

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018747	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/02/2026
NAME OF PROVIDER OR SUPPLIER VITACARE LIVING - LADYSMITH II		STREET ADDRESS, CITY, STATE, ZIP CODE 1105 BAKER AVE LADYSMITH, WI 54848		
(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 08/19/2026, Surveyor conducted a complaint investigation at Vitacare Living Ladysmith II. Data was collected through 09/02/2026. Two of 4 complaints were substantiated. Three violations were identified. One of 3 violations was a repeat deficiency. See Statement of Deficiency (SOD) 7EER11, dated 10/13/2022. Census: 14	N 000		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not immediately notify Resident 1's legal representative when there was a significant change in Resident 1's physical condition. This is a repeat deficiency. See Statement of Deficiency (SOD) 7EER11, dated 10/13/2022. Findings include: On 08/18/2026 and 08/20/2026. The Department	N 169		

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

TITLE

(X6) DATE

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N 169	Continued From page 1 received complaints regarding resident care. The provider is licensed to care for 16 residents in the client groups; physically disabled, irreversible dementia/Alzheimer's disease, advanced aged, and terminally ill. On 08/31/2026 from 1:53 PM to 2:31 PM, Surveyor interviewed Registered Nurse (RN) D who stated Team Lead (TL) B had informed him/her that Resident 1 was found unresponsive on 08/10/2026. RN D stated when incidents occurred, staff were to contact the resident's legal representative and hospice, and a note was added to the computer. On 09/01/2026 from 12:35 PM to 12:55 PM, Surveyor interviewed Caregiver E. Caregiver E stated s/he was aware that Resident 1 had been sleeping on the floor on 08/10/2026. Caregiver E began work at 6:00 AM and s/he received report from the nighttime shift. Caregiver E stated s/he received a phone call at approximately 9:00 AM on 08/10/2026 from Guardian G. Caregiver E informed Guardian G that Resident 1 was still sleeping, but Caregiver E did not state where Resident 1 was sleeping. Caregiver E stated it was not normal for Resident 1 to sleep in the morning. Caregiver E stated s/he believed Resident 1 fell asleep on the floor around 5:00 PM on 08/09/2026. Caregiver E stated s/he and Caregiver F moved Resident 1 from the floor to a chair at approximately 10:00 AM on 08/10/2026 and noted Resident 1 was not coherent, seemed tired, and did not help with moving, which was unusual. Caregiver E stated s/he called TL B for assistance with moving Resident 1 from the chair to his/her bed. Caregiver E stated s/he called	N 169		

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N 169	Continued From page 2 hospice around 11:00 AM on 08/10/2026 and sometime after that s/he called Guardian G. Surveyor asked if the notification was documented and s/he responded it was not. On 09/01/2026 at approximately 1:20 PM, Surveyor interviewed TL B who stated the only place notification would be documented would be on an incident report. TL B stated s/he understood if documentation did not occur there was no proof the notification occurred. TL B stated s/he was very frustrated that staff were not trained to document. On 09/01/2026, Surveyor reviewed Resident 1's incident reports for dates 07/01/2026 to 08/05/2026. There was no record of Resident 1 sleeping on the floor, a change in condition, or proof of notification to the guardian. There were no incident reports dated after 08/05/2026. On 09/02/2026 at approximately 8:05 AM, Surveyor interviewed Guardian G. Guardian G stated Hospice Nurse I called Guardian G at approximately 3:30 PM on 08/10/2026, and updated him/her on Resident 1's significant change of condition. Guardian G stated the provider did not notify him/her of Resident 1's change of condition. The provider did not immediately notify Guardian G when Resident 1 had a significant change of condition.	N 169			
N 200	83.14(2)(e) Notify within 7 days of administrator change The licensee shall notify the department within 7 days after there is a change in the administrator.	N 200			

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N 200	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify the department within 7 days after there was a change in the administrator. Findings include: The provider is licensed to care for 16 residents in the client groups physically disabled, advanced aged, irreversible dementia/Alzheimer's disease, and terminally ill. On 08/19/2026, Surveyor reviewed the Department's record. Surveyor found on the provider's face sheet that Administrator A was listed as the current administrator. A review of the Department's correspondence included a document dated 02/27/2025, that indicated Administrator A was the current administrator. On 08/31/2026 at 9:42 AM, Surveyor received an email communication from Registered Nurse (RN) E that read, in part, " ...The administrator for Ladysmith is currently [Administrator C]. The forms were completed and send [sic] in to [sic] state ..." On 09/01/2026 at approximately 10:35 AM, Surveyor interviewed Team Lead (TL) B who stated s/he thought Administrator A's employment ended approximately September 2025. The provider did not notify the Department when there was a change in administrator.	N 200		
N 431	83.38(1)(g) Health monitoring.	N 431		

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N 431	Continued From page 4 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not document communication with Resident 1's health care provider (hospice) and record changes in Resident 1's health when there was a significant change in condition. Resident 1 slept on his/her bedroom floor for approximately 17 hours between 08/09/2026 and 08/10/2026 and when staff attempted to move him/her, they observed significant changes in his/her condition.	N 431		

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N 431	Continued From page 5 Findings include: On 08/18/2026 and 08/20/2026, the Department received complaints regarding resident care. The provider is licensed to care for 16 residents in the client groups; physically disabled, irreversible dementia/Alzheimer's disease, advanced aged, and terminally ill. On 08/31/2026 from 1:53 PM to 2:31 PM, Surveyor interviewed Registered Nurse (RN) D. Surveyor asked if there was documentation regarding Resident 1 sleeping on the floor. RN D stated Team Lead (TL) B had informed him/her that Resident 1 had been crawling on the floor and hitting walls on 08/07/2026. Surveyor asked if Resident 1 had recent changes in condition. RN D stated Resident 1 was found unresponsive on 08/10/2026. RN D stated TL B and hospice would have additional information. On 09/01/2026 from 10:19 AM to 10:53 AM, Surveyor interviewed TL B who stated there were 2 occasions when Resident 1 had slept on the floor. TL B stated the first time this happened staff were directed to provide Resident 1 with a pillow and a blanket, but Resident 1 got back up. TL B stated the second time, on 08/10/2026, Resident 1 laid on the floor, half under his/her bed until the morning. TL B stated Caregiver E called him/her sometime between 10:00 AM and 11:00 AM for assistance in moving Resident 1 from the chair to his/her bed. TL B stated Resident 1 swung at staff but did not open his/her eyes. TL B stated s/he had not been contacted about this situation prior to 10:00 or 11:00 AM. TL B stated an incident report had not been filled out. TL B stated s/he noted Resident 1 presented in a different	N 431		

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N 431	Continued From page 6 manner. TL B stated s/he was not happy that Resident 1 was left on the floor. Surveyor asked if this event had been documented. TL B stated if there was documentation it would be in the electronic health record where staff tasks were assigned. TL B stated an investigation did not occur. On 09/01/2026, Surveyor reviewed Resident 1's record which included: -A Resident Profile indicating Resident 1 was admitted on 06/26/2026 and was diagnosed with, " ...Dementia with behavioral disturbance (primary) ...Alzheimer's Disease ...Epilepsy ...Other abnormalities of gait and mobility ...Prior hospice and palliative care admission ...Psychotic disturbance, mood disturbance ...anxiety ...Restlessness and Agitation ..." Resident 1 had a guardian. -New Resident Notes dated 06/01/2026 to 08/19/2026 that included staff charting for the following dates: 07/01/2026, 07/04/2026, 07/16/2026, 08/01/2026 and 08/07/2026. -Resident Notes dated 07/26/2026 to 08/19/2026 that included entries dated 08/01/2026, 08/06/2026, and 08/07/2026. -Incident Reports dated 07/01/2026 to 08/05/2026. There were no incident reports dated after 08/05/2026. On 09/01/2026 from 12:35 PM to 12:55 PM, Surveyor interviewed Caregiver E who stated when s/he arrived for the 6:00 AM shift, s/he was informed that Resident 1 had been sleeping on the floor and s/he let Resident 1 sleep because s/he knew Resident 1 had not slept at all the	N 431		

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N 431	Continued From page 7 previous night. Caregiver E stated s/he did not immediately assist Resident 1 off the floor because s/he was working with other residents. Caregiver E stated that at approximately 10:00 AM s/he and Caregiver F moved Resident 1 from the floor to a chair, and that Resident 1 was not coherent, seemed very tired, and did not assist them, which was unusual. Caregiver E stated Resident 1's legs were under the bed up to his/her knees. Caregiver E stated s/he called TL B to assist moving Resident 1 from the chair to his/her bed. Caregiver E stated s/he called hospice at approximately 11:00 AM. Caregiver E stated s/he then called Guardian G. Caregiver E stated it was normal behavior for Resident 1 to be on the floor but not to sleep all night. Caregiver E stated s/he believed Resident 1 fell asleep on the floor around 5:00 PM on 08/09/2026. On 09/01/2026 from 11:19 AM to 11:54 AM, Surveyor interviewed Hospice Nurse (HN) I. HN I stated Resident 1 was enrolled in hospice on 07/02/2026 and passed away on 08/12/2026. HN I stated s/he was informed of Resident 1 sleeping on the floor on 08/10/2026 and arrived at the facility around lunch to assess. HN I stated Resident 1 had a history of putting him/herself on the floor (or crawling on the floor) and described it as "typical behavior." HN I stated s/he did not find it unusual that Resident 1 chose to sleep on the floor. HN I stated Resident 1 had medication changes that could have contributed to his/her sleepiness. On 09/01/2026 at 2:17 PM, Surveyor received an email from the provider which included an email from Caregiver E to Regional Director (RD) H, dated 08/10/2026 at 12:23 PM, that read, in part,	N 431		

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N 431	Continued From page 8 " ...[Resident 1] was sleeping on the floor all night cockeyed under [his/her] bed ...was wet and not really coherent ...[Caregiver E] was told [Resident 1] fell asleep on the floor during the pm shift ..." The provider did not document Resident 1's change in condition in his/her record when there was a significant change in condition.	N 431			