STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019178	A. BUILDING: _____ B. WING _____	R-C 08/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MOUNT HOREB	104 LINCOLN CT MOUNT HOREB, WI 53572

(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 From 08/11/2026 to 08/12/2026, Surveyors conducted 2 verification visits and 4 complaint investigations at VitaCare Living Mount Horeb, a CBRF in Mount Horeb. Eleven deficiencies were identified. Eight deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) VTVD11, dated 07/16/2025, SOD VTVD12, dated 12/08/2025 and SOD VTVD13, dated 04/14/2026. One of 4 complaints was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 15	{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 observation, interview and record review, the provider did not ensure the facility and its operation complied with all laws governing the CBRF. This is a repeat deficiency. See Statement of Deficiency (SOD) VTVD12, dated 12/08/2025 and SOD VTVD13, dated 04/14/2026. Findings include: From 08/11/2026 to 08/12/2026, Surveyors	{N 196}		

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

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{N 196}	Continued From page 1 conducted a verification visit and 4 complaint investigations at the provider's facility. CURRENT NON-COMPLIANCE: On 08/11/2026, 11 deficiencies were identified, 8 of which were repeat deficiencies. The following deficiencies were identified: - One of 3 individual service plans (ISP) reviewed were not followed. *Repeat deficiency. - Two of 3 ISPs were not updated when there was a change in need and/or signed by the legal representative to acknowledge agreement with the plan. *Repeat deficiency. - Three of 4 residents reviewed did not have medication administration, including insulin administration and response to PRN administration, documented in their records. *Repeat deficiency. - The provider did not ensure daily activity programming was provided. *Repeat deficiency. - One of 4 residents reviewed did not have their health monitored and recorded as ordered. *Repeat deficiency. - The provider did not ensure the facility was clean, comfortable and homelike. *Repeat deficiency. - The provider did not ensure clean and dirty laundry were stored separately, including in a container that was clean, leak-proof and had a tight-fitting lid. - Two of 3 cloth dryer vents were not made of rigid material. *Repeat deficiency. - The provider did not ensure 3 of 3 bathrooms were equipped with single use paper towels. - The provider did not ensure the laundry rooms, which were located on the same floor as resident bedrooms had self-closing doors kept closed. NON-COMPLIANCE WITH SPECIAL ORDERS:	{N 196}		

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{N 196}	Continued From page 2 On 05/29/2026, the department issued an enforcement letter with SOD VTVD13, dated 04/14/2026, that stated the following: "2. Pursuant to Wis. Stat. § 50.03(5g)(b)6., WITHIN 7 DAYS of receipt of this notice, the licensee shall provide the legal representative and case manager (if any) of each resident with a copy of Statement of Deficiency VTVD13 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 the legal representative and case manager. The documentation required will be available to department representatives upon request." On 08/11/2026 at approximately 12:00 p.m., Surveyor requested documentation from Assistant Director B regarding special orders issued with SOD VTVD13. On 08/11/2026 at 1:00 p.m., Assistant Director B provided Surveyor with documentation of training completed. Assistant Director B stated s/he had not completed any notifications to legal representatives and case managers as ordered. On 08/11/2026 at approximately 2:30 p.m., Surveyors reviewed deficient practices identified and non-compliance with special orders with Assistant Director B and Regional Nurse O. Regional Nurse O stated s/he thought the facility's prior nurse completed notifications and that s/he would follow up with Surveyor. On 08/12/2026 at 10:24 a.m., Surveyor received	{N 196}		

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{N 196}	Continued From page 3 updated documentation from Regional Nurse O. Surveyor noted follow up documentation from Regional Nurse O did not include documentation of notifications to legal representatives and case managers. SURVEY HISTORY: On 08/12/2026 at 12:00 p.m., Surveyor reviewed the provider's history with the department. Since the provider received a regular license on 04/15/2024, the department has conducted 13 complaint investigations, 6 verification visits and 1 standard licensing survey. As a result of the investigations and surveys, the department has substantiated 6 complaints and identified 56 deficiencies. Cross Reference: N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0415 DHS 83.37(2)(d) Documentation Of Medication Administration N0427 DHS 83.38(1)(c) Leisure Time Activities N0431 DHS 83.38(1)(g) Health Monitoring N0481 DHS 83.43(1) Environment Safe, Clean, And Comfortable N0487 DHS 83.44(1)(b) Separate Landry Storage Areas Or Containers N0488 DHS 83.44(1)(c) Clothes Dryers Enclosed And Vented N0612 DHS 83.55(3) Bath And Toilet Areas: Hand Drying N0640 DHS 83.59(2)(b) Solid Core Wood Doors Or Equivalent	{N 196}		

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N 388	Continued From page 4	N 388		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the individual service plan (ISP) for 1 of 3 residents reviewed was followed. Resident 13's fall preventions specified in his/her ISP were not followed. This is a repeat deficiency. See Statement of Deficiency (SOD) VTVD12, dated 12/08/2025. Findings include: RECORD REVIEW: On 08/11/2026 at approximately 7:00 a.m., Surveyor reviewed Resident 13's hospice notes, obtained by Surveyor. Progress notes, dated 04/24/2026 to 08/03/2026, documented the following concerns regarding fall preventions for Resident 13: - 04/24/2026 9:50 a.m.: Found patient resting in bed. Floor mat alarm box was in off position. - 05/11/2026 9:44 a.m.: Found resident sitting in wheelchair in the bathroom about to self-transfer. Tab alarm not on. - 05/14/2026 10:15 a.m.: Follow up on fall last evening. Found to be unattended sitting on the toilet. Pants are pulled down but depends still up while sitting on the toilet. Resident reported s/he took him/herself to the bathroom, which would indicate tab alarm was not being utilized as it was not sounding. S/he should not be left unattended	N 388		

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in the bathroom.
- 05/26/2026 12:59 p.m.: Found patient sitting at the edge of bed. Patient reports s/he wheeled him/herself back from lunch and self-transferred into bed. Tab alarm not sounding and does not appear as though it was attached to him/her at mealtimes.
- 06/02/2026 9:00 a.m.: Resident found sitting at edge of bed with a half full urine container on his/her walker. Floor mat alarm is not sounding. Appeared resident independently used urine container.
- 06/03/2026 10:31 a.m.: Fall follow up. Floor mat sensor alarm receiver located in kitchenette was found vibrating with no staff present. Resident found to be in wheelchair attempting to self-transfer to his bed. Tab alarm not in place.
- 06/05/2026 9:56 a.m. Checked resident's fall mat sensor receiver box which was kept in the kitchen area and observed it was on vibrate with no staff in the area. Resident found in bed with pants wet but depends not wet. Suspected that resident may have attempted to use the urine container independently.
- 06/13/2026 9:42 a.m.: Found with wheelchair and walker placed on top of mat, which affects how alarm functions. Floormat did not sound when nurse stepped on mat.
- 06/15/2026 8:44 a.m.: Found sitting in wheelchair with depends down at his/her knees. Pressure sensor alarm is not sounding. Tab alarm is attached to the bed and the clip is stuck firmly under the boxspring and mattress.
- 06/17/2026 9:57 a.m.: Found sitting in his/her wheelchair, attempting to self-transfer. Tab alarm was not in place. Pressure sensor pad is on the bed but there is no box attached to the mat, so it would not function.
- 06/24/2026 9:45 a.m.: Found resting in bed with bed mat alarm not in place. Mat was found

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behind the TV next to the bed. Resident appeared to have taken him/herself back to his/her room from breakfast and self-transferred, which should have activated the chair alarm if it were in place to alert staff of self-transfer.
- 07/01/2026 9:33 a.m.: Patient resting in bed. Pants are wet, pull up is dry, appears as though resident likely used the urine container independently and urinated on his/her pants. Bed alarm in place. Management unable to weigh in on whether or not the tab alarm was in place after breakfast to notify of self-transfer. Family reported concerns of resident being wet when they visit, recently found placement sitting in wheelchair with depends up and pants down to ankles without tab alarm in place.
- 07/14/2026 8:59 a.m.: Resident was in wheelchair. Had alarm on chair but it was not attached to resident's shirt.
- 07/22/2026 9:50 a.m.: Resting in bed, reset button on bed alarm box has corner pushed in and is not functioning. Nurse fixed the button and it began beeping low battery.
- 07/27/2026 10:02 a.m.: Found sitting in wheelchair. Alarm not in place - It is clipped to the back of his wheelchair. Pants smelled of urine. Pull up was not wet, indicating resident likely attempted to use the urine container him/herself and urinated on his/her pants.
- 07/29/2026 10:26 a.m.: Corner of the reset button on the bed alarm box is pushed in which doesn't allow the alarm to go off if resident removes weight from it.
- 08/03/2026 9:58 a.m.; Found resting in bed. Corner of bed alarm reset button was pressed on causing the alarm to not go off if resident removed weight from the pad.

A hospice note, dated 06/05/2026 9:56 a.m., indicated a meeting was held with Assistant

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N 388	Continued From page 7	N 388		

Director B and RN R to discuss concerns with noncompliance of patient's plan of care, specifically fall interventions.

On 08/11/2026 at approximately 10:00 a.m., Surveyors reviewed Resident 13's record, provided by Assistant Director B. Resident 13 admitted to the provider's facility on 07/08/2020. Resident 13's ISP, dated 07/25/2026, included the following regarding toileting assistance, mobility and fall preventions:

- Assist of 1 with 2 wheeled walker and gait belt to transfer.
- One assist with wheelchair mobility. Ensure wheelchair alarm is in place while resident is in wheelchair.
- Assist of 1 and supervision with urine container at bedside and while sitting on the toilet.
- High fall risk. Bed alarm in place. Safety checks every 2 hours.

INTERVIEW:

On 08/11/2026 at 2:19 p.m., Surveyor requested Resident 13's ISP that would have been effective prior to 07/25/2026 from Assistant Director B. Assistant Director B stated s/he was unable to provide Surveyor with a previous ISP as the document did not save when the document was updated. Surveyor asked Assistant Director B how long Resident 13 had chair or bed alarms in place as a fall prevention. Assistant Director B stated approximately 2 to 3 months.

OBSERVATION:

On 08/11/2026 at approximately 2:30 p.m., Surveyor asked Assistant Director B to show Surveyor Resident 13's alarms that were in place

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N 388	Continued From page 8 for fall prevention. Surveyor and Assistant Director B went to Resident 13's room and observed him/her laying in bed. Surveyor observed the reset button on the bed alarm box was pushed in, indicating the alarm would not activate if Resident 13 began getting up on his/her own. Assistant Director B acknowledged the reset button was pushed in, pushed the button to activate the alarm and heard a beep which informed the alarm was now on. Assistant Director B stated staff should be checking to make sure the alarm is engaged.	N 388		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 individual service plans (ISP) reviewed were updated when there was a change in needs, abilities or condition and/or that the ISP was signed by the resident or resident's legal representative acknowledging	N 389		

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their involvement in the plan.

Resident 16's ISP was not updated to include verbal aggression, physical aggress, or calls to 911.

Resident 13's ISP was not signed by his/her legal representative to acknowledge his/her involvement, understanding of and agreement with the ISP.

This is a repeat deficiency. See Statement of Deficiency (SOD) VTVD11, dated 07/16/2025 and SOD VTVD12, dated 12/08/2025.

Findings include:

Example 1 - Resident 16

On 08/11/2026 at 9:54 a.m., Surveyor interviewed Resident Care Specialist N about any aggressive residents. Resident Care Specialist N stated Resident 16 was very belligerent. Physically and verbally aggressive and abusive. Resident Care Specialist N stated that if any of the caregiver did something Resident 16 didn't like that s/he would fly off the handle. S/he stated that the nurse told the caregiver to walk away from Resident 16 if nothing else worked.

On 08/11/2026 at approximately 11:00 a.m., Surveyor reviewed Resident 16's record, provided by Assistant Director B. Resident 16 admitted to the provider's facility on 05/26/2026 with diagnoses including anxiety, bipolar disorder, borderline personality disorder, major depressive disorder, obsessive compulsive disorder, and hallucinations.

Surveyor reviewed Resident 16's progress notes

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N 389	Continued From page 10 which documented: -06/09/2026, Resident 16 voiced concerns about money missing from his/her wallet. Nurse offered to call police. Resident 16 stated s/he was unsure if s/he misplaced the money or if someone took it, explaining that s/he has a history of miss placing money. -06/11/2026, Staff overheard resident use profanity when referring to staff member. -06/14/2026, Resident came to kitchen and stated that someone had stolen $200 out of his/her room. Resident stated that this has happened before and someone took $160 from him/her. -06/16/2026, Resident was upset saying that staff were refusing to give him/her medications and that s/he can't take medication on his/her own. Staff explained to resident that they have the medications out for him/her to talk and that they are not refusing to administer his/her medications. -06/18/2026, Resident was very impatient and aggressive towards staff. Resident was cussing, screaming and making a scene whenever something doesn't go his/her way. -06/18/2026, Resident became very verbally aggressive, using profanity and derogatory language towards staff, and yelling that staff should get off the phone and do some work. Management was present via phone and witnessed the interaction. -06/18/2026, Resident could be heard screaming very loudly and clearly at staff member and slamming doors. -06/19/2026, Resident became extremely upset and yelling, "I will call the ombudsman and report you to the state." -06/23/2026, Requested to review ISP with resident. Resident 16 refused stating, "I will not go over that with you. Everything on it is a lie	N 389		

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N 389	Continued From page 11 about me. I will be leaving this [expletive] hole soon anyway." -06/24/2026, Resident stated s/he was having very bad anxiety and stated that his/her medication needed to be upped. -06/24/2026, Resident is very upset, loud, and screaming this morning after several staff asked if they could administer his/her medication. S/he exploded on staff. Another incident occurred when resident became upset because s/he could not find his/her phone. This happened 3 times and s/he had the phone on his/her person the whole time. Staff asked him/her to take a second, relax, and breathe. Resident responded negatively to staff by telling them to shut up and not tell him/her what to do. -06/27/2026, Resident 16 was rambling continuously regarding many things about medications, however, the things Resident 16 was stating were not completely making sense. Resident 16 began yelling at staff and became very verbally aggressive. -07/05/2026, Resident 16 began shouting at staff to "go to [expletive]" and then went outside to smoke. -07/06/2026 Resident 16 expressed his/her excitement regarding his/her grievance with the managed care organization. -07/06/2026, At around 10pm resident began going through the building trying to find med passer. Upon finding med passer, resident shouted from the other side of the hallway regarding their medications and that they want it. Staff reminded Resident 16 that they did receive their medication. Resident could be heard screaming from outside of the door and pounding on the door saying, "you're a big fat liar", "Good luck becoming a nurse", "I'll talk to my case working tomorrow at 10 am", "You're getting fired, that's refusal of medications".	N 389		

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N 389	Continued From page 12 -07/07/2026, Resident pushed his/her call button repeatedly and was anxious due to his/her phone glitching. When both staff attempted to help resident, s/he became upset when s/he had been informed that staff weren't able to fix the phone. Resident 16 got upset calling staff useless. -07/08/2026, Resident 16 started yelling, demanding that staff had to help him/her right now. Resident 16 started yelling again and calling staff mean (expletives) because they did not do exactly what s/he wanted them to do when s/he wanted them to do the task at hand. Resident 16 stated, "I am calling the Ombudsmen and filing a grievance on all of you for abuse and not doing your jobs." -07/09/2026, Resident was super anxious, kept chasing staff down even when tending to other residents. -07/15/2026, Resident 16 was upset with the caregiver and started yelling and being very rude. Staff member walked away and resident started saying that staff pushed his/her wheelchair and that was assault then proceeded to come up behind staff and hit them in the back and dug his/her nails into caregiver's arm. As the police arrived, Resident 16 was already shaking and stated, "I can't go to jail I'm going to the hospital." Resident was visibly upset and scared that the police arrived before the ambulance. The police were taking statement and Resident 16 began arguing with EMS (emergency medical services) and could be heard yelling at them to take him/her to jail. EMS confirmed with Resident 16 that s/he wants to go to the hospital or not and stated that they were just out here for the same thing yesterday. Resident 16 stated, "That was for anxiety, this is heat stroke." Resident 16 left via ambulance. -07/16/2026, Resident 16 asked about his/her new prescription for Lorazepam. Education	N 389		

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provided on the process of sending prescriptions to the pharmacy and waiting for pharmacy to deliver the medication. Resident 16 stated, "This is not right. You are not allowed to hold my medication like that. I have to have 2 pills a day otherwise I will go back to the ER just to get my medication that you refuse to give me." Resident 16 wanted the facility fan because the one in his/her room wasn't enough and stated, "I don't care about them, I want a fan now. This is elder abuse."
-07/18/2026, Resident was screaming and yelling at med passing this morning, threatening to call law enforcement.
-07/18/2026, Resident went out via 911 due to high anxiety.
-07/18/2026, Resident 16 was yelling that s/he needed his/her medication and that the doctor told him/her s/he could have it whenever s/he asked. Resident 16 stated s/he was going to call the police because the facility was abusing him/her and refusing to give medications then proceeded to continue to yell at use swear words.
-07/20/2026, Resident 16 called 911. Caregiver administered medications and s/he spit the medication and the water on the floor. After going back and forth with EMS and law enforcement, Resident 16 agreed to take his/her medication.
-07/20/2026, Resident 16 was demeaning and racist towards staff.
-07/20/2026, Resident 16 was very upset and told caregiver they are lazy and doesn't do anything and began with racial slurs and comments.
-07/20/2026, Resident 16's blood sugar was taken per scheduled in the MAR (medication administration record) at 8:00 p.m., Around 10:30 p.m., Resident approached staff member accusing them of not taking his/her blood sugar. Staff offered to take his/her blood sugar again, Resident 16 refused and stated, "My doctor is not

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going to like this, I'm reporting you, just wait until state comes."
-07/21/2026, EMS was called by resident stating staff were refusing to give him/her his/her medications. Resident 16 was combative, agitated, and claiming confusion. Resident 16 stated that both the nurse and manager will be fired because s/he would call the state. Resident 16 started to use vulgar language and then made self harm comments. Resident was taken to hospital.
-07/21/2026, Resident called 911 again for unknown reason.
-07/21/2026, Resident returned from the hospital and began demanding medication, Resident 16 slammed the door to the nurse's office so hard that the trim broke off. Resident 16 was upset about medication and was provided a list of his/her prescribed medications. Resident 16 stated s/he was going to catch staff lying to him/her and began yelling and cursing at staff. Resident stated, "This is why you are loosing your job. I'm calling the Ombudsman on you" and slammed the door.
-07/22/2026, Resident 16 stated s/he did not get his/her 4:00 p.m. medications today; there were two witnesses to medications being administered to the resident at 4:00 p.m.
-07/23/2026, "Mt Horeb Deputy fire chief, Lieutenant police office, UW Health MD met with [Resident 16] today to discuss a plan of action on how to help decrease the number of 911 calls [Resident 16] places."

Surveyor reviewed Resident 16's ISP, dated 06/09/2026, which documented:
Behavior: Agitation, specify: -Note: talk fast, talk too much, anger
Behavior: Resistive tendencies, specify: - Note: History of non-compliance with dressing,

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N 389	Continued From page 15 grooming, toileting, bathing and medications. Behavior: Resident refuses to comply with wound care orders and self-care - hygiene, resident demand that staff are to work for him/her. Behavior: Self-isolation, specify: - Note: Likes to read, watch tv, or take a nap. Behavior: Other behavioral health needs, specify: - Note: Resident has history of paranoia, thinks staff members are against him/her. Resident 16's ISP was not updated to include verbal aggression, physical aggress, or calls to 911. The ISP did not document the program services, frequency and approaches provided to Resident 16 to address these behaviors. Example 2 - Resident 13: On 08/11/2026 at approximately 10:00 a.m., Surveyor reviewed Resident 13's record, provided by Assistant Director B. Resident 13 admitted to the provider's facility on 07/08/2020. Resident 13 had an activated Health Care Power of Attorney (HCPOA). Resident 13's record included an ISP, dated 07/25/2026, that was not signed by his/her HCPOA. On 08/11/2026 at 2:19 p.m., Surveyor requested an ISP from Assistant Director B that was signed and dated to acknowledge agreement with the plan. Assistant Director B stated s/he was unable to locate documentation of a signed ISP.	N 389		
{N 415}	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person	{N 415}		

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{N 415}	Continued From page 16 administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure medication administration, including the dosage and/or the response to a PRN medication, was documented for 3 of 4 residents reviewed. Resident 9's Insulin Lispro administration was not documented. Resident 13 received PRN Lorazepam 5 times with the response to the medication not documented 2 times. Resident 16 received PRN Lorazepam 14 times with the response to the medication not documented 7 times and PRN Hydroxyzine 1 time and the response to the medication was not documented. This is a repeat deficiency. See Statement of Deficiency (SOD) VTVD11, dated 07/16/2025, SOD VTVD12, dated 12/08/2025 and SOD VTVD13, dated 04/14/2026. Findings include: On 08/11/2026 at approximately 10:00 a.m.,	{N 415}		

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{N 415}	Continued From page 17 Surveyors reviewed resident records and identified the following concerns: Example 1 - Resident 9: Resident 9 admitted to the provider's facility on 08/01/2025 with diagnoses including diabetes. Resident 9's physician orders included the following: - Accu-Check 4 times daily at 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. for diabetes. - Insulin Lispro 100u/ml 3 times daily per sliding scale (70-139=0 units, 140-189=1 unit, 190-239=2 units, 240-289=3 units, 290-339=4 units, 340-389=5 units) after meals at 8:00 a.m., 12:00 p.m. and 4:00 p.m. for diabetes. Resident 9's record, dated 07/13/2026 to 08/11/2026, included the following occurrences when the amount of insulin administered was not documented: - 07/19/2026 8:00 a.m. Insulin Lispro signed as administered, but number of units not documented (Blood sugar = 171, indicating 1 unit should have been administered). - 07/19/2026 12:00 p.m. Insulin Lispro signed as administered, but number of units not documented (Blood sugar = 151, indicating 1 unit should have been administered). - 07/19/2026 5:00 p.m. Insulin Lispro signed as administered, but number of units not documented (Blood sugar = 196, indicating 2 units should have been administered). - 07/26/2026 8:00 a.m. Insulin Lispro signed as administered, but number of units not documented (Blood sugar = 165, indicating 1 unit should have been administered). - 07/26/2026 12:00 p.m. Insulin Lispro signed as	{N 415}		

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{N 415}	Continued From page 18	{N 415}		

administered, but number of units not documented (Blood sugar = 147, indicating 1 unit should have been administered).
- 08/02/2026 8:00 a.m. Insulin Lispro signed as administered, but number of units not documented (Blood sugar = 157, indicating 1 unit should have been administered).
- 08/02/2026 12:00 p.m. Insulin Lispro signed as administered, but number of units not documented (Blood sugar = 151, indicating 1 unit should have been administered).
- 08/07/2026 12:00 p.m. Insulin Lispro signed as administered, but number of units not documented (Blood sugar = 178, indicating 1 unit should have been administered).
- 08/07/2026 5:00 p.m. Insulin Lispro signed as administered, but number of units not documented (Blood sugar = 170, indicating 1 unit should have been administered).
- 08/09/2026 12:00 p.m. Insulin Lispro signed as administered, but number of units not documented (Blood sugar = 188, indicating 1 unit should have been administered).

On 08/11/2026 at approximately 2:30 p.m., Surveyor reviewed concern with Assistant Director B and Regional Nurse O that insulin administration was not documented each time insulin was administered. Assistant Director B stated no one audited documentation of insulin administration to ensure the documentation was being completed.

Example 2 - Resident 13:

Resident 13 admitted to the provider's facility on 07/08/2020. Resident 13's physician orders included Lorazepam .5 mg 3 times daily as needed for anxiety. Resident 13's medication administration record (MAR), dated 07/13/2026 to

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{N 415}	Continued From page 19 08/11/2026, documented 5 administrations of Lorazepam PRN. Of the 5 administrations, the administrations on 07/22/2026 and 07/24/2026 did not document Resident 13's response to the Lorazepam. On 08/11/2026 at approximately 2:30 p.m., Surveyor reviewed concern with Assistant Director B and Regional Nurse O that resident response to PRN medication was not documented. Assistant Director B nodded his/her head and stated no one audited documentation of PRN administration. Example 3 - Resident 16: Resident 16 admitted to the provider's facility on 05/26/2026 with diagnoses including anxiety, bipolar disorder, borderline personality disorder, major depressive disorder, obsessive compulsive disorder, and hallucinations. Resident 16's physician orders included Hydroxyzine HCL Tab 10 mg to take 1/2-1 tablet as needed daily for anxiety; and Lorazepam Tab 0.5 mg to take 1/2 tablet every 12 hours as needed for anxiety. Resident 16's MAR, dated 07/13/2026 to 07/26/2026, documented 14 administrations of Lorazepam PRN. Of the 14 administrations, 7 the administrations did not document Resident 16's response to the Lorazepam. Resident 16's MAR, dated 07/13/2026 to 07/26/2026, documented 1 administration of Hydroxyzine PRN on 07/18/2026, which did not include Resident 16's response to the Hydroxyzine PRN. On 08/11/2026 at approximately 2:30 p.m., Surveyor reviewed concern with Assistant Director B and Regional Nurse O that resident response to PRN medication was not documented. Assistant Director B nodded his/her	{N 415}		

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{N 415}	Continued From page 20 head and stated no one audited documentation of PRN administration.	{N 415}		
{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 daily activity programming was provided to meet the interests and capabilities of the residents and employees did not encourage and promote resident participation in activity programs. This is a repeat deficiency. See Statement of Deficiency (SOD) VTVD12, dated 12/08/2025 and SOD VTVD13, dated 04/14/2026. Findings include: From 08/11/2026 to 08/12/2026, Surveyors conducted a complaint investigation alleging the provider did not offer activities.	{N 427}		

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{N 427}	Continued From page 21 On 08/11/2026 at 9:00 a.m., Surveyor observed the provider's activity calendar for the day, which stated the following 10:00 Snack, 11:00 Daily Chronicles, 2:00 Crafts. On 08/11/2026 at 9:50 a.m., Surveyor interviewed Resident 15. Resident 15 stated there was nothing to do at the facility. Resident 15 stated at times s/he would sit in the common area, but that activities didn't take place. On 08/11/2026 at approximately 10:00 a.m., Surveyors observed residents served popcorn. On 08/11/2026 at 10:05 a.m., Surveyor interviewed Resident 14. Resident 14 stated the provider did not offer activities. S/he stated "I live in isolation." Resident 14 stated s/he doesn't often leave his/her room because of a fear of riding the elevator, but that if activities were going on s/he would try to work with staff to get upstairs and participate. From 8:55 a.m. to 2:30 p.m., Surveyors did not observe residents engaged in activity, other than being served a snack. On 08/11/2026 at approximately 2:30 p.m., Surveyors discussed concern with Assistant Director B and Regional Nurse O that the provider did not offer daily activity programming as posted. Assistant Director B stated caregivers should have been organizing activities and s/he was unsure why that was not done.	{N 427}		
{N 431}	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents	{N 431}		

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{N 431}	Continued From page 22 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 ensure 1 of 4 residents received appropriate health monitoring to meet his/her needs. Resident 9's blood glucose level was not monitored and documented 4 times daily as ordered. This is a repeat deficiency. See Statement of Deficiency (SOD) VTVD12, dated 12/08/2025 and	{N 431}		

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{N 431}	Continued From page 23 SOD VTVD13, dated 04/14/2026. Findings include: On 08/11/2026 at approximately 10:00 a.m., Surveyor reviewed Resident 9's record, provided by Assistant Director B. Resident 9 admitted to the provider's facility on 08/01/2025 with diagnosis of diabetes. Resident 9's record included an order to check blood glucose 4 times daily at 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. for diabetes. Resident 9's record, dated 07/13/2026 to 08/11/2026, did not document blood glucose readings 13 times, including the following dates and times: 07/16/2026 at 8:00 a.m., 07/20/2026 at 8:00 a.m., 07/23/2026 at 8:00 a.m., 07/24/2026 at 8:00 a.m., 07/27/2026 at 8:00 a.m., 07/29/2026 at 8:00 a.m., 08/03/2026 at 8:00 a.m., 08/04/2026 at 8:00 a.m., 08/05/2026 at 8:00 a.m., 08/06/2026 at 8:00 a.m., 08/07/2026 at 8:00 a.m., 08/09/2026 at 12:00 p.m. and 08/11/2026 at 8:00 a.m. On 08/11/2026 at approximately 2:30 p.m., Surveyor reviewed concern with Assistant Director B and Regional Nurse O that Resident 9's blood glucose reading was not documented each time a reading was due. Assistant Director B stated s/he and Caregiver I were supposed to audit blood glucose documentation weekly.	{N 431}		
{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 24	{N 481}		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure a living environment that is clean, comfortable, and homelike.

This is a repeat deficiency. See Statement of Deficiency (SOD) VTVD11, dated 07/16/2025; SOD VTVD12, dated 12/08/2025; and SOD VTVD13, dated 04/14/2026.

Findings include:

On 08/11/2026, at approximately 9:40 a.m., Surveyor toured the facility and observed:

Kitchen:
The kitchen cabinets were discolored from what appeared to be water marks and had dust and debris build up on the cabinet lips.
One cabinet door was broken and did not close properly, one cabinet door had been removed.
The wall behind the sink had paint missing and drip marks down it.
There was dark marks on the ceiling above the dishwasher.

Stairwell to Downstairs:
A full garbage bag was left on the landing at the top of the stairs. Surveyor observed a caregiver take the garbage bag to the dumpster at 10:05 a.m. Surveyor observed another full garbage bag left on the landing at the top of the stairs at 12:23 p.m.
Carpeting was discolored with what appeared to be a dirt-like buildup and there was debris throughout the stairwell.
The walls were discolored and had drip marks on

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	0019178	A. BUILDING: _____ B. WING _____	R-C 08/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MOUNT HOREB	104 LINCOLN CT MOUNT HOREB, WI 53572

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{N 481}	Continued From page 25	{N 481}		

them.
The door handle leading downstairs fell off each time the door was opened. At 9:54 a.m., Resident Care Specialist N stated the door handle comes off all the time because it doesn't fit properly.

Downstairs:
There were several patched marks that remained white and had not been repainted to match the wall paint.
There were cobwebs that reached from the light fixtures to sprinkler heads.
There were drip marks down the walls of the downstairs.
A storage room ceiling had a section approximately 4 feet by 3 ft that was brown which appeared to be water damage. The drywall appeared to be pealing.
The hallway ceiling was discolored and appeared to be pealing.

Dining Room:
Surveyor observed that the facility was warm throughout the duration of the survey. At 10:00 a.m., Surveyor took the temperature of the facility dining room while residents were having a snack, the temperature was 90.2°F.
The window shades were not attached to the holders above the doors and windows in the dining room. Two large cloths were attached to the wall and hanging over the patio doors to go outside.
It was muggy outside and the facility windows were open. Surveyor took the temperature of the facility hallway at 11:41 a.m., the temperature was 88.4°F.

Some of the air vents throughout facility were covered with a layer of dust. An air vent located near the upstairs bathroom had 2 unknown

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{N 481}	Continued From page 26 yellowish objects that appeared as if something was growing in there. On 08/11/2026, at approximately 2:30 p.m., Surveyor shared the above concerns with Assistant Director B who stated s/he just had the air conditioning company come out, so s/he will reach out to them again. Assistant Director B stated that s/he did clean some of the air vents, but did not get to all of them.	{N 481}		
N 487	83.44(1)(b) Separate laundry storage areas or containers Storage and transport. The CBRF shall have separate clean and dirty laundry storage areas or containers. Storage containers shall be clean, leak-proof and have a tight fitting lid. The CBRF may not transport, wash or rinse soiled laundry in areas used for food preparation, serving or storage. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure there were separate storage areas or containers for clean and soiled laundry in 2 of 2 laundry rooms. Findings include: On 08/11/2026 at 9:41 a.m., Surveyor toured the provider's laundry room with Resident Care Specialist N. Surveyor observed 5 laundry baskets over flowing with laundry, with some laundry touching the ground. Surveyor observed an additional 2 laundry baskets of laundry on top of the dryer. Resident Care Specialist N stated that 3rd shift is supposed to do laundry but there was no laundry detergent, so the laundry is	N 487		

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N 487	Continued From page 27 backing up. Resident Care Specialist N stated that that 5 laundry baskets on the ground were dirty and waiting to be washed and that s/he believes that the laundry on top of the dryer is clean but they are waiting for more laundry to fill the basket. On 08/11/2026, at 9:45 a.m., Surveyor observed the provider's downstairs laundry room with Caregiver I. Surveyor observed a table in the laundry room that had a basket filled with laundry as well as loose garments covering the table. Caregiver I stated s/he does not know who the laundry belong to or whether it is clean or dirty. On 08/11/2026 at 12:23 p.m., Surveyor observed the upstairs laundry room with 4 full laundry baskets on the floor and 1 empty one and 1 empty laundry basket on top of the dryer. On 08/11/2026, at 1:24 p.m., 1:36 p.m., and 1:46 p.m., Surveyor observed Resident Care Specialist N dragging three different laundry baskets on the ground down the hallways of the facility. Resident Care Specialist N confirmed that the laundry was clean and s/he was working on putting it away. Surveyor observed that each laundry basket had what appeared to be a garbage bag tied around the handle so they could be dragged rather than carried. On 08/11/2026, at approximately 2:43 p.m., Assistant Director B stated that Caregiver I was able to find laundry detergent so the facility was washing and putting away laundry.	N 487		
{N 488}	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any	{N 488}		

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{N 488}	Continued From page 28 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 that 2 of 3 clothes dryers had vent tubing of rigid material. Two clothes dryers were observed to have semi-rigid vent tubing in the laundry room downstairs. This is a repeat deficiency. See Statement of Deficiency (SOD) VTVD12, dated 12/08/2025, and SOD VTVD13, dated 04/14/2026. Findings include: On 08/11/2026, Surveyors conducted a verification visit and complaint investigations. The provider was issued a regular license on 04/15/2024 as a class CNA (non-ambulatory) community based residential facility able to serve up to 23 residents within the client groups of irreversible dementia/Alzheimer's, physically disabled, and advanced age. On 08/11/2026 at 9:45 a.m., Surveyor toured the facility's laundry rooms. Surveyor observed that the dryer vents for 2 of 2 dryers downstairs were semi-rigid. On 08/11/2026, at approximately 2:30 p.m., Surveyor shared the above concerns with Assistant Director B who stated a plumbing company was just at the facility to address the venting, so s/he'll have to reach out to them.	{N 488}		

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N 612	83.55(3) Bath and toilet areas: hand drying. Hand drying. All sink areas shall have dispensers for single use paper towels, cloth towel dispensing units that are enclosed for protection against being soiled or electric hand dryers. This requirement does not apply to sink areas located in toilet rooms accessed directly from a resident bedroom. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure dispensers for single use paper towels were being maintained and utilized, as required, in 3 of 3 common use bathrooms available to residents, visitors, and/or caregivers. The findings include: On 08/11/2026 at approximately 9:45 a.m., Surveyor toured the facility including 2 common use bathrooms upstairs including a sink and toilet. Surveyor observed a single use paper towel dispenser located in both common use bathrooms. Surveyor observed the dispenser was empty and no towels of any type were available within either bathroom. Surveyor toured the downstairs of the facility, including 1 common use bathroom downstairs that included a sink and toilet. Surveyor observed a single use paper towel dispenser located in the bathroom. Surveyor observed the dispenser was empty and no towels of any type were available within the downstairs bathroom. On 08/11/2026 at 11:41 a.m., Surveyor observed that both upstairs bathrooms paper towel dispensers remained empty and there was no paper towels in the bathrooms.	N 612		

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N 612	Continued From page 30 On 08/11/2026 at 1:43 p.m., Surveyor observed that 1 of 2 upstairs bathrooms now had a small stack of paper towel on the bathrooms sink; the paper towels were not enclosed. The other bathroom upstairs and the bathroom downstairs remained without paper towel. Throughout the duration of the survey, Surveyor observed 2 of 3 staff members use the facility's upstairs bathrooms. On 08/11/2026, at approximately 2:30 p.m., Surveyors shared the above concerns with Assistant Director B who stated s/he would look into refilling the paper towel dispensers.	N 612		
N 640	83.59(2)(b) Solid core wood doors or equivalent A solid core wood door or an equivalent fire resistive door shall be provided at any interior stair between the basement and the first floor. The door shall have a positive latch and an automatic closing device and normally shall be kept closed. Enclosed furnace and laundry areas with self-closing doors in a split level home may substitute for the self-closing door between the first and second levels. Enclosed furnace and laundry areas shall have self-closing solid core wood doors or an equivalent fire resistive door when located on a common level with resident bedrooms. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that 2 of 2 laundry rooms, which were on a common level with resident bedrooms, had a self-closing door. Findings include:	N 640		

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N 640	Continued From page 31 On 08/11/2026, at 9:41 a.m., Surveyor observed the provider's upstairs laundry room, which was located on the main level with resident bedrooms. The door to the laundry room was propped open with a cleaning cart. On 08/11/2026, at 9:45 a.m., Surveyor observed the provider's downstairs laundry room, which was located on the same level as resident bedrooms. The door to the laundry room was propped open with a paint can. On 08/11/2026, at 12:23 p.m., Surveyor observed the provider's upstairs laundry room was now propped open vacuum. The downstairs laundry door remained propped open with a paint can. On 08/11/2026, at approximately 2:30 p.m., Surveyors shared the above concerns with Assistant Director B who stated s/he was aware the doors were propped open was not aware that was wrong.	N 640		