STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018750	A. BUILDING: _____ B. WING _____	C 09/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MENOMONIE II	1902 TALEN STREET MENOMONIE, WI 54751

(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 08/26/2026, Surveyors completed 4 complaint investigations at Vitacare Living - Menomonie II. Data collected through 09/03/2026. Three of 4 complaints were substantiated. Eight deficiencies were identified. Six of 8 deficiencies were repeat violations. See Statement of Deficiency (SOD) CN9L11, dated 11/11/2022; SOD QLT611, dated 05/17/2023, SOD QLT613, dated 03/28/2025, SOD QLT614, dated 09/15/2025, and SOD QLT615, dated 02/24/2026. Census: 11	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, record review, and interview the provider did not ensure that the Community Based Residential Facility (CBRF) and its operation complied with all laws governing the CBRF. As a result of this 4-complaint survey, a total of 8 violations were issued and 3 of the 4 complaints were substantiated. Six of the 8 violations were repeat violations. This was a repeat deficiency. See Statement of Deficiency (SOD) QTL611, dated 05/17/2026; and SOD QLT614, dated 09/15/2025.	N 196		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MENOMONIE II	1902 TALEN STREET MENOMONIE, WI 54751

(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 196	Continued From page 1 Findings include: On 09/03/2026, Surveyor reviewed department records for Vitacare Living - Menomonie II, licensed on 10/07/2021. Since initial licensure on 10/07/2021, the facility has had 11 substantiated complaints, resulting in 39 deficiencies. The provider was issued a No New Admit Order on 10/07/2025. Extended on 03/16/2026. Lifted on 06/03/2026. The following information was reviewed: SOD CN9L11 was issued on 12/16/2022. Seven deficiencies were identified: 1. 83.17 (1) Licensee Conduct Caregiver Background Check 2. 83.32 (3)(i) Rights of Residents: Prompt and Adequate Treatment. 3. 83.35 (1)(a) Pre-admission and Ongoing Assessments 4. 83.35 (2) Temporary Service Plan 5. 83.39 (1) Infection Control Program 6. 83.43(1) Environment Safe, Clean, and Comfortable 7. 83.48(7)(a) Equipment for Hearing or Vision Impaired On 11/16/2021, the provider was sent a Notice and Order letter with SOD CN9L11 which contained special orders. The special orders read, in part, "The licensee shall correct all violations identified in Statement of Deficiency (SOD) # CN9L11 and will achieve substantial compliance with all laws and administrative rules governing the facility and its operation prior to expiration of the facility's Probationary License ..." SOD QLT611 was issued on 07/19/2023. Nine deficiencies were identified:	N 196		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MENOMONIE II	1902 TALEN STREET MENOMONIE, WI 54751

(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 196	Continued From page 2 1. 83.14(2)(a) Licensee Ensures Facility Complies With Laws 2. 83.32(3)(h) Rights of Residents: To Receive Medication 3. 83.35(3)(d) Service Plans Updated Annually or On Changes 4. 83.36(2) Maintain Current Written Staffing Schedule 5. 83.37(1)(j) Proof-of-Use Record 6. 83.37(1)(k) Medication Error or Adverse Reaction 7. 83.37(2)(d) Documentation of Medication Administration 8. 83.38(1)(b) Supervision 9. 83.38(1)(h) Medication Administration SOD QLT612 was issued on 11/15/2024. Two deficiencies were identified: 1. 83.17(2)(a) Employees Screened for Communicable Disease 2. 83.19 Orientation SOD QLT613 was issued on 05/22/2025. Four deficiencies were identified. 1. 83.12(5)(a) Notification: Incident, Injury, Changes 2. 83.17(2)(a) Employees Screened for Communicable Disease 3. 83.36(1)(a) Adequate Staff to Meet Resident Needs 4. 83.39(1) Infection Control Program SOD QLT614 was issued on 10/07/2025. Five deficiencies were identified. 1. 83.14(2)(a) Licensee Ensures Facility Complies with Laws 2. 83.32(3)(h) Rights of Residents: To Receive Medication 3. 83.35(3)(d) Service Plans Updated Annually or On Changes	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MENOMONIE II	1902 TALEN STREET MENOMONIE, WI 54751

(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 196	Continued From page 3 4. 83.36(1)(a) Adequate Staff to Meet Resident Needs 5. 83.37(1)(k) Medication Error or Adverse Reaction On 10/07/2025, the provider was sent a notice and order letter for SOD #QLT614 which contained an order not to admit new or additional residents and special orders. The orders read in part, "Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b)7., EFFECTIVE UPON RECEIPT OF THIS NOTICE AND ORDER, THE DEPARTMENT OF HEALTH SERVICES HEREBY ORDERS THAT VITACARE LIVING - MENOMONIE II NOT ADMIT ANY NEW OR ADDITIONAL RESIDENTS until all violations in SOD #QLT614 are corrected, compliance is verified by the Department, and this Order is rescinded in writing. Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Vitacare Living - Menomonie II: 1. Pursuant to Wis. Stat. § 50.03(5g)(b)3. and (b)6., effective immediately, the licensee will comply with requirements specified by Wis. Admin. Code § DHS 83.36(1)(a) and shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. The facility will develop (or review/revise) written procedures to ensure: -Staffing patterns will be sufficient to meet the personal care needs of residents, to ensure needed supervision, to provide needed services (e.g., toileting, bathing, medication management, interventions to prevent falls, personal cares, meals), and to facilitate a safe evacuation of the building in the event of an emergency. -When a resident or residents (as a	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MENOMONIE II	1902 TALEN STREET MENOMONIE, WI 54751

(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 196	Continued From page 4 group) require the assistance of two or more staff members to address care and service needs, to provide supervision, or to evacuate the building in an emergency, the licensee will ensure sufficient, qualified staff members are on duty, present and available to assist residents at all times. -Written staff schedules will be current and shall include each employee's full name, job assignment and time worked. Records will be amended, as necessary, to ensure an accurate and complete record of time worked by all facility employees, and/or employees of contract agencies providing routine services to facility residents. Additionally: - All managers and resident care staff (as appropriate) will receive in-service training regarding the provider's written procedures required by Order #1. - Training will be documented in employee files and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. - A copy of the written procedures and all documentation as evidence of meeting the requirements in Order #1 will be made available to department representatives upon request. 2. Pursuant to Wis. Stat. § 50.03(5g)(b)6., within 7 days of receipt of this notice, the CBRF will provide each resident's legal representative and case manager (if any), with a copy of Statement of Deficiency (SOD) QLT614 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 each legal representative and case manager (if any). The documentation required by Order #2 will be available to department representatives upon request."	N 196		

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VITACARE LIVING - MENOMONIE II	1902 TALEN STREET MENOMONIE, WI 54751

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N 196	Continued From page 5 The provider appealed SOD QLT614. A stipulated settlement agreement was put into place on 12/19/2025. The settlement agreement rescinded the Rights of Residents: Adequate Treatment tag and the associated forfeiture. In exchange, the provider agreed to comply with the NNAO order, comply with special orders listed above, ensure all citations in QLT614 were corrected, and pay the forfeitures. On 10/09/2025, the Department issued the facility a warning letter that read in part, "This letter constitutes a warning regarding substantial noncompliance with: Wis. Admin Code, DHS Chapter 50, Uniform Licensure Wis. Admin Code, DHS Chapter 83, Community Based Residential Facilities Failure to correct this pattern of noncompliance will result in license revocation." SOD QLT615 was issued on 03/16/2026. Four deficiencies were identified. 1. 83.32(3)(a) Rights of Residents: Communications 2. 83.37(1)(a) Written Order for Medications, Supplements 3. 83.37(1)(k) Medication Error or Adverse Reaction 4. 83.38(1)(g) Health Monitoring On 03/16/2026, the provider was sent a notice and order letter for SOD #QLT615 which contained an order not to admit new or additional residents and special orders. The orders read in part, "Based on the results of the Department's investigation and pursuant to authority provided in Wis. Stat. § 50.03(5g)(b)7., the Department of Health Services HEREBY EXTENDS the ORDER issued on August 31, 2020 with SOD #QLT614	N 196		

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N 196	Continued From page 6 that Vitacare Living - Menomonie II NOT ADMIT ANY NEW OR ADDITIONAL RESIDENTS until all violations are corrected, compliance is verified by the Department, and this Order is rescinded in writing. Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Vitacare Living - Menomonie II: 1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., the licensee shall develop and implement corrective measures to ensure all residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. The licensee's corrective measures shall ensure the following: WITHIN 7 DAYS of receipt of this notice, the licensee shall provide Resident 1's and Resident 3's legal representative and case manager (if any), with a copy of Statement of Deficiency QLT615 and a copy of this Notice and Order letter. The licensee shall retain documentation, acceptable to the department, to verify compliance with this Order. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from each legal representative and case manager. WITHIN 45 DAYS of receipt of this notice, the licensee will develop (or review/revise) procedures to address: Medication Management and Administration Including how the provider will: a) document medication orders, medication administration, and missed/refused doses; b) administer medications to ensure residents receive medications at the intervals and dosages prescribed; c) prevent medication errors; d) respond to medication errors if they occur; e) monitor for adverse side effects; f) ensure medications are securely stored; and g) discontinue and dispose of medications. Pressure	N 196		

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N 196	Continued From page 7 Injury Prevention Including how the provider will: a) assess risk factors contributing to skin integrity concerns including pressure injuries; b) implement pressure injury prevention and treatment; c) monitor and document changes in a resident's health; d) notify the physician, notify the resident's legal representative or family, notify the care manager (if any) when a resident experiences a change in health status or medical emergency; e) ensure timely medical assessments and emergency medical care; f) review and revise individualized service plans annually or when there is a change in a resident's needs, abilities or physical or mental condition, and g) implement standards of practice for medical records to ensure each resident's record is accurate, current, and complete. ADDTIONALLY: - All managers, and resident care staff (as appropriate) will receive in-service training regarding the written procedures required by Order #1. - Training will be documented in employee files and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. - A copy of all documentation required by Order #1 will be made available to department representatives upon request." On 04/27/2026, an additional letter was sent to the provider regarding the previous stipulated agreement for SOD QLT614. The letter read in part, "Based on the foregoing, in accordance with paragraphs 10.c. and 12 of the Agreement, the Agreement is rendered null and void and all terms and requirements of the original Notice and Order dated October 7, 2025, go into effect immediately, without right to further appeal, including:- Reinstatement of Tag N353 - Rights Of Residents: Adequate Treatment (Wis. Admin. Code § DHS 83.32(3)(i)). -The Facility is	N 196		

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N 196	Continued From page 8	N 196		

responsible for the balance of the original $4,130 forfeiture. As part of the Agreement, the Facility paid a reduced forfeiture of $2,191. Because the Agreement is now null and void, a balance of $1,939 for the remainder of the forfeiture is due to the Department. Please remit payment postmarked within ten (10) days of receipt of this letter and payable to "Division of Quality Assurance": Division of Quality Assurance, Attn: Bureau of Assisted Living, Central Office, PO Box 2969, Madison, WI 53703. The Order Not to Admit New or Additional Residents remains in effect until all violations in SOD QLT614 are corrected, compliance is verified by the Department, and this Order is rescinded in writing."

On 06/03/2026, a letter was sent to the provider with an Order Lifting No New Admissions.

On 08/26/2026 at approximately 9:00 AM, Surveyor entered the building and was greeted by Caregiver C and Caregiver D. Surveyor asked to speak with the person in charge. Caregiver C reported that Director B quit a few days ago. S/he stated Director A was overseeing, but s/he was on vacation. Caregiver C stated that the team leads were going to help run things until a new director was hired. Caregiver C stated Director A was going to train the team leads on what needed to be done, but they had not yet received training. Caregiver C stated they had limited access to records and were unable to print. Caregiver D was able to reach Regional Director (RD) G by phone on the day of survey. Caregiver D reported that RD G would not be coming on site, but s/he would pass along the record request to RD G who would be able to e-mail Surveyor documents.

On 09/02/2026 at approximately 11:30 AM,

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N 196	Continued From page 9 Surveyors interviewed Director A and Registered Nurse (RN) E. Director A stated s/he was the director of 3 other buildings but had started overseeing this building when Director B left. Surveyor asked who was overseeing the day-to-day operations of the facility. Director A stated s/he was responsible for the daily oversight, and that Regional Nurse (RN) F was the administrator. RN E stated that s/he had been in casual status (working limited hours) but had returned full time as of 09/01/2026. RN F was overseeing the nurse responsibilities while RN E was casual. Director A stated that the team leads would be helping RN E with the day-to-day once they were trained. Director A stated s/he had not yet trained the team leads. Throughout the survey, Director A and RN E had difficulties locating some of the required documentation. Director A and RN E noted that Director B may have deleted e-mails or did not complete his/her job duties. On 09/03/2026, at approximately 2:55 PM, Surveyors interviewed Director A and Registered Nurse (RN) E. Director A noted that there had been some performance concerns related to Director B. Surveyor asked who was overseeing Director B during his/her employment. Director A noted that Regional Nurse (RN) F was overseeing Director B. Director A noted that Director B would report that s/he was completing all required tasks, but during the survey process it was noted that multiple things were in fact not completed. At approximately 4 PM, Director A stated s/he worked hard to clean up and keep things running	N 196		

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N 196	Continued From page 10	N 196		

smooth at his/her 3 locations. Director A stated that s/he was disappointed with how the survey went. S/he noted s/he had a lot to clean up, but s/he would start working on things right away.

During the survey, 8 deficiencies were identified. Six of 8 deficiencies identified during this survey were repeat deficiencies.

The survey was prompted by 4 complaints related to resident care and supervision. Three of 4 complaints were substantiated, and the following concerns were identified. Concerns identified with an asterisk (*) were concerns identified during previous surveys (i.e. repeat violations):
- *Residents did not receive their medications as ordered.
- All parties were not involved in the development of resident individual service plans (ISPs).
- *Staffing was not adequate to meet the needs of the residents.
- *Medication refusals were not reported to the prescribing physician.
- *Residents were not adequately supervised.
- Activities were not being performed.
- *The environment was not safe, clean, and comfortable.

Cross Reference:
N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication
N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved
N0396 DHS 83.36(1)(a) Adequate Staff To Meet Resident Needs
N0410 DHS 83.37(1)(k) Medication Error Or Adverse Reaction
N0426 DHS 83.38(1)(b) Supervision
N0427 DHS 83.38(1)(c) Leisure Time Activities

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N 196	Continued From page 11 N0481 DHS 83.43(1) Environment Safe, Clean, And Comfortable	N 196		
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 1 and Resident 2 received all prescribed medications in the dosage and intervals prescribed by a practitioner. This is a repeat deficiency. See Statement of Deficiency (SOD) QLT611, dated 05/17/2023 and SOD QLT614, dated 09/15/2025. Findings include: The department received a complaint related to medication concerns. The provider is licensed to care for 16 residents in the client groups terminally ill, irreversible dementia/Alzheimer's disease, and advanced aged. On 08/26/2026 at approximately 10:10 AM, Surveyor interviewed Caregiver C. Caregiver C stated they often had issues with getting medications timely from the pharmacy. Caregiver C noted that it happened a lot.	N 352		

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N 352	Continued From page 12 On 08/27/2026 at approximately 3:00 PM, Surveyor reviewed Resident 1's and Resident 2's MAR (medication administration record). Resident 1 was admitted to the facility on 11/28/2023. Resident 1 had diagnoses that included hypertension, mild cognitive impairment, and schizophrenia. Resident 2 was admitted on 04/21/2025. Resident 2 had diagnoses that included dementia with psychotic disturbance, and amnesia. Surveyor reviewed Resident 1's and Resident 2's July 2026 and August 2026 MARs. Resident 1 did not receive the following medications on the noted days because they were unavailable or out of stock: July 2026 -Lorazepam Tab 0.5mg (Daily) Take 1 tablet by mouth at 8:00 AM. Missed doses on the 15th, 16th, 18th through 21st. -Vitamin D3 Cap (Capsule) 50000unt (Wed) Take 1 capsule by mouth once every week for 7 doses. Missed doses on the 1st, 8th, 15th, and 29th. -Lorazepam Tab 0.5mg (Daily) Take 1 tablet by mouth at 8:00 PM. Missed doses on the 18th through 23rd and on the 25th. August 2026 -Vitamin D3 Cap (Capsule) 50000unt (Wed) Take 1 capsule by mouth once every week for 7 doses. Missed a dose on the 5th. Resident 2 did not receive the following medications on the noted days because they were unavailable or out of stock:	N 352		

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(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 352	Continued From page 13 July 2026 -Lorazepam 0.5mg tab (daily) Give 1 tab by mouth two times a day. Missed evening doses on the 18th, 19th, and 20th. Missed morning doses on the 20th and 21st. August 2026 -Olanzapine 5mg Odt (Daily) Dissolve 1/2 tablet (2.5mg) by mouth at bedtime. Missed doses on the 7th, 8th, 9th, and 10th. -Lorazepam 0.5mg tab (daily) Give 1 tab by mouth two times a day. Missed an evening dose on the 22nd and a morning dose on the 23rd. On 09/03/2026 at approximately 3:10 PM, Surveyors interviewed Director A and Registered Nurse (RN) E. RN E stated that s/he had followed up with pharmacy when his/her employment started back on 09/01/2026 and pharmacy stated that they needed new orders form the provider. Director A stated the provider should reach out to the pharmacy and PCP (primary care physician) when they notice medications were not filled.	N 352		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the	N 387		

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N 387	Continued From page 14 development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 4 residents reviewed (Resident 1, Resident 3, and Resident 4) or legal representatives were involved in the development of their individual service plans (ISPs). Resident 1 did not sign his/her ISP to acknowledge their involvement in and agreement with the plan. Resident 3's and Resident 4's legal representatives did not sign their ISPs to acknowledge their involvement in and agreement with the plans. Findings include: The Department received a complaint related to guardians not being involved in ISP creation and review. On 08/27/2026, Surveyor reviewed resident records. Resident 1 was admitted to the facility on 11/28/2023. Resident 1's record did not indicate s/he had a guardian. Resident 1's Planned Services document and Master Care Plan (MCP) dated 05/21/2026 did not include evidence that it was reviewed or signed by Resident 1. Resident 3 was admitted to the facility on 06/19/2025. Resident 3's record indicated s/he	N 387		

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N 387	Continued From page 15 had a guardian. Resident 3's Planned Services document and Master Care Plan (MCP) dated 05/21/2026 did not include evidence that it was reviewed or signed by Resident 3's guardian. Resident 4 was admitted to the facility on 02/02/2017. Resident 4's record indicated s/he had a guardian or power of attorney. Resident 4's Planned Services document and Master Care Plan (MCP) dated 05/21/2026 did not include evidence that it was reviewed or signed by Resident 4's guardian. On 08/31/2026 at approximately 4:20 PM, Surveyor interviewed Regional Director (RD) I. RD I stated that the Planned Services document is what they considered the ISP for Residents. RD I stated in addition, the residents would have an MCP. RD I stated they send both documents for guardians to review. On 09/03/2026 at approximately 2:45 PM, Surveyors interviewed Director A and Registered Nurse (RN) E. RN E stated s/he sent Resident 3's ISP to his/her guardian and care team for signature and never received a response. RN E stated s/he often got ignored. RN E stated it was his/her fault that Resident 1's ISP was not signed, and s/he would have him/her sign it today. RN E stated s/he knew that Resident 4's was sent for signature as well. RN E said s/he would look for confirmation and send over if s/he found it. Surveyor asked if additional attempts were made to obtain a signature after an initial e-mail was sent. RN E stated s/he would attempt to call, but s/he did not document those attempts. At 4:30 PM, Surveyor did not receive confirmation that Resident 4's ISP was sent for signature.	N 387		

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N 396	Continued From page 16	N 396		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: The provider did not provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This is a repeat deficiency. See Statement of Deficiency (SOD) QLT613, dated 03/28/2025 and SOD QLT614, dated 09/15/2025. Findings include: On 06/04/2026, the Department received a complaint regarding staffing concerns. On 08/26/2026 at approximately 9:30 AM, Surveyor asked Caregiver C about staffing. Caregiver C stated they staff 2 people on dayshift (6:00 AM until 2:00 PM), 2 people on evening shift (2:00 PM until 10:00 PM), and 1 person on night shift (10:00 PM until 6:00 AM). Surveyor asked Caregiver C if they had any residents that required assistance from 2 staff members. Caregiver C stated that Resident 1 was a 2-assist. Caregiver C also stated that Resident 3 and Resident 4 may require 2-assist, depending on the day. At 10:00 AM, Surveyor requested Resident 1's, Resident 3's, and Resident 4's record. At 4:30 PM, Surveyor reviewed Resident 1's Assessment dated 06/20/2026. Under the	N 396		

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N 396	Continued From page 17	N 396		

mobility section of his/her assessment it read in part, "Mobility- Bed. Needs assistance with bed mobility, specify: Sleeps in recliner, Sit to stand [sic] assist to get [him/her] up with 2 staff."

On 08/27/2026 at 7:00 AM, Surveyor reviewed Resident 1's Planned Services, which the provider referred to as the ISP (Individualized Service Plan). The Planned Services was dated 05/21/2026. Under the section titled Outcome-ADL's (Activities of Daily Living) it read in part, "...[Resident 1] will continue to be assisted by 2 staff for dressing needs." Under the Dressing section it read in part, "[Resident 1] will need full assist of 2 staff for dressing."

On 08/26/2026 at 12:30 PM, Surveyor asked Caregiver C and Caregiver D for the June 2026, July 2026, and August 2026 staff schedule. Caregiver D provided Surveyor with the August 2026 schedule. Caregiver D stated Caregiver J would have the June 2026 and July 2026 schedule.

At 2:30 PM, Surveyor asked Caregiver J for June 2026 and July 2026 schedule. Caregiver J provided Surveyor with the June 2026 schedule and stated that someone disposed of the July 2026 schedule.

At 5:34 PM, Surveyor requested July 2026 schedule from Regional Director (RD) G and RD I.

On 07/27/2026 at 12:30 PM, Surveyor reviewed the staff schedules provided for June 2026, July 2026, and August 2026.

The June 2026 schedule indicated that only 1 person worked the night shift (10:00 PM until 6:00

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N 396	Continued From page 18 AM) for the whole month of June. The July 2026 schedule indicated that only 1 person worked the night shift (10:00 PM until 6:00 AM) for the whole month of July except for July 5th, July 7th, July 8th, when a second staff was noted to be training on night shift. The August 2026 schedule indicated that only 1 person worked the night shift (10:00 PM until 6:00 AM) for the whole month of August except for August 23rd, when a second staff was noted to be training on night shift. On 09/02/2026 at approximately 12:15 PM, Surveyor interviewed Director A and Registered Nurse (RN) E. Surveyor asked how staffing accommodated Resident 1's assessed need of 2-assist. Director A stated it should be 2 staff on all shifts. Director A was unsure when the staffing pattern changed from 2 to 1 on night shift. At 12:25 PM, Director A stated that Director B was told by Regional Nurse (RN) F that s/he needed to schedule 2 staff on all shifts. Surveyor asked when Director B was told s/he needed to make that change. Director A stated that RN F (also listed at the provider's administrator) stated, "It was a long time ago." At 3:33 PM, Surveyor received an e-mail from Director A. The email stated that RN F told Director B sometime in June that it was supposed to be 2 staff on every shift.	N 396		
N 410	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record	N 410		

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N 410	Continued From page 19	N 410		

any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after Resident 3 refused a medication for 2 consecutive days multiple times in July 2026 and August 2026.

This is a repeat deficiency. See Statement of Deficiency (SOD) QLT611, dated 05/17/2023; SOD QLT614, dated 09/15/2025; and SOD QLT615, dated 02/24/2026.

Findings include:

On 08/26/2026 at approximately 10:00 AM, Surveyor requested Resident 3's record from Regional Director (RD) G and RD I.

On 08/27/2026 at approximately 3:30 PM, Surveyor reviewed Resident 3's MAR (medication administration record).

Resident 3 was admitted to the facility on

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N 410	Continued From page 20	N 410		

06/19/2025. Resident 3 had diagnoses that included paranoid schizophrenia, dementia, and depression major recurrent severe - with psychotic symptoms.

Surveyor reviewed Resident 3's July 2026 and August 2026 MARs.

Resident 3 refused the following medications on the following days:

July 2026
- Nitrofurantoin Mono Cap 100mg take 1 capsule by mouth twice daily for 7 days. Refusals documented on the 27th through 30th.
- Polyeth Gly Powder mix 1 capful in liquid and take my mouth once daily. Refusals documented on the 1st through the 31st.

August 2026
- Polyeth Gly Powder mix 1 capful in liquid and take my mouth once daily. Refusals documented on the 1st through the 24th.

On 09/01/2026 at 8:40 AM, Surveyor requested physician or guardian notification for Resident 3. Surveyor did not receive any documentation with notification to Resident 3's physician regarding his/her consecutive refusal of medication for July 2026, and August 2026.

On 09/02/2026 at approximately 12:00PM, Surveyors interviewed Director A and Registered Nurse (RN) E. Surveyor asked if all requested physician or guardian notifications were sent to Surveyor. RN E stated "yes;" s/he sent all the ones s/he was able to find. RN E stated s/he did not have access to Director B's email notifications to physicians or guardians. Director A stated they would try to get into Director B's email and send

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N 410	Continued From page 21 any additional documentation by end of day. Surveyor did not receive any physician notification documentation by end of day on 09/02/2026. On 09/03/2026 at approximately 9:00 AM, Surveyor interviewed Guardian H. Guardian H explained that s/he was notified from Resident 3's MCO (managed care team) on 07/31/2026 regarding Resident 3's consecutive refusal of his/her entire course of antibiotic. Guardian H expressed concern that the antibiotic was for a UTI (urinary tract infection) and that it was important that s/he took the medication, so s/he did not end up septic. Guardian H notified that facility of the importance of notifying the physician and him/her when Resident 3 refused medications. At approximately 3:00 PM, Surveyors interviewed Director A and Registered Nurse (RN) E. Director A confirmed they could not find any notification regarding medication refusals for Resident 3. Director A stated it would have been Director B's responsibility to ensure that notifications were done.	N 410		
N 426	83.38(1)(b) Supervision. 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: Supervision. The CBRF shall provide supervision appropriate to the resident's needs.	N 426		

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N 426	Continued From page 22	N 426		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not provide appropriate supervision to meet Resident 3's needs when s/he was unsupervised during transportation to and from appointments.

This is a repeat deficiency. See Statement of Deficiency (SOD) QLT611, dated 05/17/2023.

Findings include:

The department received a complaint related to supervision concerns.

On 08/26/2026 at 10:00 AM, Surveyor requested Resident 3's record.

Resident 3 was admitted to the facility on 06/19/2025. Resident 3 had diagnoses that included paranoid schizophrenia, dementia, and depression major recurrent severe - with psychotic symptoms.

On 08/27/2026, Surveyor reviewed Resident 3's ISP (individual service plan). Resident 3's ISP dated 05/21/2026 read in part, "Decisions poor; cues/supervision required."

Surveyor reviewed Resident 3's appointment record. Resident 3's record indicated that s/he had an appointment on 07/20/2026 and 08/12/2026.

On 09/02/2026 at approximately 12:00 PM, Surveyor interviewed Director A and Registered

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N 426	Continued From page 23 Nurse (RN) E. Surveyor asked if Resident 3 was allowed unsupervised time in the community. RN E stated no. Surveyor asked about the provider's supervision expectations during medical transport and appointments for residents who were not able to have unsupervised time. Director A stated that if a resident was not supposed to be left alone, it would not be appropriate for him/her to be left alone in the clinic or in transportation. Director A stated there were multiple times s/he went with residents before to appointments to ensure that supervision needs were being met. On 09/03/2026 at approximately 9:30 AM, Surveyor interviewed Guardian H. Guardian H expressed concern that Resident 3 was being sent to appointments without supervision. Guardian H was told that Resident 3 would not be supervised during the transportation to and from the appointments because the facility did not have enough staff to do so. Guardian H stated that on 07/17/2026, s/he had a meeting with Director B, adult protective services (APS), the regional ombudsman, and his/her supervisor. The meeting was to discuss the supervision concerns with Resident 3. Guardian H stated with Resident 3's diagnoses, cognitive function, behavior, and eyesight, it was not safe for him/her to be unsupervised. Guardian H stated the meeting went well, and s/he was under the understanding that Resident 3 would be accompanied to his/her appointment on 07/20/2026. Guardian H stated that on 07/20/2026, Resident 3 arrived to his/her appointment without a staff member present. Guardian H stated that after the appointment, the transportation was over 1.5 hours late. Guardian H stated s/he called Director	N 426		

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N 426	Continued From page 24 B, who did not respond to him/her for over 30 minutes. S/he expressed concern that if Resident 3 were alone s/he would not have been able to call the facility or the transportation company to get back to the facility. On 08/12/2026, Guardian H stated that s/he arrived to Resident 3's appointment approximately 15 minutes early. S/he stated that Resident 3 had already been dropped off and was back in the room, arguing and being rude to hospital staff. Guardian H noted that Resident 3 was sent alone, without a face sheet or any facility documentation. The provider did not ensure that Resident 3 was provided supervision when s/he was sent alone to and from his/her appointments, arrived early, or had to stay late due to transportation issues.	N 426		
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.	N 427		

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VITACARE LIVING - MENOMONIE II	1902 TALEN STREET MENOMONIE, WI 54751

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N 427	Continued From page 25 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a daily activity program to meet the interests and capabilities of the residents. The provider did not develop and post the activity schedule in an area available to residents. Findings include: On 08/26/2026 at 9:30 AM, Surveyor toured the building and noted that no activity schedule was posted. Surveyors were on site until about 3:30 PM and did not observe any activities take place. At approximately 12:55 PM, Surveyor interviewed Resident 5 about activities. Resident 5 stated they go over to the provider's other building for bingo on Fridays. At approximately 1:00 PM, Surveyor interviewed Caregiver C. Caregiver C stated that s/he used to do activities for both buildings. S/he stated recently it had been hard to complete activities due to low staff numbers. Caregiver C stated they provided bingo on Fridays for residents. On 09/03/2026 at approximately 3:30 PM, Director A stated activities would be addressed as soon as possible. S/he stated s/he would start scheduling tasks on the computer. Director A stated s/he would keep track to make sure activities were completed. Surveyor asked about the no posted activity calendar for the month of August. Director A stated s/he did not know why it was not completed.	N 427		
N 481	83.43(1) Environment safe, clean, and comfortable	N 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018750	A. BUILDING: _____ B. WING _____	C 09/03/2026

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N 481	Continued From page 26 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. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a living environment that was safe, clean, comfortable, and homelike for Resident 1 and Resident 2. This is a repeat deficiency. See Statement of Deficiency (SOD) CN9L11, dated 11/11/2022. Findings include: On 05/28/2026, the Department received a complaint regarding environmental concerns. On 8/26/2026 at 9:33 AM, Surveyor entered Resident 2's room. Surveyor was immediately hit with a strong urine like smell. Surveyor walked towards Resident 2's bathroom and noticed a large wet spot that started in the bathroom and spread into the room. The wet spot was yellow in color and smelled of urine. Surveyor also noted multiple brown and yellow stains on Resident 2's bathroom floor. Surveyor noted that Resident 2's bedroom window blinds were bent and sticking out on both sides. At approximately 9:40 AM, Surveyor entered Resident 1's room and noticed a strong urine like smell. Resident 1's recliner was covered in stains. At approximately 9:45 AM, Surveyor interviewed Caregiver C about Resident 2's room. Caregiver	N 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 481	Continued From page 27 C stated Resident 2 never goes to the bathroom in his/her toilet. S/he stated that Resident 2 urinated and had bowel movements on the floor. Caregiver C stated the urine like smell was coming from his/her bathroom, and most likely his/her dresser. Caregiver C stated that Resident 2 would often hold onto his/her dresser and urinate on it. Caregiver C noted that his/her bathroom did get cleaned, but it had yellow and brown stains on the floor. S/he noted it was a constant struggle. Caregiver C noted that Resident 2's blinds were bent because s/he liked to look out his/her window at people. On 09/03/2026 at approximately 2:00 PM Surveyors interviewed Director A and Registered Nurse (RN) E. Director A stated that s/he knew they bought a special urine enzyme cleaner to help. Director A stated staff should be using that and s/he would look into it.	N 481		