STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018755	A. BUILDING: _____ B. WING _____	C 08/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - LADYSMITH I	910 SHADY LANE 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 I. Data was collected through 08/31/2026. Two of 4 complaints were substantiated. Two violations were identified. Census: 15	N 000		
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. 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 group advanced aged. On 08/19/2026, Surveyor reviewed the Department's record. Surveyor found on the provider's face sheet that Administrator F was listed as the current administrator. A review of the Department's correspondence included a document dated 02/27/2025, indicating Administrator F 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 G]. The	N 200		

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

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N 200	Continued From page 1 forms were completed and send [sic] in to [sic] state ..." On 08/31/2026 at approximately 1:30 AM, Surveyor interviewed RN E who stated s/he was unsure of the date Administrator F left but that it was some time ago. The provider did not notify the Department when there was a change in administrator.	N 200		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure a safe environment or safeguard Resident 1 from an environmental hazard when maggots were found 2 times on his/her toe wounds. Findings include: On 07/21/2026 and 07/22/2026, the Department received complaints regarding resident care. The provider is licensed to care for 16 residents in the client group advanced aged.	N 358		

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N 358	Continued From page 2 On 08/26/2026, Surveyor reviewed Resident 1's record which included: -A Resident Profile indicating Resident 1 was admitted 09/17/2025 and was his/her own decision maker. Resident 1 was diagnosed with, " ...candidiasis of the skin and nail ...chronic venous hypertension (idiopathic) with ulcer of left lower extremity ...lymphedema, muscular dystrophy ...venous insufficiency (chronic and peripheral) ..." -A General Surgery Clinic Office Note, dated 07/15/2026, read, in part, " ...suffering from chronic stasis dermatitis brought up by ...immobility ...I have been treating [him/her] repeatedly for stasis dermatitis-ulcerations and cellulitis ...saw [him/her] last month all ulcers were healed ...Yesterday, [s/he] came to see [another medical provider] ...painful swelling of both great toes ...maggots were observed ...started on Keflex ...feet swollen ...toes are bluish ...nail beds macerated with fluid emerging under the nail fold ...will see again on Monday [07/20/2026] ..." -A General Surgery Clinic Office Note, dated 07/20/2026, read, in part, " ...a week on [antibiotic] ...reports maggots still present in [his/her] feet ...great toes ...macerated proximally to the nail folds ...maggots crawling ...both feet ..." -A [Hospital Name] Health System note dated 07/22/2026, read, in part, " ...presented to the emergency room at the request of [Wound Doctor] ...for failing outpatient antibiotics for bilateral cellulitis of the lower extremities ...Approximately 10 days prior ...noted maggots ...presented to clinic and was prescribed [antibiotic] ...7 days of medication without improvement ...recommended to present to emergency room for additional workup and IV antibiotics ..."	N 358		

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N 358	Continued From page 3 On 08/19/2026 from 9:55 AM to 11:00 AM, Surveyor interviewed Team Lead (TL) A who stated that Resident 1 had issues with his/her legs and toes and had been under medical care off and on for some time. TL A stated, on 07/12/2026, staff found a maggot on Resident 1's toe, the toes were washed and bandaged. Resident 1 saw a medical provider the following day who referred Resident 1 to a wound clinic the following day. TL A stated, on 07/19/2026 at 6:38 AM, s/he received a call from Caregiver B who stated Resident 1 had many maggots on both of his/her toes. TL A directed Caregiver B to clean the toes and send him/her out by ambulance but Resident 1 refused to go because s/he had an appointment the following day. Surveyor inquired if there were concerns about flies or pests in the building and TL A responded not to the extent of needing an exterminator. TL A stated Resident 1's room was cleaned daily or as needed. At approximately 11:05 AM, Surveyor interviewed TL C who stated s/he had never observed an excessive number of flies in Resident 1's bedroom. From 11:33 AM to 12:10 PM, Surveyor interviewed Resident 1 who was lying in bed with his/her lower half completely covered by bedding. Resident 1 stated s/he had problems with his/her toes for about 3 months and s/he had leg edema for about a year. Resident 1 stated his/her toes should have been completely covered to avoid getting the maggots from flies laying eggs. During the interview with Resident 1, Surveyor observed multiple dead flies on the window ledge. Surveyor observed 6-8 live flies flying around the room and landing on Resident 1's bedding, legs,	N 358		

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N 358	Continued From page 4 arms, and head area. At approximately 2:25 PM, Surveyor asked if TL A if s/he would have done anything differently with Resident 1's care and s/he responded that nursing had directed them to deep clean Resident 1's room. On 08/27/2026 from 12:42 PM to 1:04 PM, Surveyor interviewed Police Investigator (PI) D who stated s/he conducted his/her investigation on 07/21/2026. PI D stated s/he observed the following in Resident 1's room: -a can of fly spray, -flies on the window screen, -flies flying around the room. PI D stated Resident 1 told him/her that Resident 1 had noticed s/he was getting more flies. From 9:16 AM to 10:27 AM, Surveyor interviewed Registered Nurse (RN) E who stated, on 07/13/2026 when s/he came to the facility to assess Resident 1's toes, s/he noted a couple of flies in Resident 1's room. RN E stated s/he informed staff that they were to use a fly swatter to eliminate the flies. RN E stated pest control had not been contacted. RN E stated after the second time maggots were found, s/he brought in a non-toxic fly spray to help eliminate the flies. RN E stated s/he was informed on 07/21/2026 that non-toxic plug-ins were to be dropped off for the whole building but that did not occur. The provider did not ensure a safe environment when 2 incidents occurred when Resident 1 had flies hatch in his/her toe's wounds.	N 358		