify compliance with this Order. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from each legal representative and case manager." On 02/24/2026, Licensee D emailed confirmation that s/he received the Notice and Order letter and SOD G7KO12. On 06/23/2026, Surveyor conducted a verification visit for SOD G7KO12. At 1:40 p.m., Surveyor requested documentation from Director A to verify the Special Orders were followed. At 2:00 p.m., Director A told Surveyor that s/he mailed the guardians the SOD and Notice and Order letter but did not mail it certified, and s/he did not retain evidence that s/he mailed them. Director A said s/he provided the case managers with the SOD and Notice and Order letter in person. On 06/24/2026, Surveyor emailed Person E, who was the legal representative for Resident 2, and	{N 196}		

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{N 196}	Continued From page 2 asked if s/he received a copy of SOD G7KO12 along with the Notice and Order letter. On 06/24/2026, Person E replied, via email, to Surveyor, which read: "I did not receive any information." On 06/24/2026, Surveyor emailed Person F, who was the quality improvement manager for a managed care organization (MCO), and asked if the case managers received a copy of SOD G7KO12 along with the Notice and Order letter. On 06/24/2026, Person F replied, via email, which indicated s/he would reach out to the care teams to ask. On 06/25/206, Person F replied to Surveyor, via email, which read, in part: "It does not appear that the IDT (interdisciplinary teams) received a copy of the Enforcement Letter or SOD. There were 2 IDT who stated that their members did not reside at the facility until late 2/2026 (past the SOD notice frame)." On 06/25/2026 at approximately 12:00 p.m., Surveyor interviewed Director A on the phone. Director A told Surveyor that s/he did mail the SOD and Notice and Order, but did not have documentation to prove this. S/he said s/he took full responsibility and would ensure that s/he retains documentation in the future. Director A went over options of how s/he could retain documented evidence, such as having the person sign to acknowledge they received. Director A said s/he has been working hard to correct previous deficiencies as during the survey for SOD G7KO12 s/he was just starting his/her role as the director. Director A said s/he has now completed the administrator's course and has learned a lot.	{N 196}		

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{N 220}	Continued From page 3	{N 220}		
{N 220}	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating 2 of 3 employee records reviewed had been screened for clinically apparent communicable disease including tuberculosis (TB). Caregiver B and caregiver C did not have a TB test within 90 days before the start of employment. This requirement is being cited for the third time. See Statement of Deficiency (SOD) EHFE11, dated 11/16/2022 and SOD G7KO12, dated 11/26/2025. Findings include: On 06/23/2026, Surveyor reviewed the employee files for Caregiver B and Caregiver C.	{N 220}		

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{N 220}	Continued From page 4 Caregiver B's date of hire was 01/21/2026. His/her orientation training indicated the first day s/he worked with residents was 03/17/2026. S/he had a communicable disease screen and questionnaire completed and signed on 03/05/2026. His/her record did not have evidence s/he was tested for TB. Caregiver C's date of hire was 03/24/2026. S/he had a communicable disease screen and questionnaire completed 03/27/2026 and another completed 05/11/2026. His/her record indicated s/he had a TB skin test placed on 05/11/2026 and read negative on 05/13/2026. The employee schedule indicated Caregiver C worked before having his/her first TB skin test. On 06/23/2026 at approximately 3:45 p.m., Surveyor interviewed Director A. Director A told Surveyor, Caregiver B refused to come in to have a TB test when the nurse was at the facility. Director A said Caregiver B will be removed form the schedule. Director A told Surveyor, Caregiver C was scheduled to have his/her 2nd TB skin test placed on Monday, June 29th. Surveyor explained concern that Caregiver C worked prior to having his/her first TB skin test placed. Director A said s/he will no longer allow staff to begin working until they have their 1st TB skin test.	{N 220}		
{N 302}	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically	{N 302}		

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{N 302}	Continued From page 5 apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 4 residents reviewed were screened for clinically apparent communicable disease, including tuberculosis (TB) within 90 days before or 7 days after admission. Resident 1's record did not contain evidence of having been screened and tested for TB. This is a repeat deficiency. See Statement of Deficiency (SOD) G7KO12, dated 11/26/2025. Findings include: On 06/23/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 01/30/2026. Resident 1's record did not have evidence Resident 1 was screened and tested for TB. On 06/23/2026 at approximately 3:45 p.m., Surveyor interviewed Director A. Director A told Surveyor s/he could not locate a TB test for	{N 302}		

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{N 302}	Continued From page 6 Resident 1. Director A said s/he reached out to Resident 1's hospice provider to check if they had documentation of Resident 1 being tested for TB. Surveyor told Director A to email Surveyor if s/he found the documentation. As of 06/25/2026, Surveyor did not receive documentation from Director A that indicated Resident 1 was screened and tested for TB.	{N 302}		
{N 488}	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the entire clothes dryer vent was made of tubing that was rigid material. This is a repeat deficiency. See Statement of Deficiency G7KO12, dated 11/26/2025. Findings include: On 06/23/2026 at 2:48 p.m., Surveyor observed the laundry room with Director A. The vent coming from the dryer was made of flexible material that joined a rigid vent that went into the wall. (Photo 8). Director A told Surveyor they had a professional come to replace the vent after the last survey. Surveyor explained to Director A that the entire vent is required to be of rigid material.	{N 488}		

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{N 488}	Continued From page 7 The Cambridge dictionary defines rigid as: "stiff or fixed; not able to be bent or moved."	{N 488}		
{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 all cleaning compounds, polishes and insecticides were stored in a secure manner. This requirement is being cited for the third time. See Statement of Deficiency (SOD) EHFE11, dated 11/16/2022 and SOD G7KO12, dated 11/26/2025. Findings include: The provider is licensed to care for up to 16 residents in the client groups of: physically disabled, advanced age, irreversible dementia/Alzheimer's disease, and terminally ill. On 06/23/2026 at approximately 9:55 a.m., Surveyor toured the facility. At approximately 10:00 a.m., Surveyor observed the door to the kitchen was open from the dining area. The door between the kitchen and the pantry was open, and the pantry door was open to the hallway. (Photo 5). Surveyor observed the kitchen cabinet located under the sink in the kitchen had a lock that was not secured. (Photo	{N 499}		

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{N 499}	Continued From page 8 3). The unsecured cabinet contained: dish detergent, furniture polish, sanitizing spray, glass cleaner, and dishwasher packets. (Photo 1 & 2). There was a jug of insecticide sitting on the pantry near the door to the kitchen. (Photo 4). There were no staff present in the kitchen, pantry, or dining room at this time. At 10:13 a.m., Surveyor observed a shared bathroom located across from Room #7. There was a cabinet above the toilet that was not secured. (Photo 7). The inside of the unsecured cabinet contained: disinfecting wipes, toilet bowl cleaner, and 2 aerosol cans of air freshener. (Photo 6). Surveyor did not observe any staff present near this bathroom. On 06/23/2026 at approximately 3:45 p.m., Surveyor interviewed Director A. Director A told Surveyor the staff were supposed to be keeping all cleaning cabinets locked.	{N 499}		