STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VITACARE LIVING - RICE LAKE II	1639 KERN AVE RICE LAKE, WI 54868

(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 07/09/2026, Surveyors conducted a standard licensing survey and complaint investigation at Vitacare Living Rice Lake II. Data was collected through 08/06/2026. Four of 6 complaints were substantiated. Eleven violations were identified. One of 11 violations was a repeat deficiency. See Statement of Deficiency (SOD) 9ZNS11, dated 10/08/2024. Census: 20	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.	N 158		

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

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N 158	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the provider did not investigate, document, and report a case of alleged abuse or neglect of a resident, or take immediate steps to ensure the safety of all residents. The provider did not report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF (community based residential facility) knew or should have known about the abuse or neglect. Findings include: On 07/14/2026, the Department received a complaint regarding resident care. The provider is licensed to care for 20 residents in the client groups: irreversible dementia/Alzheimer's disease, physically disabled, advanced aged, and terminally ill. On 07/30/2026 at approximately 4:50 PM, Surveyor interviewed Resident 4's Power of Attorney (POA) O. POA O stated they had installed a camera in Resident 4's room so they could observe staff interactions with Resident 4. POA O stated s/he had concerns about Caregiver D's abrasive approach and harassing demeanor. On 08/02/2026 at 6:22 PM and 6:24 PM, Surveyor received 2 email communications from POA O that included video recordings from 06/06/2026 and 07/01/2026. The first email was initially sent to Administrator B on 07/10/2026 and included the following narrative, "Video of [Caregiver D] giving [Resident 4], a hard time about [his/her] eye drops and [Resident 4] saying to [Caregiver D] how nervous [s/he] is around	N 158		

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N 158	Continued From page 2 [Caregiver D]." Surveyor watched the first video recorded on 06/06/2026 in the morning. The following are a few of the comments made by Caregiver D and Resident 4: -Caregiver D's comments regarding administering eye drops, " ...I'm not playing a game ...wasting all our time ...I'm not pulling your eye open every day ...big challenge ...all other girls have the same problem ..." -Resident 4's comment, " ...I am so nervous when you are around ..." -Caregiver D's comments, " ...whatever ...don't blame your problems on someone else ...you are a nervous person ...that's why you take all those pills ...we have to do so many things for you ..." The second email, sent to Administrator B on 07/10/2026, included the following narrative, "[Caregiver D] talking to [Resident 4] in an intimidating way. [Sic] Saying no shower today and drilling [him/her] about why [s/he] needs help with a shower. [Sic] Then 10 minutes later [Resident 4] was told it was time for a shower." Surveyor watched the second video which was recorded on 07/01/2026 in the morning and included the following comments made by Caregiver D and Resident 4: -Caregiver D's comments " ...no shower today ...we are going to see how well you do washing ...you can use your hands so I don't know why you can't wash your bottom ...you said you need help with what ...your hands work ...do they go on your head ...I'm trying to get why you need help ...I don't understand what you can't do ...why can't you wash your hair ...I think because your [family member] needs help you need help ...they said	N 158		

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you need help ...with your bottom ...still trying to figure out what you need help with ...we can't stop you from falling ...we need to figure out what you need help with ...you want someone in there in case you fall ...what do you need help with ..."
-Resident 4's comment, " ...need help with my face ....and water ...almost drowned ..."
-Caregiver D's comment, ": ...that's what I'll tell them then ..."

On 08/03/2026 from 1:58 PM to 3:13 PM, Surveyor interviewed Administrator B and Regional Director (RD) C. Administrator B stated that s/he received statements from 3 staff regarding Resident 4's 06/30/2026 shower. Surveyor received an email communication from Administrator B on 07/22/2026 at 11:28 AM that included a statement from Caregiver S. Surveyor received an email communication from Administrator B on 08/03/2026 at 9:40 AM and 9:41 AM that included statements from Caregiver D and Caregiver T. Caregiver D's statement was dated 07/08/2026. Caregiver S and Caregiver T's statements were not dated. Administrator B stated no one was reprimanded regarding Resident 4's shower.

Surveyor asked Administrator B if s/he watched the videos of Caregiver D interacting with Resident 4 and s/he stated Resident 4's managed care organization (MCO) had sent the videos to him/her. Administrator B stated s/he did observe the video of Caregiver T with Resident 4, but s/he had not watched a video involving Caregiver D.

On 08/06/2026 from 1:32 PM to 2:16 PM, Surveyor interviewed Administrator B who stated s/he did not conduct an investigation because s/he understood Caregiver D did not interact with

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N 158	Continued From page 4 Resident 4. Administrator D stated Resident 4's MCO did not seem concerned about the video of Caregiver D interacting with Resident 4. The provider did not investigate an alleged incident of caregiver misconduct or report to the Department.	N 158		
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 the resident's legal representative when there was an incident or injury to the resident for 1 of 3 residents. Findings include: On 06/12/2026 and 6/16/2026, the Department received 3 complaints regarding notification. The provider is licensed to care for 20 residents in the client groups: irreversible dementia/Alzheimer's disease, physically disabled, advanced aged, and terminally ill.	N 169		

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N 169	Continued From page 5 On 07/09/2026 at approximately 10:36 AM, Surveyor interviewed Administrator B and Regional Director (RD) C who stated that Resident 3 currently was attending wound care appointments and around 06/11/2026 they found Resident 3 had missed wound care appointments. Administrator B stated it was probably true that no one had updated the guardian about Resident 3's wound. On 07/14/2026 at 3:00 PM, Surveyor received an email from Administrator B that included a document titled Service Recap. The document indicated Resident 3 was receiving left ankle treatment from staff from 05/08/2026 to 05/22/2026. On 07/14/2026 at 2:43 PM, Surveyor received an email from Administrator B that included a document titled patient rounding form dated 05/05/2026. The document indicated Resident 3 had been referred to wound management. On 07/14/2026 at 7:47 PM, Surveyor received an email from Administrator B that read, in part, "I [Administrator B] called the wound care clinic- [Resident 3] had appts on 05/21/26 (initial intake) ..." On 07/21/2026 from 11:50 AM to 12:11 PM, Surveyor interviewed Guardian J who stated s/he may have been informed of Resident 3's left ankle skin tear in May 2026, but s/he had not been informed that the area had gotten worse or that Resident 3 had received treatment at a wound care clinic. Guardian J stated on 06/02/2026 s/he visited Resident 3, and Resident 3 had informed him/her that s/he had an appointment.	N 169		

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N 169	Continued From page 6 The provider did not notify Resident 3's legal representative when his/her wound became worse, and s/he was being treated at a wound care clinic.	N 169		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 2 received all prescribed medications in the dosage and at intervals prescribed by a practitioner. Findings include: On 06/19/2026, the Department received a complaint regarding resident care and medications. The provider is licensed to care for 20 residents in the client groups: irreversible dementia/Alzheimer's disease, physically disabled, advanced aged, and terminally ill. On 07/09/2026 at approximately 9:10 AM, Surveyor interviewed Resident 2 who stated s/he recently had cataract surgery. On 07/22/2026 at approximately 11:00 AM, Surveyor interviewed Caregiver D who stated	N 352		

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N 352	Continued From page 7 Resident 2 did not have all his/her eye drops administered prior to his/her cataract surgery. On 07/22/2026 at approximately 2:45 PM, Surveyor interviewed Team Lead (TL) E who stated s/he did not know much about Resident 2's surgery but was able to access Resident 2's record and provided 3 electronic prescriptions for medications Resident 2 was to receive prior to surgery. On 07/23/2026, Surveyor reviewed Resident 2's record which included the following: -A Resident Profile indicated s/he was admitted on 05/03/2026. -Shift Notes dated 06/09/2026 read, "out [sic] for eye surgery." -The June 2026 Medication Administration Record (MAR) included; " ...Ketorolac 0.5% Ophth Sol ...Instill one drop to surgical eye 3 times daily starting three days before surgery ..." The June MAR indicated the first dose administered was on 06/10/2026 at 9:12 AM. " ...OcuSoft Lid Scrub Plus (Daily) Apply one pump to right eye lid and lashes, gently scrub, do not rinse off. User twice a day starting two days before surgery, as well as the morning of surgery ..." The June MAR indicated no doses were administered. " ...Tobramycin/Dexamethasone 0.3% (Daily) Both eyes. Instill one drop to surgical eye three times a day, starting 3 days before surgery and continue for one month ..." The June MAR indicated the first dose administered was on 06/10/2026 at 9:12 AM. -Electronic Prescriptions for Resident 2 dated 06/04/2026 read, in part, "...Ketorolac 0.5%...Instill one drop to surgical eye three times a day starting three days before surgery	N 352		

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N 352	Continued From page 8 ...Tobramycin 0.3%-dexamethasone 0.1% eye drops ...Instill one drop to surgical eye three times a day starting three days before surgery ...OccSoft Lid Scrub Plus topical foam ...apply one pump to right eye ...Use twice a day starting two days before surgery as well as the morning of surgery ..." On 07/23/2026 at approximately 3:08 PM, Surveyor interviewed Administrator B and Regional Director (RD) C who stated a director in another facility licensed by the same provider, Director F, added 3 eye drop prescriptions to the MAR on 06/05/2026 but had indicated the medications were on hold. Administrator B and RD C stated the medications were in the building, but no direction was provided to staff. Administrator B and RD C stated they spoke with Director F on 07/14/2026 and Director F did not recall inputting the medications. Director F resigned on 07/21/2026. The provider did not ensure Resident 2 received 3 prescribed eye medications that were to be administered 2 and 3 days prior to his/her surgery.	N 352		
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	N 389		

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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 update the individualized care plan (ISP) when there was a change in a resident's need.

Findings include:

On 06/12/2026 and 06/19/2026, the Department received complaints regarding resident care.

The provider is licensed to care for 20 residents in the client groups: irreversible dementia/Alzheimer's disease, physically disabled, advanced aged, and terminally ill.

On 07/09/2026 at approximately 8:50 AM, Surveyor toured Resident 3's bedroom and bathroom with Caregiver A. Caregiver A, who had returned to work approximately 2 to 3 weeks prior, stated Resident 3's dentures were cleaned before Resident 3 woke up and between meals. Caregiver A stated there had been no concerns with Resident 3's dentures. Surveyor observed the dentures which appeared clean

At approximately 10:51 AM, Administrator B and Regional Director (RD) C stated Resident 3 did not wear his/her dentures as s/he did not have the bone structure to support them. Surveyor inquired if there were reports of mold on the dentures and s/he responded there had been reports, and the dark areas were most likely

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N 389	Continued From page 10 because the dentures were stored in a container of water. Administrator B stated after this incident s/he added denture care to Resident 3's ISP. On 07/21/2026 From 11:50 AM to 12:11 PM, Surveyor interviewed Guardian J who stated s/he observed mold on Resident 3's dentures in April 2026 and May 2026 and had reported the issue to Administrator B who had brushed off his/her concerns. Guardian J stated Resident 3 rarely wore dentures, but they still should not have mold on them. On 07/21/2026, Surveyor reviewed Resident 3's record which included the following: - Planned Services dated 04/10/2025 and 06/15/2026 did not include instructions for denture care. - Planned Services dated 06/29/2026 included; " ...Denture Care ...Every 3 days ...Resident refuses to wear dentures ...Staff to encourage resident to wear dentures ...Every 3 days staff to ensure ...denture's are clean, DRY and placed in a clean cup WITHOUT WATER ..." The provider did not update Resident 3's ISP until 06/29/2026. Guardian J had notified the provider twice, in April and May 2026, before the ISP was updated, a delay of approximately 3 months.	N 389		
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	N 427		

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N 427	Continued From page 11 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, record review, 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 8:46 AM, Surveyor interviewed Resident 1 who stated activities were not done, the posted activity schedule was not accurate, and they were on their own for activities. At approximately 9:18 AM, Surveyor interviewed Caregiver A who stated it was difficult to do activities with all the call lights and meals. Caregiver A stated we try to get the residents outside. At approximately 10:36 AM, Surveyor interviewed Administrator B and Regional Director (RD) C who stated that a church service was held monthly, and they tried to play Bingo. At approximately 9:30 AM, Surveyor observed the posted July Activities calendar that read, " ...Thursday ...9th ... 10:00 Snack 11:00 Daily Chronicles	N 427		

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N 427	Continued From page 12 2:00 Bingo" From 8:20 AM to 4:20 PM, Surveyors did not observe any activities being offered to residents. The provider did not ensure to provide an activities program for residents.	N 427		
N 431	83.38(1)(g) Health monitoring. 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.	N 431		

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N 431	Continued From page 13 This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not monitor the health of Resident 3 and Resident 4 and document communication with the resident's physician. Findings include: On 06/12/2026, 06/16/2026, and 07/14/2026, the Department received 3 complaints regarding resident care and medications. The provider is licensed to care for 20 residents in the client groups: irreversible dementia/Alzheimer's disease, physically disabled, advanced aged, and terminally ill. RESIDENT 3 - Monitoring wound conditions, monitoring nutritional intake, and following diet orders: On 07/09/2026 at approximately 8:50 AM, Surveyor toured Resident 3's bedroom with Caregiver A, who had returned to work approximately 2-3 weeks ago. Surveyor interviewed Caregiver A regarding wound care provided to Resident 3. Caregiver A stated Resident 3 had occasional redness to the buttocks area; however, the redness had been resolved. When asked if there were concerns with Resident 3's left foot s/he stated it looked good, staff were working to ensure healing, and the wound area was currently not open. At approximately 10:36 AM, Surveyor interviewed Administrator B and Regional Director (RD) C who stated that Resident 3 currently was attending wound care appointments and his/her last appointment was on 07/07/2026. Administrator B stated s/he was assigned to work at another facility from March to June 2026.	N 431		

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N 431	Continued From page 14 Administrator B stated Resident 3 was enrolled in and receiving wound care services when Administrator B returned to the facility on 06/11/2026. Administrator B stated staff were not to be providing wound care as the wound care was overseen by the wound clinic. Administrator B stated within the first week of his/her return s/he became aware Resident 3 had a foot bandage in place and observed the date on the foot bandage was 1 week prior. Administrator B stated s/he found Resident 3 had missed wound care appointments. Administrator B stated it was probably true that no one had updated the guardian. Administrator B stated that s/he was frustrated with the lack of communication. On 07/21/2026 from 12:33 PM to 12:58 PM, Surveyor interviewed Managed Care Nurse (MCN) H who stated Registered Nurse (RN) I had contacted him/her on 05/12/2026 asking for assistance finding a clinic to provide wound care for Resident 3. MCN H stated s/he was able to set up an initial intake on 05/21/2026 at a wound care clinic. MCN H stated s/he had requested updates from RN I on 05/26/2026, 06/01/2026, and 06/05/2026 but had not received a response. MCN H stated things went downhill fast and communication was terrible when Administrator B was moved out of the program (March to June 2026). From 11:50 AM to 12:11 PM, Surveyor interviewed Guardian J who stated Resident 3 had informed him/her around 06/02/2026 that s/he had a wound on his/her left ankle. Guardian J understood Resident 3's managed care organization had not been informed, and s/he also had not been informed. Guardian J stated s/he rarely saw Administrator B and the lack of care provided by the facility was concerning.	N 431		

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N 431	Continued From page 15 On 07/21/2026 at 12:23 PM, Surveyor received the following email communication from Guardian J that included emails between Guardian J, the provider, and managed care: An email sent 06/10/2026 at 9:43 AM to MCN H and Director F, who is a nurse, read; "When I had arrived to visit my [Resident 3] on June 2nd, I wasn't aware of this wound that [s/he] had on [his/her] left ankle. [S/he] had told me that [s/he] was seeing Someone [sic] for it that day, but then told me yesterday that [s/he] didn't go see anybody. [S/he] had an appointment with [his/her] primary yesterday and I had them take a look at it. The wound was packed with something that hadn't been changed in at least a few weeks. The appearance of the wound originally looked like it was necrotic. After examination, we determined that it wasn't necrotic. It was The [sic] appearance of neglected dressing change. I spoke with a couple of the Nursing [sic] staff at the facility and they informed me that they were told not to change the dressing on the wound. My [family's] primary doctor prescribed [him/her] an antibiotic to help heal the wound and put in a referral for wound care through the [clinic]. I have pictures of the wound if you would like to see what I was referring to." An email sent to Surveyor on 07/21/2026 at 2:38 PM, included pictures of Resident 3's left ankle wound and dentures. On Resident 3's left ankle there was an area approximately ½-1 inch in diameter, was covered with at least one bandage, and the bandage had a blackened area approximately ½-1 inch in diameter. Surveyor reviewed pictures of Resident 3's dentures and observed the dentures were covered in multiple	N 431		

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N 431	Continued From page 16 black spots. On 07/21/2026, Surveyor received the following email communications: -An email from Guardian J to Administrator B dated 03/03/2026, read, "I just wanted to let you know that they could tell [Resident 3] was dehydrated during [his/her] scan, so I told [Resident 3] that I would let everyone know to encourage [Resident 3] to drink more water. One of the aids had suggested like a flavoring to add into [Resident 3's] water but [Resident 3] said [s/he] wasn't interested in that. Could you maybe implement something into [his/her] chart to encourage a little more water intake? I told [Resident 3] I wasn't going to force [him/her] to drink it but at least to encourage it ..." -An email from Guardian J to Director F dated 06/10/2026 at 10:21 AM read, in part, " ...My [Resident 3] also needs to have [his/her] water intake increased, [s/he] is dehydrated. This has been spoken about in the past to staff but hasn't been really put into effect. My [Resident 3] was supposed to have lab work done yesterday but because of dehydration, they weren't able to access much for veins and barely had enough blood for 1 vial. [Resident 3] is diabetic, so water intake or some sort of replenishment should be necessary..." -An email from Guardian J to Administrator B and MCN H dated 07/09/2026 at 4:39 PM contained a screenshot from Resident 3's Nurse Practitioner (NP) M that read, in part, " ...anemia is stable, kidney function is stable, but very dehydrated. needs [sic] to drink more water ..." and the email narrative read, "This is a message from [Resident	N 431		

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3's] Primary [sic]. [Resident 3] NEEDS to be consuming more water. This has been talked about sooo [sic] many times already. [Administrator B]- I thought that you had implemented it into [his/her] chart for [him/her] to be drinking water? I know you can't force [him/her] to drink water but something needs to be applied, especially with it being summer and the humidity and I know how much [Resident 3] enjoys being in the sun ..."

-An email from Guardian J to Administrator B and MCN H dated 07/24/2026 at 10:25 AM read, in part, " ...I am emailing you all this morning to let you know that my [Resident 3's] surgery instructions were not followed properly. [Resident 3] was not supposed to eat anything prior to [his/her] surgery. [Resident 3] was fed toast this morning and was given a glass of milk. Because of this, [his/her] surgery is delayed and might possibly have to be rescheduled." The email also included screenshots of instructions regarding Resident 3's surgery preparations, " ...Do not eat anything after midnight the night before surgery ...NO solid food after midnight ..."

On 07/21/2026, Surveyor reviewed Resident 3's record which included the following:
-Resident Profile for Resident 3 indicated s/he was admitted on 09/20/2024. Diagnoses included; acquired absence of right leg below knee, anemia in chronic kidney disease, vitamin D deficiency, cerebral infarction, chronic kidney disease, disorder of bone, major depressive disorder, and type II diabetes mellitus with diabetic polyneuropathy. Resident 3 had a guardian.
-A Service Recap dated 04/01/2026 to 06/01/2026 included, " ...Instructions: Treat, and document wound care (specify): Cleanse left

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outer ankle wound with wound wash with gauze and pat dry. Applu [sic] bordered foam dressing. Change daily, home health referral has been sent for wound care. Notify RN if: any s/s [signs/symptoms] of infection, abnormal discharge, redness, pain ..." The document indicated a dressing change was completed daily from 05/08/2026 to 05/22/2026.
-A Wound Assessment dated 04/10/2026 and signed by RN K indicated a skin tear on the left ankle. Instructions for staff were to: "...wash with mild soap and water, pat dry, apply bacitracin per standing orders, cover with nonadherent dressing ..."
-A Patient Rounding Form dated 05/05/2026 and signed by Nurse Practitioner (NP) L read, in part, "...referral to home health wound management ..."
-A Wound Assessment dated 05/06/2026 and signed by RN I read, in part, "...Who is managing wound care ...homehealth [sic] pending ..."
-A Wound Assessment dated 05/21/2026 and signed by RN I read, in part, "...Who is managing wound care ...[Clinic Name] wound care ..."
-Wound Assessments dated 05/22/2026, 05/27/2026, 05/30/2026, 06/05/2026, 06/18/2026, 06/29/2026, and 07/02/2026 all indicated wound care was managed by [Clinic Name] wound care.

-Planned Services dated 04/10/2025 and 06/15/2025 did not include guidance to increase Resident 3's water intake.
-Planned Services dated 06/29/2026 included the following; " ...Drinking assistance ...Encourage fluids and/or provide assistance in drinking; staff to ensure [Resident 3's] water cup is full at all times. Staff to give cues and reminders throughout the day in between meals for [Resident 3] to drink fluids ...Staff to update ED/RN [Executive Director/Registered Nurse] with concerns or change in condition."

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N 431	Continued From page 19 On 07/21/2026 from 11:50 AM to 12:11 PM, Surveyor interviewed Guardian J who stated s/he s/he had brought up concerns multiple times with the provider regarding Resident 3's dehydration and was frustrated that medical providers continued to report dehydration, and s/he felt the provider had not addressed the concern. On 07/14/2026 from 2:29 PM to 3:25 PM, Surveyor interviewed Administrator B and RD C who confirmed that Resident 3 was seen at [Clinic Name] wound care from 05/21/2026 and after that staff were no longer to provide wound care as that would be managed by [Clinic Name] wound care. Resident 3's records indicated s/he was not seen again by [Clinic Name] wound care until 06/11/2026, approximately 3 weeks after his/her 05/21/2026 intake. Administrator B confirmed there were missed appointments. On 08/06/2026 at 2:41 PM, Surveyor received an email communication from Administrator B concerning wound care that read, in part, "...The provider...was on vacation from 05/25/2026 to 05/29/2026. No appts were scheduled for this time...[His/her] follow-up appt was for 6-9-2026. This appt was missed..." RESIDENT 4 - Blood sugar monitoring and physician notifications: On 07/22/2026 at approximately 10:15 AM, Surveyor interviewed Resident 4. Resident 4 stated s/he was diabetic and his/her blood sugar was tested 4 times a day. Resident 4 stated if his/her blood sugar was low the staff would provide something to eat. Resident 4 stated s/he recalled there were a few occasions when s/he had to wait for food. Resident 4 stated when	N 431		

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his/her blood sugar was low s/he often got a headache, had body shakes, and felt terrible. Resident 4 stated sometimes when s/he had low blood sugars, staff did not always retest him/her.

At approximately 10:30 AM, Surveyor observed Resident 4's Free Style continuous blood sugar meter alarming. Resident 4 stated it did that when his/her blood sugar was high and Resident 4 stated s/he had food to eat and that it was good to eat the food items s/he had because they lowered blood sugar. Resident 4 stated s/he was also to be drinking water. Surveyor observed him/her periodically drinking water.

At approximately 11:43 AM, Surveyor interviewed Caregiver N who stated Resident 4's blood sugar was to be tested before meals and if low staff provided him/her peanut butter or orange juice, documented on the MAR, and rechecked the blood sugar. Caregiver N stated Resident 4 was on hourly safety checks.

On 08/03/2026 from 1:58 PM to 3:13 PM, Surveyor interviewed Administrator B and RD C. Administrator B stated that when s/he returned, approximately early June 2026, to oversee the building, s/he found that staff had not been checking Resident 4's blood sugars as ordered. Administrator B stated staff were retrained on 06/29/2026. Administrator B stated the staff were directed to call the nurse to receive further guidance when Resident 4 had a low blood sugar reading and the on-call nurse would provide guidance to administer food. Administrator B stated Resident 4's as-needed (PRN) blood sugar readings may be recorded on the PRN documents or possibly in staff Shift Notes. Administrator B stated staff received training on completing blood sugar rechecks during nurse

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delegation. Administrator B stated staff were retrained on 06/29/2026.

On 07/30/2026 at approximately 4:50 PM, Surveyor interviewed Power of Attorney (POA) O who stated s/he did not believe the staff were always completing blood sugar rechecks when Resident 4's blood sugar was low. POA A stated s/he did not think staff were consistently offering food when Resident 4 had a low blood sugar reading.

On 08/06/2026 from 3:35 PM to 3:47 PM, Surveyor interviewed POA O who confirmed that the low blood sugar readings s/he had reported to Surveyor on 07/30/2026 were procured from video camera footage from Resident 4's room.

On 8/03/2026, Surveyor reviewed Resident 4's record which included the following;
-Resident Profile included the following; Resident 4 was admitted on 07/29/2022 and was diagnosed with chronic pain, depression, arthropathy, dysphagia, essential primary hypertension, hyperlipidemia, mild cognitive impairment, mood disorder, obesity, Parkison's Disease, spinal stenosis, and Type II diabetes mellitus. Resident 4 had an activated POA.

-Planned Services dated 06/22/2026 included, in part, " ...Blood Glucose...8:00 AM ...12:00 PM ...5:00 PM ...9:00 PM ...check blood glucose and record ...Notify RN if ...Blood Glucose is less than 70 or greater than 400 ...HOLD MEALTIME INSULIN IF ...LESS THAN 100 ..."
-Planned Services dated 06/29/2026 included, in part, " ...Blood Glucose ...8:00 AM ...12:00 PM ...5:00 PM ...Notify RN if ...blood glucose greater than 400 ...HOLD MEALTIME INSULIN IF..,.B/S [blood sugar] IS LESS THAN 100 ..."

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N 431	Continued From page 22 On 07/30/2026 at approximately 4:50 PM, Surveyor interviewed POA O who stated they had installed a camera in Resident 4's room to remotely assist him/her with operating his/her television and to observe staff interactions. POA O stated due to reviewing the camera footage, s/he became aware of the following low blood sugar readings: -06/29/2026: Blood sugar at 3:00 PM was 61. Blood sugar 5:00 PM was 52. -06/30/2026 BS at 7:40 AM was 69. Blood sugar 3:00 PM was low. -07/02/2026: Blood sugar at 2:30 PM in 50's and staff rechecked at 4:30 PM and BS was 120. -07/03/2026: Blood sugar between 2:30 PM-3:00 PM was low and rechecked at 4:00 PM. -07/05/2026: Blood sugar at 5:00 PM was 71. Surveyor reviewed Resident 4's Vital Sign-Blood Glucose tracking and observed there were only 4 boxes per day to enter blood sugars. On the Vital Sign-Blood Glucose was a section for Notes. A second document titled Chore Recap sometimes included notes from staff. Surveyor found the following regarding the low blood sugars: -06/29/2026: Blood sugar at 3:00 PM was 61 was not recorded on the Vital-Sign Blood Glucose document, there were no notes recorded and no notes recorded in Chore Recap. Blood sugar 5:00 PM was 52 was recorded on the Vital Sign-Blood Glucose document and no notes were documented. There was nothing documented in Shift Notes. - 06/30/2026 BS at 7:40 AM was 69 was recorded on the Vital Sign-Blood Glucose document but there were no notes documented nor	N 431		

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documentation in Chore Recap.
-06/30/2026: Blood sugar at 3:00 PM was low. The blood sugar was not recorded on the Vital Sign-Blood Glucose document nor were there any notes documented. There were no notes documented in Chore Recap.
-07/02/2026: Blood sugar at 2:30 PM was in the 50's, staff rechecked at 4:30 PM and blood sugar was 120. The blood sugars were not recorded on the Vital Sign-Blood Glucose document and there was nothing documented in Chore Recap.
-07/03/2026: Blood sugar between 2:30 PM-3:00 PM was low and rechecked at 4:00 PM. There was no record of a low reading on the Vital Sign-Blood Glucose document and no notes and nothing documented in Chore Recap.
-07/05/2026: Blood sugar at 5:00 PM was 71. This blood sugar was recorded on the Vital Sign-Blood Glucose but no notes were documented. There was nothing documented in Chore Recap.

The following Provider Orders included:

- 07/03/2026 Novolog Hold if less than 150. If BS low, recheck every 15 minutes until blood sugar is greater than 75. Admin 30 grams of sugar in OJ. Surveyor did not find evidence blood sugar rechecks were completed every 15 minutes.
-07/07/2026 Blood sugar goal is 100-250. Please give a snack and then call our office if BS less than 90.

On 08/04/2026 at 12:03 PM, Surveyor received an email communication from Administrator B responding to Surveyor request for other locations blood sugar checks and rechecks may be documented and if a physician was notified if there were blood sugars out of parameters. Administrator B responded, "I was unable to locate BS [blood sugar] reading [sic] on any other

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N 431	Continued From page 24 reports. All BS [blood sugar] are on the blood sugar log." and "No notifications were located." Summary: Resident 3 had significant delays receiving wound care on his/her left ankle, complaints of dehydration had not been immediately addressed, and surgery had to be canceled due to staff not following surgical instructions. Resident 4 low blood sugars were not consistently rechecked and were not consistently documented. There were no records the medical provider was notified when blood sugars were out of parameters. The provider did not monitor the health of Resident 3 and Resident 4.	N 431		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving.	N 452		

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N 452	Continued From page 25 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was handled in a sanitary manner. This is a repeat deficiency. See Statement of Deficiency (SOD) 9ZNS11, dated 10/08/2024. Findings include: The provider is licensed to care for 20 residents in the client groups: irreversible dementia/Alzheimer's disease, physically disabled, advanced aged, and terminally ill. The 2022 Food Code from The U.S. Food and Drug Administration reads, in part, "Except when APPROVAL is obtained from the REGULATORY AUTHORITY ...EMPLOYEES are preventing cross-contamination of READY-TO-EAT FOOD with bare hands by properly using suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves ..." On 07/09/2026, at approximately 8:45 AM, Surveyor observed Caregiver A and Caregiver G preparing and cutting fresh strawberries and grapes. Surveyor observed both staff were touching the fruit, and neither were wearing gloves. At approximately 9:29 AM, Surveyor asked Caregiver A and Caregiver G about the use of gloves when touching food. Caregiver A stated this was his/her fault, that Caregiver G was new, and that normally s/he would use gloves, but s/he forgot as s/he slept in that morning.	N 452		

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N 452	Continued From page 26 The provider did not ensure sanitary conditions when handling food.	N 452		
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, record review, and interview, the provider did not ensure all resident records were adequately safeguarded against destruction or loss Findings include: The provider is licensed to care for 20 residents in the client groups: irreversible dementia/Alzheimer's disease, physically disabled, advanced aged, and terminally ill. The provider installed an electronic monitoring system, an artificial intelligence (AI) system in all the residents' rooms. Staff carried handheld devices similar to a cell phone that received alerts and allowed the staff to spot check residents. 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	N 479		

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N 479	Continued From page 27	N 479		

required by the [company brand name] application..."

At approximately 8:45 AM, Surveyor observed the AI's system handheld device. The device depicted a picture of Room 24 and indicated a spot check was completed at 8:42 AM.

On 07/22/2026 at approximately 12:00 PM, Surveyor observed the AI's system handheld device which indicated there was a fall clip to view.

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.

On 07/09/2026 at approximately 10:15 AM, Surveyor interviewed Administrator B who stated when a resident fell, s/he was sent an alert, s/he reviewed the fall, and any new information was entered into the AI system. Administrator B stated once that was completed, the video clip was deleted.

On 07/22/2026 at approximately 11:50 AM, Surveyors interviewed Caregiver N who stated they were able to complete virtual checks in a room by clicking on the tile (on the handheld device) of a resident room. Caregiver N stated if a resident fell, the system produced a video for review. Caregiver N stated the system monitored falls and virtual checks so they could see what a resident was doing.

On 07/29/2026 from 10:00 AM to 12:00 PM,

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N 479	Continued From page 28 Surveyors interviewed System Administrator (SA) P, Administrator B, Regional Director (RD) Q. Surveyor asked if data from AI data was being retained in the resident record. SA P stated the data was meant to be a quick glance and that overall, it was being under-utilized. SA P stated the only data we were gathering were fall alerts and detection, none of which were retained in the resident record. SA P stated the AI system was a fall detection tool that provided staff alerts, directed the care of the residents, and they used the data to direct resident care plans. During the interview, RD Q stated all resident data that was collected and used to train the system was deleted once a resident moved out. Administrator B stated when completing an incident report, they viewed the incident on the AI system to determine how a resident fell and investigated the fall by interviewing residents and staff. Administrator B stated the AI video helped to understand what occurred and once reviewed the video was deleted. 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 29	N 481		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure the living environment was homelike when an electronic monitoring system was installed in Resident 5's room when s/he had not consented.

Findings include:

The provider is licensed to care for 20 residents in the client groups: irreversible dementia/Alzheimer's disease, physically disabled, advanced aged, and terminally ill.

On 07/09/2026 at approximately 8:30 AM, Surveyor observed in Resident 5's room there was a round object installed on the ceiling with wire tubing running across part of the ceiling.

At approximately 8:41 AM, Surveyor interviewed Caregiver G who stated the objects installed in the resident rooms were a camera system so that staff could see if a resident falls. Caregiver G showed Surveyor a handheld phone-like device and stated that the device would ping an alert if a fall occurred. Caregiver G stated that for example, if a resident who was a fall risk was in bed all night, got him/herself up and moved to the edge of the bed, the handheld would ping staff to assist. Caregiver G stated Resident 5 did not consent to the use of the system.

At approximately 9:45 AM, Surveyor interviewed Administrator B and Regional Director (RD) C who stated the camera system was an alternative intelligence (AI) system. Administrator B stated that the AI system was installed in all the resident

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N 481	Continued From page 30 rooms in February 2026. Administrator B stated the system alerts when there was a fall and can also alert to breathing changes. On 07/22/2026 at approximately 11:50 AM, Surveyor interviewed Caregiver N who stated that AI system was not turned on in Resident 5's room and showed Surveyor that the handheld device indicated Resident 5's room was "Turned Off." On 07/29/2026 from 10:00 AM to 12:00 PM, Surveyors interviewed System Administrator (SA) P, Administrator B, and RD Q. SA P described the AI system as having 2 components in each resident room; a camera affixed to the ceiling and a minicomputer that powers the AI system. RD Q stated they had no plan to remove the AI devices in the event a resident did not consent or withdrew consent. SA P stated the system was affixed to the wall and ceiling and could not be easily removed. On 08/03/2026 from 1:58 PM to 3:13 PM, Surveyor interviewed Administrator B and RD C Surveyor asked if there was a form a resident signed when not consenting to use of the AI system. Administrator B stated there wasn't a declination form and the absence of a a signed consent form was the declination. The provider did not ensure a homelike environment for residents.	N 481		
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	N 488		

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N 488	Continued From page 31 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 clothes dryer at the facility had tubing of a rigid material. Findings include: The provider is licensed to care for 20 residents in the client groups: irreversible dementia/Alzheimer's disease, physically disabled, advanced aged, and terminally ill. On 07/09/2026, Surveyor observed the dryer in the facility had a vent that consisted partially of non-rigid, flexible tubing. On 07/22/2026 at approximately 9:50 AM, Surveyor interviewed Administrator B who stated s/he was not aware the dryer vent tubing wasn't rigid or that any repairs on the venting had occurred. The provider did not ensure clothes dryer vent tubing was of a rigid material.	N 488		
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	Y3235		

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Y3235	Continued From page 32 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 for fall detection. Staff were able to view live still images of resident rooms on handheld devices. Staff used the system to spot check residents. Findings include: The provider is licensed to care for 20 residents in the client groups: irreversible dementia/Alzheimer's disease, physically disabled, advanced aged, and terminally ill. 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	Y3235		

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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 1, admitted on 04/01/2025 included:
- A consent declaration, signed by Resident 1 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 include specific guidance how to withdraw consent.

On 07/09/2026, Surveyor observed the handheld device. The screen read "Spot Check" and indicated Room 24 at 8:42 AM. The handheld device depicted an individual, indicated by a heat signature. Under the room picture was a tile that showed Room 24's bathroom and next to it a narrative read "Sitting in chair a few seconds."

On 07/22/2026, Surveyor observed the handheld device. The screen showed tiles for Rooms 16-27 and current status that included sitting in chair or lying in bed. The time was 12:02 PM. The screen had an additional tile that read "Fall clips (1)."

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Y3235	Continued From page 34 On 07/09/2026 at approximately 8:39 AM, Surveyor interviewed Caregiver G and Caregiver A. Surveyor asked Caregiver A about the new devices mounted in the resident rooms and s/he responded s/he thought they were heat sensors. Caregiver G stated it was a camera system and showed Surveyor a handheld device (similar to an iPhone) that received alerts. Caregiver G stated the system's electronic monitoring device's purpose was to alert staff when a resident fell or had the potential to fall. Caregiver G provided the following example: If a resident, who was a fall risk, was in bed all night and then moved to the edge of the bed, we would get an alert on the handheld device to assist. Caregiver G stated in some of the residents' rooms the electronic monitoring system was not functioning. Caregiver G stated Room 27 was offline and there was 1 resident (Resident 5) that had not consented to the system in their room. Caregiver G showed the Surveyor on the handheld device that Resident 5's room was "turned off." At 9:45 AM, Surveyor interviewed Administrator B and Regional Director (RD) C. Administrator B stated that the new AI system (electronic monitoring system) was installed in February 2026. Administrator B stated a resident did not necessarily have to have risk factors to utilize the AI system, and the AI system provided extra health monitoring. Administrator B stated when a fall occurred the AI system sent an alert to him/her to review the occurrence, any new information was entered into the AI system, then the system adjusted the pattern. At approximately 11:23 AM, Administrator B stated the AI system did not keep a log of anything.	Y3235		

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Y3235	Continued From page 35 On 07/22/2026 at approximately 11:50 AM, Surveyor interviewed Caregiver N who stated the handheld device would alert if someone was up, in the bathroom too long, or had a fall. Caregiver N stated staff could do virtual checks in the room. Caregiver N stated the handheld device would indicate if there was a fall via video. Caregiver N stated we use the information on the video to fill out a fall incident report. Caregiver N stated that sometimes the system did not work; for example, it did not indicate a resident had fallen when they had. Caregiver N stated, in some rooms, the residents consented to the system, but it did not work. Caregiver N stated s/he learned about the AI system through a 1-hour class. Caregiver N stated s/he understood the data gathered was stored and if s/he had any problems to contact Administrator B. Caregiver N stated s/he was not sure if the system monitored heart rate. Caregiver N stated if a resident asked to have the system shut off, s/he did not know how. Surveyor asked if the AI system made his/her job easier. Caregiver N stated, "Yes, because we can do a virtual check." Surveyor asked if there was any signage posted in the building regarding the AI system and Caregiver N stated s/he did not believe so. Caregiver N stated, "I would not want this system because I would feel like I was watched." At approximately 12:00 PM, Caregiver N assisted Surveyors with explaining and demonstrating how the handheld device functions. One surveyor entered Room 30 and acted out a mock fall. The second surveyor and Caregiver N could see that the surveyor entered Room 30, but there was a delay with the system sending a fall alert to the handheld device. Surveyors observed that a few moments later a staff in the kitchen's handheld alerted for the fall.	Y3235		

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Y3235	Continued From page 36 At approximately 12:30 PM, a surveyor entered Room 29 and acted out a mock fall. The system did not send an alert to the handheld device. At approximately 2:43 PM, Surveyors interviewed Team Lead (TL) E. TL E stated s/he did not like the system as it would alert to false alarms. TL E stated Administrator B was the one who could access videos and settings. TL E 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 E stated staff had not received much training on the system. TL E stated the training had been provided by the electronic monitoring system company, not by the provider. TL E stated s/he did not know how to turn off the monitoring system. 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 E stated s/he had never seen the policy. On 07/29/2026, at approximately 10:00 AM, Surveyors interviewed Administrator B, Regional Director (RD) Q, RD C, Licensee R, and System Administrator (SA) P. During the interview, SA P 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	Y3235		

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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 was 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.
- 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 P that Surveyors had observed staff performing live spot checks while on site, SA P stated that they should not be able to. SA P stated spot checks should only be able to be conducted while in maintenance mode.

During the interview, RD Q stated the following:
- The system did not allow staff to conduct checks while a staff member was in the room with

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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/or 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.

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, 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 was on-site at the neighboring facility also licensed by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018753	A. BUILDING: _____ B. WING _____	C 08/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - RICE LAKE II	1639 KERN AVE RICE LAKE, WI 54868

(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
Y3235	Continued From page 39	Y3235		

provider. S/he stated that s/he was able to see both facilities on the handheld device.

During the interview, Licensee R 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.
- The system increased the level of care.

In summary, the provider installed an electronic monitoring system with AI functionality. The system was installed in every resident room regardless of consent and was "turned on" when residents signed a consent. Residents were not individually assessed to need the monitoring system. The system monitored and captured resident movement, respirations, walking speed, sleep patterns, staff presence, etc. Resident data was stored within the system and could be accessed by staff not working onsite at the facility. Staff working from the facility and the other facility licensed by the provider could perform "spot checks" on handheld devices to view resident activity within their rooms, including when other people entered their room. 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, creating a privacy concern.

The provider did not ensure all residents had the right to privacy.