STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018761	A. BUILDING: _____ B. WING _____	R-C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - RICE LAKE I	1631 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 09/09/2024, Surveyor conducted a standard survey, verification visit, and complaint investigation at Vitacare Living Rice Lake I. Data was collected through 09/12/2024. The complaint was unsubstantiated. The citation from Statement of Deficiency (SOD) 3ITR12, dated 05/01/24 was corrected. Ten new violations were identified. Four of 10 violations were repeat deficiencies. See SOD 9C5111, dated 08/17/2022. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 13.	{N 000}		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by:	N 220		

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
	0018761	A. BUILDING: _____ B. WING _____	R-C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - RICE LAKE I	1631 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 220	Continued From page 1	N 220		

Based on record review and interview, the provider did not ensure 3 of 3 employees reviewed had obtained documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating they had been screened within 90 days before the start of employment for clinically apparent communicable disease, including tuberculosis (TB).

This is a repeat violation. See Statement of Deficiency (SOD) 9C5111, dated 08/17/2022.

Findings include:

The provider is licensed to care for 16 residents in the client groups terminally ill, physically disabled, advanced aged, and irreversible dementia/Alzheimer's disease.

On 09/09/2024, Surveyor reviewed the employee records of Care Specialist (CS) A, B, and C.
-CS A, hired 06/20/2024, did not have documentation of a communicable disease screen but did contain a TB test completed on 07/31/2024, approximately 5 weeks after hire.
-CS B, hired, 03/15/2024, did not have documentation of a screen for communicable disease, including TB.
-CS C, hired 02/02/2024, did not have documentation of a screen for communicable disease, including TB.

On 09/10/2024 at 11:59 AM, Surveyor received an email communication from Clinical Nurse Director (CND) D that read, in part, "[CS B] ... Health report - TB... AED [Assistant Executive Director (AED) E] working to obtain a copy from staff...unable to find in folder ..." and "[CS C]...Health report - TB - unable to locate, staff is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018761	A. BUILDING: _____ B. WING _____	R-C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - RICE LAKE I	1631 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 220	Continued From page 2 resigning and unwilling to provide a document at this time." The provider did not screen 3 of 3 employees for communicable disease including TB.	N 220		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 employees reviewed had completed orientation training that included job responsibilities, prevention and reporting of resident abuse, neglect and misappropriation of resident property, information regarding assessed needs and individual services for each resident for whom the employee is responsible, emergency and disaster plan and evacuation procedures, CBRF (community based residential facility) policies and procedures, and recognizing and responding to resident changes of condition before performing any job duties.	N 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018761	A. BUILDING: _____ B. WING _____	R-C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - RICE LAKE I	1631 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 230	Continued From page 3 This is a repeat violation. See Statement of Deficiency (SOD) 9C5111, dated 08/17/2022. Findings include: The provider is licensed to care for 16 residents in the client groups terminally ill, physically disabled, advanced aged and irreversible dementia/Alzheimer's disease. On 09/09/2024, Surveyor reviewed the employee records of Care Specialist (CS) A, B, and C. CS B, hired, 03/15/2024 and CS C, hired 02/02/2024, did not have documentation of all 6 components of orientation training. On 09/10/2024 at 11:59 AM, Surveyor received an email communication from Clinical Nurse Director (CND) D that contained a document titled Assisted Living/Wisconsin CBRF Orientation Checklist for CS B and CS C. The hire date on CS B's training checklist was 05/15/2024, 2 months after his/her actual hire date, and the document was not signed. CS C's training checklist was not signed. On 09/10/2024 at 3:10 PM, Surveyor received an email communication from CND D that contained a document titled "Transcripts" for CS B that did not include indication of training in job responsibilities, prevention and reporting of abuse and neglect, emergency and disaster plan and evacuation procedures, CBRF policy and procedures, and recognizing and responding to changes of condition. CS B's transcript did not include any of the 6 components of orientation training. The provider did not ensure orientation training	N 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018761	A. BUILDING: _____ B. WING _____	R-C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - RICE LAKE I	1631 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 230	Continued From page 4 was completed prior to staff performing job duties.	N 230		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018761	A. BUILDING: _____ B. WING _____	R-C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - RICE LAKE I	1631 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 243	Continued From page 5 property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 employees reviewed, obtained all training as required within 90 days after starting employment. Care Specialist (CS) B and CS C did not have training in resident rights within 90 days after starting employment. CS B and CS C did not have training in recognizing, preventing, managing and responding to challenging behaviors within 90 days after starting employment. This is a repeat violation. See Statement of Deficiency (SOD) 9C5111, dated 08/17/2022. Findings include: On 09/09/2024, Surveyor conducted a review of 3 employees to verify compliance with all employee training requirements. Surveyor requested training records from Executive Director (ED) F for CS A, B, and C. Resident Rights: The record for CS B, hired 03/15/2024, did not	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018761	A. BUILDING: _____ B. WING _____	R-C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - RICE LAKE I	1631 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 243	Continued From page 6	N 243		

contain evidence of training or evidence of meeting an exemption for resident rights. On 09/10/2024, at 11:59 AM, Surveyor received an email communication from Clinical Nurse Director (CND) D that read, in part, "...[CS B] ...resident rights, abuse & neglect ...attached [training] transcript." Surveyor reviewed CS B's transcript and did not find evidence of completion of resident rights training within 90 days of hire.

The record for CS C, hired, 02/02/2024, did not contain training or evidence of meeting and exemption for resident rights. On 09/10/2024 at 11:59 AM, Surveyor received an email communication from CND D that read, in part, "... [CS C]...resident rights, abuse & neglect...-no classes assigned in [on-line training]. Discussed the severity of this with Assistant Executive Director (AED) E."

On 09/12/2024 at approximately 1:30 PM, Surveyor interviewed CND D who confirmed they did not have evidence that CS B or CS C completed resident rights training.

Recognizing, Preventing, Managing and Responding to Challenging Behaviors:

The record for CS B, hired 03/15/2024, and CS C, hired 02/02/2024 did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. On 09/10/2024 at 11:59 AM, Surveyor received an email communication from CND D that included training records for CS B and CS C. The records did not contain evidence of training in challenging behaviors.

CND D was given the opportunity to submit any additional evidence of training by 09/12/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018761	A. BUILDING: _____ B. WING _____	R-C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - RICE LAKE I	1631 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 243	Continued From page 7 Surveyor did not receive any new evidence.	N 243		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation.	N 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018761	A. BUILDING: _____ B. WING _____	R-C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - RICE LAKE I	1631 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 247	Continued From page 8	N 247		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 3 employees obtained all task specific training.

Care Specialist (CS) B and CS C, who perform dietary duties, did not have training in dietary services within 90 days after assuming these job duties.

This is a repeat violation. See Statement of Deficiency (SOD) 9C5111, dated 08/17/2022.

Findings include:

On 09/10/2024, Surveyor conducted a review of 3 employees to verify compliance with task specific training requirements. Surveyor requested training records from Executive Director (ED) F for CS A, B, and C.

Dietary Training:

On 09/09/2024 at approximatley11:30 AM, Surveyor observed staff preparing meals.

The record for CS B, hired 03/15/2024, and CS C, hired 02/02/24 did not contain evidence of training or evidence of meeting an exemption for dietary training. On 09/10/2024 at 11:59 AM, Surveyor received an email communication from Clinical Nurse Director (CND) D that read, in part, " ...[CS B] ...Dietary education - assigned but not completed ...[CS C] Dietary education - no classes completed ..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018761	A. BUILDING: _____ B. WING _____	R-C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - RICE LAKE I	1631 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 247	Continued From page 9 On 09/12/2024 at approximately 1:30 CND D stated there was a problem with training and ensuring follow-up, which resulted in a huge error. CND D confirmed they did not have evidence that CS B and C completed or met an exemption for dietary training, within 90 days after staff assuming these job duties.	N 247		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner, or a licensed registered nurse, screen each person admitted to the CBRF (community based residential facility) for clinically apparent communicable disease, including tuberculosis (TB), and document the	N 302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018761	A. BUILDING: _____ B. WING _____	R-C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - RICE LAKE I	1631 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 302	Continued From page 10 results of the screening. Findings include: The provider is licensed to care for 16 residents in the client groups terminally ill, physically disabled, advanced aged and irreversible dementia/Alzheimer's disease. On 09/09/2024, Surveyor reviewed the records of Resident 1 and Resident 2. Resident 1 was admitted on 05/31/2024. The record included a TB test completed on 10/31/2023, approximately 7 months prior to admission. On 09/10/2024 at 11:59 AM, Surveyor received an email communication from Clinical Nurse Director (CND) D that read, in part, " ...[Resident 1] ...TB test - unable to find a TB test or chest xray [sic] ...misinformed by previous facility that TB was up-to-date and within 90 days ...working with ...hospice team ...to obtain this testing result to remain compliant ...policies in place not to admit resident without TB results ..." The provider did not ensure Resident 1 had a TB test.	N 302		
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 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	N 488		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018761	A. BUILDING: _____ B. WING _____	R-C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - RICE LAKE I	1631 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 488	Continued From page 11 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 had rigid vent tubing. Findings include: The provider is licensed to care for 16 residents in the client groups terminally ill, physically disabled, advanced aged and irreversible dementia/Alzheimer's disease. On 09/09/2024 at approximately 10:36 AM, Surveyor observed the dryer did not have rigid vent tubing. On 09/10/2024 at 11:59 AM, Clinical Nurse Director (CND) D stated s/he had requested their maintenance department replace the flexible vent tubing with rigid vent tubing. The provider did not ensure the dryer had rigid vent tubing.	N 488		
N 497	83.45(1)(f) Furnishings clean, safe, and maintained Furnishings. The CBRF shall keep all furnishings clean, safe, and maintained in good repair. This Rule is not met as evidenced by: Based on observation and interview, the provider did not keep all furnishings clean, safe, and, maintained in good repair. Findings include:	N 497		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018761	A. BUILDING: _____ B. WING _____	R-C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - RICE LAKE I	1631 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 497	Continued From page 12 The provider is licensed to care for 16 residents in the client groups terminally ill, physically disabled, advanced aged and irreversible dementia/Alzheimer's disease. On 09/09/2024, Surveyor observed the living room and dining room of the home. The living area contained a television, 2 brown loveseats, and 5 stuffed armchairs with flower patterned fabric with a beige-colored background. The arms and seating areas of the stuffed armchairs were darkened with stains on the seat area and especially on the arms. The dining area contained multiple lunch tables and chairs with cloth seats. The cloth area on most of the dining chairs were covered in stains. At approximately 2:25 PM, Surveyor interviewed Clinical Nurse Director (CND) D and Executive Director (ED) F, who stated they were aware of the condition of the furniture and would be bringing in a spot bot to clean the stains. CND D stated there was a plan to replace the furniture, but other unexpected expenditures took precedence. On 09/10/2024 at 11:59 AM, Surveyor received an email communication from CND D that read, "Furniture cleanliness - will ensure services are in place for cleanliness of common areas and dining room; covers for furniture being priced out to be purchased until able to purchase new furniture." The provider did not ensure the living room and dining room furniture were kept in a clean manner.	N 497		
N 507	83.46(1)(f) Combustibles.	N 507		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018761	A. BUILDING: _____ B. WING _____	R-C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - RICE LAKE I	1631 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 507	Continued From page 13 Combustible materials shall not be placed within 3 feet of any furnace, boiler, water heater, fireplace or other similar equipment. This Rule is not met as evidenced by: Based on observation and interview, the provider stored combustible materials within 3 feet of 2 furnaces. Findings include: The provider is licensed to care for 16 residents in the client groups terminally ill, physically disabled, advanced aged and irreversible dementia/Alzheimer's disease. On 09/09/2024 at approximately 11:30 AM, Assistant Executive Director (AED) E unlocked the 2 furnace rooms and Surveyor observed there were multiple items stored within a foot of the furnace in both furnace rooms. The items included flammable decorations and multiple large plastic totes. AED E stated that both furnaces had recently been replaced and that leadership was planning on purchasing an outdoor storage shed due to lack of storage in the program. On 09/10/2024 at 11:59 AM, Surveyor received an email communication from Clinical Nurse Director (CND) D that read, "Furnace rooms clutter within 3 foot radius - working to remove the clutter and place in other building where additional storage is located." The provider stored combustibles within 3 feet of 2 furnaces.	N 507		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018761	A. BUILDING: _____ B. WING _____	R-C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - RICE LAKE I	1631 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 525	Continued From page 14	N 525		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire evacuation drills were conducted at least quarterly, with both employees and residents, and documentation included the date and time of the drill and the CBRF 's (community based residential facility) total evacuation time. Findings include: The provider is licensed to care for 16 residents in the client groups terminally ill, physically disabled, advanced aged and irreversible dementia/Alzheimer's disease. On 09/09/2024 at 11:59 AM, Surveyor received	N 525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018761	A. BUILDING: _____ B. WING _____	R-C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - RICE LAKE I	1631 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 525	Continued From page 15 an email communication from Clinical Nurse Director (CND) D that read, "Fire Evacuation Drills for 2023-2024 - attached is the task for fire drill and smoke detectors showing completed in rTasks [on-line tracking system], however no formal documents were located by [Executive Director (ED) F] ...". Attached to the email was a document titled Fire Emergency Drills that included the following information: -06/21/2024 Fire Drill NOC (nighttime) -07/16/2024 2:00 PM Emergency Evacuation Drill, Smoke Detectors -08/1/2024 Other Emergency Evacuation Drill. The documentation did not indicate the drills were completed, residents participating, or the time it took to evacuate. The document did not include any drill information for 2023. On 09/12/2024 at 3:10 PM, Surveyor received an email communication from CND D that read, "Unable to locate any fire or emergency drills from 2023...". CND D stated the 2023 drills were recorded on paper and staff were unable to locate them. CND D stated the 2024 drills were to be recorded on documents and uploaded in their rTask (online tracking) system but unfortunately that had not occurred. The provider did not ensure fire drills were conducted in 2023 and appropriately documented.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually.	N 526		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018761	A. BUILDING: _____ B. WING _____	R-C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - RICE LAKE I	1631 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 526	Continued From page 16 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure other evacuation drills such as tornado, flooding, or other emergency or disaster evacuation drills, were conducted semi-annually. Findings include: The provider is licensed to care for 16 residents in the client groups terminally ill, physically disabled, advanced aged and irreversible dementia/Alzheimer's disease. On 09/10/2024 at 11:59 AM, Surveyor received an email communication from Clinical Nurse Director (CND) D that read, "Fire Evacuation Drills for 2023-2024 - attached is the task for fire drill and smoke detectors showing completed in RTasks [on-line tracking system], however no formal documents were located by [Executive Director (ED) F] ...". Attached to the email was a document titled Fire Emergency Drills that included the following: -07/16/2024 2:00 PM Emergency Evacuation Drill, Smoke Detectors -08/1/2024 Other Emergency Evacuation Drill. The documentation did not indicate what type of drill, if completed, or any information on other drills completed in 2023. On 09/12/2024 at 3:10 PM, Surveyor received an email communication from CND S that read, "Unable to locate any fire or emergency drills from 2023..." The provider did not ensure other evacuation drills were conducted semi-annually in 2023.	N 526		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018761	A. BUILDING: _____ B. WING _____	R-C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - RICE LAKE I	**1631 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