STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 12/02/2024, Surveyor conducted 2 complaint investigations and a standard survey at Vitacare Living - Medford II. Data was collected through 12/10/2024. Two of 2 complaints were substantiated. Fifteen deficiencies were identified. One of the 15 deficiencies was a repeat deficiency. See Statements of Deficiency (SOD) 8R5711, dated 06/27/2022 and SOD 8R5712, dated 11/10/2022. Census: 16	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 licensee did not ensure the community based residential facility (CBRF) and its operations complied with all laws governing the CBRF. The licensee did not ensure there was a qualified administrator to supervise the daily operations of the CBRF. Findings include: The provider is licensed to care for up to 18 residents in the client groups of: irreversible	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
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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	N 196		

dementia/Alzheimer's disease, advanced age, and terminally ill. At the time of the survey the census was 16.

On 12/02/2024 at approximately 8:50 a.m., Surveyor interviewed Director A. Director A told Surveyor the licensee terminated their management company and as of 11/01/2024, Licensee F and licensee G had been managing the CBRF. Director A told Surveyor Former Administrator B worked for the previous management company and was no longer the administrator as of 11/01/2024. Surveyor asked who the current administrator was. Director A said s/he was not sure. Director A told Surveyor s/he thought the new administrator was going to be a new nurse. Director A told Surveyor s/he only knew his/her first name.

On 12/05/2024 at 9:42 a.m., Surveyor emailed Licensee F and Licensee G and asked who the current administrator was for the CBRF and when they assumed the responsibility as the administrator. At 9:42 a.m., Surveyor received a confirmation email indicating the email was delivered. At 4:42 p.m., Surveyor received a notification email that indicated Licensee F read the email. As of 12/09/2024, Surveyor did not receive a response from Licensee F or Licensee G.

Surveyor conducted a standard licensing survey and 2 complaint investigations from 12/022/2024 - 12/06/2024. The provider was found to be out of compliance. Two of the 2 complaints were substantiated and 15 deficiencies were identified in areas of resident care and services, the physical plant, and the environment.

The licensee did not ensure the CBRF and its

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 operations complied with all laws governing the CBRF. Cross References: N0200 DHS 83.14(2)(e) Notify Within 7 Days Of Administrator Change N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0392 DHS 83.35(4) Resident Satisfaction Evaluation N0407 DHS 83.37(1)(h) Scheduled Psychotropic Medications N0408 DHS 83.37(1)(i) PRN Psychotropic Medication N0427 DHS 83.38(1)(c) Leisure Time Activities N0431 DHS 83.38 (1)(g) Health Monitoring N0432 DHS 83.38(1)(h) Medication Administration N0452 DHS 83.41(3)(b) Food Safety N0490 DHS 83.44(2)(b) Toilet And Bathing Area N0497 DHS 83.45(1)(f) Furnishings Clean, Safe, And Maintained N0526 DHS 83.47(2)(e) Other Evacuation Drills N0616 DHS 83.55(6)(a) Bath And Toilet Areas: Water Supply Z0012 Wis Stat § 50.065(2)(bm) Out Of State Background Checks	N 196		
N 200	83.14(2)(e) Notify within 7 days of administrator change The licensee shall notify the department within 7 days after there is a change in the administrator. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not report to the Department within 7 days after there was a change in administrators.	N 200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 200	Continued From page 3 Findings include: On 12/02/2024 at approximately 8:50 a.m., Surveyor interviewed Director A. Surveyor reviewed the provider's contact information with Director A. Director A told Surveyor Former Administrator (FA) B was no longer the administrator as of 11/01/2024. Director A told Surveyor the licensee terminated their management company and FA B worked for that management company. Surveyor asked who the current administrator was. Director A did not know. Director A said the licensee hired a new nurse that will become the administrator. Director A only knew this person's first name. On 12/03/2024, Surveyor reviewed the Department's electronic record for the provider. Surveyor did not locate a report indicating there was a change in administrator. On 12/05/2024 at 9:42 a.m., Surveyor emailed Licensee F and Licensee G and asked who the current administrator was, and when they assumed the responsibility as the administrator. At 9:42 a.m., Surveyor received a confirmation email indicating the email was delivered. At 4:42 p.m., Surveyor received a notification email that indicated Licensee F read the email. As of 12/09/2024, Surveyor did not receive a response from Licensee F or Licensee G.	N 200		
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	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 389	Continued From page 4	N 389		

on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not review and revise Resident 9's individual service plan (ISP) when s/he had a change in his/her physical condition.

This requirement is being cited for the third time. See Statements of Deficiency (SOD) 8R5711, dated 06/27/2022 and SOD 8R5712, dated 11/10/2022.

Findings include:

On 08/28/2024, the Department received a complaint with allegations staff did not transfer a resident appropriately and the resident fell.

On 12/04/2024, Surveyor reviewed Resident 9's record.

Resident 9 had multiple diagnoses, including Parkinson's disease, venous stasis of both lower extremities, and diabetes mellitus with circulatory complications.

Resident 9's ISP, dated 11/14/2023, read, in part: "[Resident 9] will perform independent exercises to maintain strength and mobility and go for a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 389	Continued From page 5	N 389		

short walk in the building 1-2 times per day."

On 01/18/2024, staff documented: "Resident used call button to gonto [sic] the bathroom. Other staff went to assist and came to writer and needed writers help to transfer resident as [his/her] legs kept giving out. Both staff transferred resident from [his/her] chair to wheel chair [sic] to toilet. Both staff had to assist resident to stand ... both staff had to assist resident into [his/her] bed."

On 01/19/2024, staff documented: "Resint [sic] was still really weak in the legs and took both staff to assist resident with transfers."

An incident report, dated 02/07/2024, indicated Resident 9 fell when staff transferred Resident 9 to the toilet. The report read, in part: "Resident was standing up to transfer to toilet when [his/her] hands slipped off the grab bar. Staff helped lower resident to ground safely."

An incident report, dated 03/02/2024 at 8:00 p.m., indicated Resident 9 fell transferring to the toilet with one staff. The report read, in part: "Resident lost control of leg muscles and was slowly assisted to floor by staff ... will monitor - resident does have Parkinson's. If falls continue we will ask hospice for a Hoyer lift."

On 03/13/2024, Resident 9's Master Care Plan (ISP) was revised. The ISP now indicated Resident 9 required 2 staff to transfer and for staff to use a mechanical lift when Resident 9 was having a bad day.

In January 2024, Staff documented Resident 9 required 2 people to transfer. Staff continued to transfer Resident 9 with one person. Resident 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 389	Continued From page 6 fell on 02/07/2024 and 03/02/2024, when 1 person transferred Resident 9. On 12/05/2024 at approximately 4:00 p.m., Surveyor interviewed Director A. Director A said Resident 9's ISP should have been updated sooner to reflect more assistance with transfers. Director A said they have a new system now that allows them to make changes to the ISP in a clinical update. Director A told Surveyor they were improving on updating the ISPs with changes.	N 389		
N 392	83.35(4) Resident satisfaction evaluation. Satisfaction evaluation. At least annually, the CBRF shall provide the resident and the resident ' s legal representative the opportunity to complete an evaluation of the resident ' s level of satisfaction with the CBRF ' s services. The evaluation shall be completed on either a department form or a form developed by the CBRF and approved by the department. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not provide residents and/or their legal representatives, an opportunity to complete an evaluation of the resident's level of satisfaction within the community-based residential facility (CBRF) services. Two of 4 residents (Resident 4 and Resident 5) reviewed, who resided at the CBRF for greater than a year, did not receive a satisfaction survey. Findings include: The provider is licensed to care for up to 18 residents in the client groups of: irreversible	N 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 392	Continued From page 7 dementia/Alzheimer's disease, advanced age, and terminally ill. On 03/01/2022, the provider took ownership of the CBRF. On 12/02/2024, Surveyor reviewed the records of Resident 4, Resident 5, Resident 6, and Resident 7. Resident 4 was admitted to the facility on 07/27/2021, prior to the current licensee taking ownership of the CBRF. Resident 4 had a legal representative. Surveyor did not locate a satisfaction survey in Resident 4's record. Resident 5 was admitted to the facility on 09/04/2019, prior to the current licensee taking ownership of the CBRF. Resident 5 had a legal representative. Surveyor did not locate a satisfaction survey in Resident 5's record. On 12/02/2024 at approximately 5:00 p.m., Surveyor requested additional information from Director A to be emailed, including the most recent satisfaction surveys for Resident 4 and Resident 5. On 12/03/2024, Director A emailed Surveyor with additional information. This included a satisfaction survey for Resident 5, which was dated 12/03/2024. On 12/05/2024 at approximately 3:00 p.m., Surveyor interviewed Director A. Director A told Surveyor s/he was not aware the satisfaction surveys were a state requirement.	N 392		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a	N 407		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 407	Continued From page 8	N 407		

psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential benefits and side effects of the medication.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure residents were reassessed by a pharmacist, practitioner, or registered nurse as needed, but at least quarterly, for the desired response and possible side effects of scheduled psychotropic medications, for 3 of 3 residents reviewed who had scheduled psychotropic medications.

Resident 4, Resident 6, and Resident 8 had scheduled psychotropic medications and the provider did not ensure they were assessed at least quarterly for the desired response and possible side effects.

Findings include:

On 12/02/2024, Surveyor reviewed Resident 4's record.

Resident 4 had multiple diagnoses including: depression, anxiety disorder, restlessness, agitation, and Alzheimer's disease.

Resident 4 had an order for scheduled quetiapine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 407	Continued From page 9	N 407		

50 milligram (mg) tablets. Take 1.5 tablets in the morning, 0.5 tablets at noon, and 1 tablet at bedtime. Quetiapine is an antipsychotic medication.

Surveyor did not locate the psychotropic medication reviews in Resident 4's record.

On 12/02/2024, Surveyor reviewed Resident 6's record.

Resident 6 had multiple diagnoses, including mild cognitive impairment.

Resident 6 had an order for scheduled escitalopram 5 mg daily in the morning for depression/anxiety. Escitalopram is an antidepressant medication.

Surveyor did not locate the psychotropic medication reviews in Resident 6's record.

On 12/02/2024, Surveyor reviewed Resident 8's record.

Resident 8 had multiple diagnoses, including: dementia and depression.

Resident 8 had an order for the following scheduled psychotropic medications:
Aripiprazole 4 mg daily in the morning. Aripiprazole is an antipsychotic medication.
Escitalopram 20 mg 2 times a day.
Lorazepam 0.5 mg 2 times a day. Lorazepam is an antianxiety medication.
Quetiapine 50 mg 2 times a day. Quetiapine is an antipsychotic medication.

Surveyor did not locate the psychotropic medication reviews in Resident 8's record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 407	Continued From page 10 On 12/02/2024 at approximately 5:00 p.m., Surveyor interviewed Director A and requested additional information, including the last 6 months of psychotropic medication reviews for Resident 4, Resident 5, Resident 6, and Resident 7. On 12/04/2024 and 12/05/2024, Surveyor reviewed the additional information Director A emailed Surveyor. Resident 4 had a psychotropic medication review for his/her scheduled quetiapine, dated 06/06/2024 and 11/21/2024, by Registered Nurse (RN) H. A psychotropic medication review should have been completed by September 2024. Surveyor reviewed Resident 4's medication administration record (MAR) for August, September, October, and November 2024. Resident 4 received the scheduled quetiapine during those months. Resident 6 had a psychotropic medication review for his/her scheduled escitalopram, dated 06/06/2024 and 11/21/2024. A psychotropic medication review should have been completed by September 2024. Surveyor reviewed Resident 6's MAR for August, September, October, and November 2024. Resident 6 received the escitalopram during those months. Resident 8 had a psychotropic medication review, dated 12/02/2024 by RN H, for his/her scheduled psychotropic medications, including: aripiprazole, escitalopram, lorazepam, and quetiapine. Surveyor reviewed Resident 8's MAR for August, September, October, and November 2024. Resident 8 received the aripiprazole, escitalopram, lorazepam, and quetiapine during those months. Resident 8 was admitted to the	N 407		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 407	Continued From page 11 facility on 06/12/2024. Resident 8 should have had a psychotropic medication review prior to 12/02/2024. On 12/05/2024 at approximately 3:00 p.m., Surveyor interviewed Director A. Director a told Surveyor s/he talked to RN H. RN H was aware the scheduled psychotropic medication reviews should be completed quarterly. The provider did not ensure residents were reassessed by a pharmacist, practitioner, or registered nurse as needed, but at least quarterly, for the desired response and possible side effects of scheduled psychotropic medications.	N 407		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given.	N 408		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 408	Continued From page 12	N 408		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure each resident's individual service plan (ISP) where the resident received a PRN (as needed) psychotropic medication, included the rationale for use and a description of the behavior(s) that indicated the need for the PRN medications. The provider did not ensure the administrator, or designee, monitored at least monthly for the inappropriate use of the PRN medication and for presence of any adverse effects from the medication, for 4 of 4 residents reviewed with orders for PRN psychotropic medications.

Findings include:

On 08/28/2024 and 11/12/2024, the Department received complaints with allegations related to care and services for residents that had behaviors.

RESIDENT 4
On 12/04/2024, Surveyor reviewed Resident 4's record.

Resident 4 had an order for lorazepam 1 mg, every 2 hours as needed for restlessness, anxiety, and nausea.

Resident 4's Behavior Plan, read:
Target behavior - Agitation/restlessness
Triggers - Confusion/forgetfulness & wanting to talk to [his/her] [daughter/son]
Goals - [Resident 4] will have minimal times of irritability and restlessness.
Interventions - Quetiapine
When to update the nurse - If [Resident 4] has

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 408	Continued From page 13	N 408		

more than [his/her] usual episodes.
Target behavior - Repetitiveness
Triggers - Dementia, forgetfulness
Goals - N/A (non-applicable)
Interventions - kindly repeat yourself and redirect [him/her] and give [him/her] an activity to keep [him/her] busy.
When to update the nurse - N/A

The behavior plan did not contain a detailed description of behaviors that would indicate the need for the PRN lorazepam. The quetiapine was Resident 4's scheduled psychotropic medication. Resident 4's psychotropic medication reviews for his/her PRN lorazepam were dated 06/06/2024 and 11/21/2024. The provider did not have a monthly review of Resident 4's PRN psychotropic medications.

RESIDENT 5
On 12/04/2024, Surveyor reviewed Resident 5's record.

Resident 5 had an order for lorazepam 0.5 mg, every 4 hours as needed for anxiety or restlessness.

Resident 5's behavior plan did instruct staff on when to use lorazepam.

Resident 5's psychotropic medication review for his/her PRN lorazepam was dated 11/18/2024. The provider did not have a monthly review of Resident 4's PRN psychotropic medications.

RESIDENT 7
On 12/04/2024, Surveyor reviewed Resident 7's record.

Resident 7 had an order for lorazepam 1 mg,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 408	Continued From page 14	N 408		

every 2 hours PRN for anxiety/restlessness/nausea.

Resident 7's behavior plan read:
Target behavior - Anxiety
Triggers - declining
Goals - NA
Interventions - PRN lorazepam
When to update the nurse - If 1 prn does not work contact hospice to give another dose.

Resident 7's behavior plan did not contain a detailed description of behaviors that would indicate the need for the PRN lorazepam.

Resident 7's psychotropic medication reviews for his/her PRN lorazepam were dated 06/06/2024 and 11/18/2024. The provider did not have a monthly review of Resident 7's PRN psychotropic medications.

RESIDENT 8
On 12/04/2024, Surveyor reviewed Resident 8's record.

Resident 8 had the following PRN psychotropic medication orders:
Haloperidol 0.5 mg, every 4 hours as needed for agitation.
Lorazepam 0.5 mg, every 4 hours as needed for anxiety.

Resident 8's behavior plan read:
Target behavior - physically touching, slapping, or grabbing staff or residents.
Triggers - mention of [his/her [spouse], evening time approaching.
Goals - [Resident 8] to remain calm and verbalize [his/her] frustrations and thoughts without being aggressive.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 408	Continued From page 15 Interventions - redirect to an activity - [Resident 8] likes to read the newspaper or watch the news on TV, last intervention is to administer ordered PRN medication for agitation. When to update the nurse - When redirection and medications do not work. Target behavior - wandering, attempts to elope. Triggers - wanting to go home or to see [his/her] [spouse]. Goals - [Resident 8] remains in building and does not attempt to elope. Interventions - Attempt to redirect [Resident 8] by asking [him/her] if [s/he'd] like to call [his/her] [spouse], distract [him/her] with an activity of reading a magazine or watching the news on TV which [s/he] enjoys. When to update the nurse - If interventions are not effective or [s/he] exhibits worsening behavior. Target behavior - Refusing daily cares, medications, or meals/snacks. Triggers - Varies but often times thoughts of family and home which [s/he] obsesses over because [s/he] misses [his/her] past life at home. Goals - Keep [Resident 8] occupied with activities [s/he] enjoys such as walks outside, reading magazines, watching the news on TV, and socializing with other residents. Interventions - Offer [Resident 8] activities that [s/he] enjoys such as walks outside, reading magazines, watching the news on TV, and socializing with other residents. When to update the nurse - If interventions are not successful or [s/he] has 2 consecutive refusals. Resident 8's behavior plan did not contain a detailed description of behaviors that indicate the need for the PRN lorazepam.	N 408		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 408	Continued From page 16 Resident 8's psychotropic medication reviews for his/her PRN lorazepam were dated 06/06/2024 and 11/18/2024. The provider did not have a monthly review of Resident 4's PRN psychotropic medications. Resident 8's master care plan, dated 12/02/2024, included a psychotropic medication review for Resident 8's scheduled and PRN psychotropic medications. Surveyor did not receive any other psychotropic reviews for Resident 8. On 12/05/2024 at approximately 3:00 p.m., Surveyor interviewed Director A. Director A told Surveyor that s/he spoke to Registered Nurse (RN) H. Director A said RN H was aware PRN psychotropic medications needed to be monitored monthly.	N 408		
N 427	83.38(1)(c) Leisure time activities. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by:	N 427		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 427	Continued From page 17	N 427		

Based on observation, record review and interview, the provider did not provide a daily activity program to meet the interests and capabilities of the residents. The provider did not post their activity schedule.

Findings include:

On 11/12/2024, the Department received a complaint that alleged there was not a daily activity program.

On 12/02/2024 at approximately 9:00 a.m., Surveyor observed a large white board near the dining area with the month of December on it. For 12/02/2024, the white board indicated it was Cyber Monday. There were no activities listed for the day.

On 12/02/2024 at approximately 9:10 a.m., Surveyor interviewed Resident 1 and asked about activities. Resident 1 told Surveyor there was "nothing." Then s/he told Surveyor s/he watched his/her television, read his/her Bible, prayed and did the exercises his doctor told him/her to do. Resident 1 told Surveyor there was Bingo once a week.

On 12/02/2024 at approximately 9:35 a.m., Surveyor interviewed Resident 2. Resident 2 told Surveyor a chaplain came in and did devotions and singing with him/her about once per week. S/he said a friend came to the facility to do bingo but not on a regular basis. Surveyor asked Resident 2 if there was activity each day. Resident 2 replied, "No." Resident 2 told Surveyor s/he would like it if there was an activity each day.

On 12/05/2024 at approximately 3:00 p.m., Surveyor interviewed Director A. Director A told

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 427	Continued From page 18 Surveyor they did not have an activity director. S/he said they rely on the staff to do activities. Surveyor asked if there was an activity daily. Director A replied, "I don't think it's every day. That's why I wanted to hire an activity person."	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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 431	Continued From page 19	N 431		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not record changes in the resident's health status in the resident's record and did not document communication with the resident's physician and health care providers, for 5 of 5 residents reviewed.

Findings include:

On 08/28/2024 and 11/12/2024 the Department received complaints that included concerns related to monitoring the health of residents.

On 12/02/2024, Surveyor reviewed the records of Resident 2, Resident 4, Resident 5, Resident 7, and Resident 8, with additional information being reviewed 12/04/2024 and 12/05/2024.

RESIDENT 2
Resident 2 was admitted to the facility on 05/22/2024. S/he had diagnoses of liver cirrhosis, congestive heart failure, diabetes, anemia, and esophageal varices.

Resident 2's medication administration record (MAR) for August 2024 and September 2024, indicated s/he was hospitalized on 08/17/2024 for 1 month.

Staff did not document on Resident 2 from 06/26/2024 - 09/22/2024.

On 12/05/2024 at approximately 3:00 p.m., Surveyor interviewed Director A. Surveyor explained concerns with the lack of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 431	Continued From page 20	N 431		

documentation in the resident's records. Surveyor asked why Resident 2 was hospitalized from August into September. Director A told Surveyor Resident 2 kept getting infections. Surveyor requested documentation of the hospitalization.

On 12/06/2024, Director A emailed Surveyor Resident 2's hospitalization documentation. Resident 2's discharge summary from the hospital indicated s/he presented to the emergency department on 08/15/2024 with reports of chest pain. S/he had elevated blood sugars, a fever, and was confused and drowsy. S/he was found to be septic with unknown cause. It was determined Resident 2 had prosthetic valve endocarditis (infection of a prosthetic heart valve). Resident 2 remained hospitalized from 08/17/2024 - 09/17/2024.

The provider did not have any staff documentation prior to Resident 2 being sent to the emergency department or when Resident 2 returned from the hospital until 09/22/2024.

On 09/22/2024, Registered Nurse (RN) H documented: "This is a one-time reminder to all of you that you NEED to be notifying me of low (70 or lower) and high (300 or over) blood sugars. My personal phone number is available to all of you but just in case you need a reminder [phone #]. If you choose not to notify me when blood sugars are outside of specified parameters that are very clearly defined in your service that you have all charted on, then you will be having a conversation with me. If my direction is not clear to you, please feel free to reach out to me for clarification; I am more than happy to clarify."

On 09/23/2024, Resident 2's endocrinologist nurse practitioner wrote insulin orders, which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 431	Continued From page 21	N 431		

included an order to call if Resident 2's blood sugars were < 70 or > 350.

Resident 2 had a discharge summary from the hospital that indicated Resident 2 was hospitalized again from 09/24/2024 - 09/28/2024, with a primary diagnosis of acute blood loss anemia. The summary indicated Resident 2 was hospitalized after s/he was noted to have a 30-pound weight gain, low hemoglobin, low platelets, and melena (dark, tarry stool indicating blood in the stool).

Staff did not document this hospitalization or when s/he returned from the hospital in Resident 2's record .

From 09/23/2024 - 12/02/2024, Resident 2's blood sugars read over 300, 81 times. Staff documented notification to a health care provider 5 of those 81 incidents as follows:
On 10/10/2024 - staff documented along with blood sugar of 370: "Facility Nurse is onsite and is aware."
On 10/16/2024, staff documented along with blood sugar of 407: "Was instructed to give additional 10 units per hospice."
On 10/17/2024, staff documented along with blood sugar of 451: "Was instructed by hospice to administrate 10 more units at 1 pm."
On 10/23/2024, staff documented along with a blood sugar of 425: "Hospice was notified and will send a nurse."
On 10/25/2024, staff documented along with a blood sugar of 364: "[Director A] informed [RN H]."

This documentation in Resident 2's record was the only information that indicated staff notified the nurse or hospice related to Resident 2's blood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 431	Continued From page 22	N 431		

sugars being greater than 300.

On 12/05/2024 at approximately 3:00 p.m., Surveyor interviewed Director A. Director A told Surveyor that staff do notify either him/her or RN H when resident's blood sugars are out of range. Surveyor explained that there were minimal notes indicating the staff notified the RN or health care provider related to Resident 2's blood sugars. Director A told Surveyor they usually see hospice staff on a daily basis and talk to them in person.

RESIDENT 4
Resident 4 was admitted to the facility on 07/27/2021, prior to the current licensee owning the facility. S/he had multiple diagnoses, including heart disease, diabetes, hypertension, Alzheimer's disease, depression, anxiety, restlessness, and agitation.

Staff did not have document notes on Resident 4 after 09/25/2024, other than in the services provided and incident reports.

On 12/05/2024 at approximately 3:00 p.m., Surveyor interviewed Director A. Director A told Surveyor Resident 4 had "weeping legs." S/he said this was due to Resident 4's edema and Resident 4 picks at his/her legs.

On 12/10/2024, Surveyor reviewed hospice notes for Resident 4 from 09/01/2024 to 12/02/2024.

The hospice nurses documented daily dressing changes to Resident 4's right lower extremity that was weeping.

On 10/04/2024, the hospice nurse documented Resident 4 was having pain and was tearful. The note read, in part: "[Resident 4] was tearful and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 431	Continued From page 23	N 431		

reporting pain to [his/her] right shin. [Resident 4] showed 6/10 non verbal pain using the PAINAD scale during assessment ..."

On 11/05/2024, the hospice nurse documented, in part: "RN writer removed [Resident 4's] dressing from [his/her] right lower leg and it was saturated with purulent drainage ...RN writer changed [Resident 4's] socks as [his/her] socks were wet from the drainage of [his/her right leg."

On 11/15/2024, the hospice nurse documented Resident 4's right leg was showing signs of infection, as it was red and warm to the touch. Resident 4 was started on an antibiotic.

There was no staff documentation to indicate Resident 4's legs were weeping, required dressing changes, or became infected and required an antibiotic.

Resident 4's individual service plan (ISP), dated 03/01/2024, indicated staff were to notify the nurse if Resident 4's blood sugar was greater than 300.

From 09/01/2024 - 12/01/2024, Resident 4's blood sugar was greater than 300, 55 times. Staff did not document communication with the nurse or health care provider regarding the blood sugar being greater than 300.

RESIDENT 5
Resident 5 was admitted to the facility on 09/04/2019, prior to the current licensee owning the facility. S/he had multiple diagnoses, including heart disease, cerebral infarction (stroke), hypertension, and dementia.

There were 3 staff notes documented on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 431	Continued From page 24 Resident 5 in 2024 on the following dates: 03/23/2024, 06/01/2024, and 07/10/2024. There was no other staff documentation on Resident 5 other than services provided. On 12/04/2024, Surveyor emailed Director A and requested any other documented notes for Resident 5. On 12/04/2024, Director A emailed Surveyor, which read, in part: "I can double check the notes but there is usually nothing to document with [him/her] - [s/he] stays the same ..." On 12/05/2024, Surveyor reviewed hospice documentation for Resident 5. On 09/23/2024, the hospice caregiver documented that staff reported to him/her Resident 5 had a blister on his/her right buttock. On 09/26/2024, the hospice caregiver documented Resident 5 had open blisters to both buttocks. On 10/03/2024, the hospice caregiver documented Resident 5 had a blister on his/her right inner thigh that opened during his/her shower. On 10/07/2024, the hospice nurse documented that there was a dressing to Resident 5's right thigh and it was healing appropriately. On 10/10/2024, the hospice caregiver documented Resident 5 had an open area to his/her coccyx. On 10/16/2024, the hospice caregiver documented open area to Resident 5's coccyx.	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 431	Continued From page 25 On 11/07/2024, the hospice caregiver documented Resident 5's bottom looked good and there were no open areas. On 11/27/2024, the hospice caregiver documented, in part: "has a big open sore on coccyx." The provider did not document on Resident 5's changes in skin, in his/her record. On 12/05/2024 at approximately 3:00 p.m., Surveyor interviewed Director A. Director A told Surveyor Resident 5's skin and wounds were an ongoing challenge as Resident 5 does not move. S/he said they are working with hospice for Resident 5's wounds. RESIDENT 7 Resident 7 was admitted to the facility on 09/15/2023. S/he had multiple diagnoses, including heart disease, hypertension, and multiple strokes. On 12/02/2024 at approximately 10:00 a.m., Surveyor interviewed Resident 10. Resident 10 was Resident 7's spouse and they shared a room at the facility. Resident 10 told Surveyor Resident 7 had a sore above his/her tailbone that was open. There was no staff documentation after 08/11/2024, other than services provided. On 12/05/2024, Surveyor emailed Director A and asked if there was any further staff documentation after 08/11/2024, and if there was any documentation on his/her skin.	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 431	Continued From page 26 On 12/05/2024, Director A emailed Surveyor, which read, in part: "It looks like there are no additional notes for [Resident 7]. [S/he] has more of like a scrape [sic] not an actual sore ..." On 12/10/2024, Surveyor reviewed hospice notes from 09/01/2024 - 12/02/2024. On 09/04/2024, the hospice nurse documented, in part: "[Resident 7] has a small open area on coccyx area. Area is slightly red around the wound." On 09/13/2024, the hospice nurse documented, in part: "[Resident 7] did tell RN writer that [his/her] butt was hurting earlier today but was not hurting right now ... Pressure sore to the top of [his/her] coccyx has broken open and gotten a bit larger than last week ..." On 10/25/2024, the hospice nurse practitioner documented the following note, which indicated Resident 7 had a change in condition: "[Resident 7] has had episodes of CVA (cerebrovascular accident) sx (symptoms) x 2 in the past 2 months. [S/he] has lost 30 lbs (pounds) since June 2024. [Resident 7] sleeps anytime [s/he] is idle. [S/he] is completely dependent and needs total assistance with all aspects of ADLs (activities of daily living). [S/he is now a hoyer [sic] lift and was still able to bear weight about 3 months ago. [S/he] is now fed, has more tremors in upper extremities. [S/he] has definitely declined in the past 2 months." On 11/21/2024, the hospice nurse documented, in part: "Sore assessed on coccyx. Stoma paste applied. It wasn't draining but was red and open. Approximately dime size ... s/he was grimacing, and it was believed that [s/he] was having pain as a result of sitting on the side of the open sore ..."	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 431	Continued From page 27	N 431		

The provider's staff did not document changes in Resident 7's condition or on his/her wound to his/her coccyx area.

RESIDENT 8
Resident 8 was admitted to the facility on 06/12/2024. Resident 8 had diagnoses, including dementia, heart disease, depression, hypertension, and diabetes.

There was no staff documentation between 07/08/2024 and 11/03/2024, other than incident reports and services provided. In November 2024, staff did document on Resident 8's behaviors.

On 09/09/2024, the hospice nurse documented Resident 8 complained of pain and tenderness to his/her right great toe. Daily dressing changes were ordered. The nurse continued to document dressing changes to Resident 8's toe through 11/22/2024.

There was no staff documentation on Resident 8's toe.

On 12/05/2024 at approximately 3:00 p.m., Surveyor interviewed Director A. Director A told Surveyor Resident 8 hurt his/her toe during one of his/her falls. S/he said it was like a rug burn. S/he said his/her toe rubbed on his/her shoe and sock and it took a long time to heal.

SUMMARY
On 12/05/2024 at approximately 3:00 p.m., Surveyor interviewed Director A. Surveyor explained the health monitoring regulation and the requirement to observe and document changes in a resident's physical and mental

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 431	Continued From page 28 health in the resident's record, along with all communication with the resident's physician and health care providers. Director A told Surveyor, s/he agreed they needed to do better on their documentation.	N 431		
N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider failed to provide medication administration appropriate to meet the needs of 5 of 6 residents reviewed. Findings include: On 08/28/2024 and 11/12/2024, the Department received complaints that included concerns related to medication administration. RESIDENT 2 Resident 2 had a diagnosis of liver cirrhosis. On 12/05/2024, surveyor reviewed Resident 2's medication administration record (MAR) for	N 432		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 432	Continued From page 29	N 432		

August, September, October, and November 2024.

In October 2024, Resident 2's gabapentin was circled and noted as: "not taking," "don't have," and "does not want" 15 times. There was no documentation in resident 2's record that indicated the provider notified Resident 2's physician of his/her refusal to take the gabapentin.

In November 2024, there were 39 entries indicating Resident 2 refused his/her lactulose.

"This drug is used by mouth or rectally to treat or prevent complications of liver disease (hepatic encephalopathy). It does not cure the problem, but may help to improve mental status. Lactulose is a colonic acidifier that works by decreasing the amount of ammonia in the blood. It is a man-made sugar solution." (Retrieved on 12/12/2024 from https://www.webmd.com/drugs/2/drug-12002-7202/lactulose-for-encephalopathy-oral/lactulose-liver-oral-rectal/details).

"Hepatic encephalopathy is a serious and potentially reversible condition that can affect individuals with advanced liver dysfunction. It is characterized by a range of neuropsychiatric and neuromuscular abnormalities resulting from the buildup of toxic substances in the bloodstream, ultimately impacting brain function." (Mandiga P, Kommu S, Bollu PC. Hepatic Encephalopathy. Last updated 2024 Mar 7 StatPearls Publishing; 2024 Jan-. Retrieved on 12/12/2024 from: https://www.ncbi.nlm.nih.gov/books/NBK430869/).

There was no documentation in Resident 2's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 432	Continued From page 30	N 432		

record to indicate the provider updated Resident 2's physician on his/her refusal to take the lactulose.

On 12/05/2024 at approximately 3:00 p.m., Surveyor interviewed Director A. Director A told Surveyor they have been educated that lactulose is not used just for Resident 2 to have a bowel movement. S/he said they were instructed on the purpose of the lactulose. Director A said Resident 2 would have diarrhea and refuse the lactulose, but now they understand the purpose of the medication.

RESIDENT 4
On 12/05/2024, surveyor reviewed Resident 4's MAR for August, September, October, and November 2024.

In August and September 2024, Resident 4's gabapentin was circled numerous times with reason that the medication was out.

A hospice registered nurse (RN) note, dated 09/10/2024, read: "Med Rec (medication reconcile) Completed. Discrepancy on Gabapentin order. Order was discontinued on 8-2-24 and faxed 3 different times asking to please get discontinued and removed from MAR. Medication is still active on their MAR as of 9-10-24."

From 08/02/2024 - 09/10/2024, staff documented the gabapentin was administered 15 times.

Resident 4's November 2024 MAR indicated s/he had an order for clindamycin (an antibiotic) for 5 days starting 11/16/2024. Resident 4's MAR indicated staff continued to administer on 11/23/2024 at 8:00 a.m. and noon, 11/24/204 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 432	Continued From page 31 noon, and 11/272024 at 8:00 a.m. On 10/04/2024, the hospice nurse documented Resident 4 was having pain and was tearful. The note read, in part: "[Resident 4] was tearful and reporting pain to [his/her] right shin. [Resident 4] showed 6/10 non verbal pain using the PAINAD scale during assessment ..." The hospice nurse noted s/he contacted the nurse practitioner who ordered tramadol scheduled every 8 hours and 2 x/day as needed for pain. Resident 4's November 2024 MAR indicated Resident 4 was out of his/her tramadol on the following dates: 11/04/2024, 11/05/2024, and 11/06/2024. RESIDENT 6 On 12/05/2024, Surveyor reviewed Resident 6's MAR for August, September, October, and November 2024. From 08/01/2024 - 10/06/2024, Resident 6 had an order on his/her MARs for Alphagan P eye drop solution, instill 1 drop to both eyes twice daily. From 08/01/2024 - 10/06/2024, Resident 6 had an order on his/her MARs for brimonidine eye drop solution, instill 1 drop to both eyes twice daily. Brimonidine is the generic name of Alphagan P. It is a medication for glaucoma. From 08/01/2024 - 10/06/2024, staff documented they administered both eye drops to Resident 6, 30 times. RESIDENT 7	N 432		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 432	Continued From page 32 On 12/05/2024, Surveyor reviewed Resident 7's MAR for August, September, October, and November 2024. Resident 7's August and September MAR included an order for atorvastatin, with a start date of 08/27/2024 and an end date of 09/12/2024. The medication was documented as given daily during those dates. The hospice RN documented, on 09/10/2024: "Med Rec Completed 9-10-24. Orders Refaxed to VitaCare requesting that Atorvastatin be discontinued as it should have been discontinued on admit and is still on Med Profile." Resident 7's November 2024 MAR included an order for atorvastatin with a start date of 11/01/2024 and an end date of 11/20/2024. The MAR indicated the atorvastatin was administered on 11/03, 11/05, 11/06, 11/09, 11/10, 11/13, 11/14, 11/15, 11/17, 11/18, 11/19, and 11/20. The other dates were circled and indicated the medication was not available. Resident 7's November MAR indicated an order for tramadol every evening between 5:00 p.m. - 9:00 p.m. for pain. From 11/11/2024 - 11/15/2024, staff documented the medication was not available. On 12/05/2024, Surveyor emailed Director A and asked about Resident 7's atorvastatin and tramadol that was not administered in November. On 12/05/2024, Director A emailed Surveyor, which read, in part: "Atorvastatin - transferred over it was supposed to be D/C (discontinued) but when we had the switch over, we had medication that ended up messing with our	N 432		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 432	Continued From page 33	N 432		

EMAR (electronic medication administration record). As for the tramadol - I do not recall what happened. We are working more diligent with ordering medications. As I explained while by the med (medication) cart [sic] we are doing weekly audits on our med cart to make sure we no longer go without any medications including scheduled/prn/NARCS (narcotics)."

RESIDENT 8
On 12/04/2024, Surveyor reviewed Resident 8's MAR for August, September, October, and November 2024.

Resident 8 was admitted to the facility on 06/12/2024.

Resident 8's August 2024 MAR indicated Resident 8 missed several doses of his/her prescribed aripiprazole (an antipsychotic medication), with reasons documented that s/he was out or that it was not received from the pharmacy.

On 08/15/2024 and 08/16/2024, Resident 8 missed his/her doses of metformin, galantamine, escitalopram and losartan with reason given as did not receive from pharmacy.

Resident 8's September and October 2024 MAR indicated s/he missed several medications. From 09/12/2024 - 10/09/2024, Resident 8 missed his/her aripiprazole medication, with the reason the medication was out. S/he also missed his/her escitalopram from 09/12/2024 - 10/09/2024, galantamine from 09/16/2024 - 10/09/2024, and metformin from 09/12/2024 - 10/09/2024. His/her scheduled lorazepam was missed in the morning of 09/16, 09/17, 09/18, and 09/20; It was also missed in the evening of 09/16, 09/17, 09/18, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 432	Continued From page 34 09/19. Staff documented the lorazepam was out. Resident 8's November 2024 MAR indicated s/he did not receive his/her losartan on the following dates: 11/07, 11/08, 11/11, 11/12, 11/16, 11/17, 11/22, 11/25, and 11/26. Staff documented they did not have the losartan to administer. Resident 8 also missed his/her scheduled doses of 4:00 p.m. lorazepam on 11/04, 11/05 and 11/06. Staff documented they were out of this medication. On 12/04/2024, Surveyor emailed Director A and asked why Resident 8 had several missed medications from August - November 2024. On 12/04/2024, Director A emailed Surveyor, which read, in part: "So when [s/he] came to us [s/he] was using VA (Veterans Affairs) medications. [S/he] then got switched to [hospice] and I was in the understanding that 1. The VA meds (medications) would go straight to pharmacy or be covered by hospice (depending on the medication). [His/her] [spouse] ended up bringing me medications that were sent to [him/her] and I told [him/her] I did not need them. In the mean time [sic] I reordered from pharmacy and they said that we need to get them from the VA. The [spouse] ended up destroying those medications. It took hospice, pharmacy and myself a long while to figure out everything. There was so much miscommunication between all of us. It was just confusing due to the VA med situation. It was a whole thing. It is now fixed and we should not be with out [sic] [his/her] medication ..." The provider failed to provide medication administration appropriate to meet the needs of	N 432		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 432	Continued From page 35 the residents.	N 432		
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. This Rule is not met as evidenced by: Based on observation and interview, the provider did not store food under sanitary conditions. The refrigerator was dirty and the lasagna was not covered. Findings include: On 11/12/2024, the Department received a complaint with allegations the food was not being stored properly.	N 452		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 452	Continued From page 36 On 12/02/2024 at approximately 9:45 a.m., Surveyor observed the kitchen. The refrigerator had something red spilled onto the shelves. The covers of the cottage cheese and sour cream had spills over them. The bottom shelf, which held fresh vegetables that were not in a sealed package, had spills on and under it. The lasagna that was for lunch was stored on the top shelf in the refrigerator, sitting on top of other containers. The lasagna was not covered and was touching the top of the inside of the refrigerator. On 12/02/2024 at approximately 4:45 p.m., Surveyor observed the refrigerator with Director A. The refrigerator remained in the same condition as it was in the morning, except the lasagna was consumed. Director A told Surveyor it will need to be cleaned. On 12/05/2024 at approximately 3:00 p.m., Surveyor interviewed Director A. Director A told Surveyor the overnight shift prepared the lasagna and they should have covered it and labeled it. Director A said the refrigerator should be cleaned nightly.	N 452		
N 490	83.44(2)(b) Toilet and bathing area. All toilet and bathing areas, facilities and fixtures shall be clean and in good working order. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all bathrooms were clean and in working order. Findings include: On 08/28/2024 and 11/12/2024, the Department	N 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 490	Continued From page 37	N 490		

received complaints. Both complaints included concerns related to cleanliness and odors.

On 12/02/2024 at approximately 8:45 a.m., Surveyor arrived at the facility. Surveyor noticed an odor like urine when entering the facility.

On 12/02/2024 at approximately 10:15 a.m., Surveyor observed Resident 4's bathroom. The lid for the water tank on the back of the toilet was missing.

On 12/02/2024 at approximately 11:00 a.m., Surveyor observed Resident 3's bathroom. There was an odor of feces and it appeared there were feces smeared on the toilet, the floor, the wall, and the storage next to the toilet. The water in the toilet was running. There was no toilet paper in the bathroom.

On 12/02/2024 at approximately 4:50 p.m., Surveyor observed these bathrooms with Director A. Resident 4 and Resident 3's bathrooms were in the same condition as they were in the morning. Director A told Surveyor Resident 4 just broke the lid from the toilet tank. S/he said Resident 3 picks at things like toilet paper steady throughout the day.

On 12/05/2024 at approximately 3:00 p.m., Surveyor interviewed Director A. Director A told Surveyor the resident bathrooms should be cleaned daily and as needed. S/he said s/he was purchasing a new handle for Resident 3's toilet and a new lid for Resident 4's toilet.

The provider did not ensure all bathrooms were clean and were in working order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 38	N 497		
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 ensure all furnishings were clean. The chairs in the dining room appeared dirty and stained. Findings include: On 12/02/2024 at approximately 9:00 a.m., Surveyor toured the facility and observed the dining room. There were multiple cloth chairs in the dining room that appeared to be dirty or stained. On 12/05/2024 at approximately 3:00 p.m., Surveyor interviewed Director A and asked how often the dining room chairs were cleaned. Director A said the overnight shift cleans them weekly. S/he said they have tried many things to clean them and it was "weird material," which did not appear clean. Director A said new dining room chairs were on their "to get list."	N 497		
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. This Rule is not met as evidenced by: Based on record review and interview, the	N 526		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 39 provider did not conduct "other" (other than fire) evacuation drills, such a tornado, flooding, or other emergency/disaster drills, at least semi-annually in 2023 and 2024. Findings include: The provider is licensed to care for up to 18 residents in the client groups of irreversible dementia/Alzheimer's disease, terminally ill, and advanced age. On 12/02/2024, Surveyor reviewed the facility's safety reports for 2023 and 2024, including evacuation drills. Surveyor did not locate any "other" evacuation drills for 2023 and 2024 other than fire drills and an elopement training. On 12/02/2024 at approximately 5:00 p.m., Surveyor requested additional information from Director A, including other evacuation drills for 2023 and 2024. On 12/05/2024 at approximately 3:00 p.m., Surveyor interviewed Director A. Director A told Surveyor they did not have documentation of evacuation drills, other than fire drills.	N 526		
N 616	83.55(6)(a) Bath and toilet areas: water supply. The CBRF shall connect each sink, bathtub and shower to hot and cold water, and supply adequate hot water to meet the needs of the residents. This Rule is not met as evidenced by: Based on observation and interview, the provider	N 616		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 616	Continued From page 40	N 616		

did not ensure the supply of hot water was adequate to meet the needs of all residents.

The hot water heater was not working in half of the building, including the kitchen.

Findings include:

On 12/02/2024 at approximately 9:30 a.m., Surveyor interviewed Resident 2. Resident 2 told Surveyor that as of yesterday morning (12/01/2024), there was no hot water. Resident 2 said they had hot water in half of the building. S/he said s/he could have showered in an open room but preferred to shower in his/her own bathroom. Surveyor checked the hot water temperature at Resident 2's bathroom sink. The water temperature was 67 ° Fahrenheit (F).

On 12/02/2024 at 9:40 a.m., Surveyor checked the hot water temperature at the kitchen sink faucet. The hot water temperature was 66.7 ° F. The dishwasher was running at the time.

On 12/02/2024 at approximately 9:43 a.m., Surveyor asked Director A what was wrong with the hot water. S/he said it quit working on 12/01/2024. S/he said the residents could use an empty room to shower in and s/he purchased paper products to serve meals on.

On 12/02/2024 at approximately 9:45 a.m., Surveyor checked the water temperature in room 15, which was empty. The water temperature at the bathroom sink reached 105 ° F.

On 12/02/2024 at approximately 4:45 p.m., Surveyor observed the hot water heater with Director A. The temperature gauge was reading 74 ° F. Director A told Surveyor they had a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 616	Continued From page 41 problem with the hot water heater a couple months ago. S/he said that, at that time, they fixed some wiring. Director A said they will probably have to get a new hot water heater. On 12/04/2024, Director A emailed Surveyor, which read: "Update on water heater - someone came to look at it. We do need a new one so they are going to move on it ASAP (as soon as possible) we should have it here within 1 - 2 days [s/he] said. So by the end of the week it will be fixed." On 12/05/2024 at approximately 3:00 p.m., Surveyor interviewed Director A. Director A told Surveyor the hot water was not fixed yet. S/he said a person was there yesterday (12/04/2024) and the new hot water heater should be there by tomorrow (12/06/2024). Surveyor requested documentation of the last time the hot water heater quit working. As of 12/09/2024, Surveyor did not receive additional information related to the hot water heater. The provider did not ensure the supply of hot water was adequate to meet the needs of all residents.	N 616		
Z 012	50.065(2)(bm) OUT OF STATE BACKGROUND CHECKS If the person who is the subject of the search under par. (am) or (b) is not a resident of this state or if at any time within the 3 years preceding the date of the search that person has not been a resident of this state, or if the department or entity	Z 012		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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
Z 012	Continued From page 42 determines that the person's employment, licensing, or state court records provide a reasonable basis for further investigation, the department or the entity shall make a good faith effort to obtain from any state or other United States jurisdiction in which the person is a resident or was a resident within the 3 years preceding the date of the search information that is equivalent to the information specified in par. (am) 1. or (b) 1. The department or entity may require the person to be fingerprinted on 2 fingerprint cards, each bearing a complete set of the person's fingerprints. The department of justice may provide for the submission of the fingerprint cards to the federal bureau of investigation for the purposes of verifying the identity of the person fingerprinted and obtaining the records of his or her criminal arrests and convictions. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have evidence of making a good faith effort to obtain out of state background check information for 1 of 1 applicable staff member. Caregiver D indicated on the Background Information Disclosure (BID) form that s/he had resided in the state of Arizona within the previous 3 years. Findings include: On 12/02/2024, Surveyor reviewed Caregiver D's employee record. Caregiver D's date of hire was 09/30/2024.	Z 012		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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
Z 012	Continued From page 43 Caregiver D's background information disclosure (BID), dated 09/23/2024, indicated s/he resided in Arizona within the past 3 years. Surveyor did not locate an out of state background check for Caregiver D. On 12/02/2024, at approximately 5:00 p.m., Surveyor requested additional information from Director A, including Caregiver D's out of state background check. Surveyor did not receive this information. On 12/05/2024 at approximately 3:00 p.m., Surveyor interviewed Director A. Director A told Surveyor s/he did not have Caregiver D's out of state background check.	Z 012		