STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018752	A. BUILDING: _____ B. WING _____	C 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING SPOONER II	W7184 GREEN VALLEY RD SPOONER, WI 54801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 08/14/2025, Surveyors conducted a standard survey and complaint investigation at Vitacare Living Spooner II. Data was collected through 08/20/2025. Two of 2 complaints were substantiated. Four violations were identified. Census: 8	N 000		
N 205	83.14(2)(j) Not permit a condition of substantial risk. The licensee may not permit the existence or continuation of any condition which is or may create a substantial risk to the health, safety or welfare of any resident. This Rule is not met as evidenced by: Based on observation and interview, the provider permitted the existence of a condition which created a substantial risk to the welfare of residents. Findings include: The provider is licensed to care for 15 residents in the client groups advanced age, physically disabled, irreversible dementia/Alzheimer's disease, and terminally ill. On 08/14/2025, at approximately 10:35 AM, Surveyors observed that Caregiver B was the only staff working at the provider, and that s/he had his/her juvenile child with him/her. Surveyors observed the lounge area television had cartoons	N 205		

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

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N 205	Continued From page 1 on. At approximately 11:00 AM, Surveyors interviewed Regional Director (RD) A, who stated Caregiver B had been bringing his/her child to work with him/her that month as Caregiver B had trouble finding a babysitter. RD A stated the residents did not seem to mind Caregiver B's child, but that Resident 3 did not like the child. At approximately 12:04 PM, Surveyor observed Caregiver B's child running in the kitchen and yelling. At approximately 1:30 PM, Surveyors observed Caregiver B's child screaming and yelling loudly and playing audio on an electronic device at a high volume in the connected lounge and dining room area. Surveyors observed the child lying on one of the lounge couches. Surveyors observed Caregiver B tend to his/her child when the child would scream. Surveyors observed Resident 3 and Resident 5 sitting at a table in the dining room. Resident 3 and Resident 5 were showing signs of agitation when Caregiver B's child screamed, such as placing their heads in their hands, wincing, and shaking their heads. At approximately 1:30 PM, Surveyors interviewed Caregiver B and asked about working while his/her child was present. Caregiver B confirmed that having his/her child at work with him/her was not ideal. At approximately 2:15 PM, Surveyor interviewed Resident 3, who stated Caregiver B allowed his/her child to "run wild." Resident 3 stated Caregiver B's child would scream and open doors at all hours, and that when the child was there, cartoons were on for him/her. Resident 3 stated	N 205		

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N 205	Continued From page 2 the residents got to watch movies occasionally in the evening, but that cartoons were on for Caregiver B's child. On 08/20/2025, Surveyors reviewed resident records: Resident 3 is diagnosed with agitation and generalized anxiety disorder. - Resident 3's care plan, dated 04/18/2025, read, "...Manage behavior - Elopement threat...Target behavior- Exit seeking, attempting to leave while outside smoking...Interventions- staff to supervise resident while outside smoking..." Resident 4 is diagnosed with agitation/aggression, migraine headaches, and moderate dementia due to Parkinson's disease with anxiety. - Resident 4's care plan, dated 06/17/2025, indicated s/he was on daily safety checks every 15 minutes. - A fall incident report for Resident 4, dated 07/03/2025, which read, "...Actions taken to prevent future falls: Staff to continue 15 minute safety checks..." The provider permitted the existence of a condition which created a substantial risk to resident welfare.	N 205		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the	N 352		

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N 352	Continued From page 3	N 352		

right to refuse medication unless the medication is court ordered.

This Rule is not met as evidenced by:
Based on interview and record review, the provider did not ensure Resident 2 received his/her medication as prescribed.

Findings include:

The provider is licensed to care for 15 residents in the client groups advanced age, physically disabled, irreversible dementia/Alzheimer's disease, and terminally ill.

On 08/14/2025 at approximately 1:05 PM, Surveyor interviewed Resident 2, who stated s/he hadn't received doses of one of his/her medications for six days.

At approximately 1:30 PM, Surveyor reviewed Resident 2's records, which included:

- Resident 2's pre-admission assessment, dated 04/02/2025, listed his/her diagnoses, which included bipolar disorder and schizophrenia.

- Resident 2's medication administration record (MAR) for August 2025, which indicated Resident 2 had not received doses of prescribed Ziprasidone HCl on 08/01/2025, 08/02/2025, and 08/03/2025. Resident 2's MAR included:

- Scheduled medication instructions, which read, "...Ziprasidone HCl (daily) Take one capsule by mouth every evening..."
- A note, dated 08/01/2025, which read, "Ziprasidone HCl- Skipped - med (medication) out of stock, Nurse notified."
- A note, dated 08/02/2025, which read,

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N 352	Continued From page 4 "Ziprasidone HCl- need refill" - A note, dated 08/03/2025, which read, "Ziprasidone HCl- need refill" On 08/20/2025 at approximately 12:14 PM, Surveyors interviewed RD A, who stated Assistant Executive Director (AED) C had called the pharmacy to refill Resident 2's medication when it was out. RD A stated that the pharmacy would only refill medications at a certain time due to insurance, so they had just waited for a refill. The provider did not ensure each resident received all medications as prescribed.	N 352		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure staff in sufficient numbers were available on a 24-hour basis. Findings include: The provider is licensed to care for 15 residents in the client groups advanced age, physically disabled, irreversible dementia/Alzheimer's disease, and terminally ill. The facility is situated next door to another community-based residential facility (CBRF) licensed by the same provider. On 04/23/2025, the Department received 2	N 396		

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N 396	Continued From page 5 complaints about staffing. On 08/14/2025 at approximately 11:00 AM, Surveyors interviewed Regional Director (RD) A. RD A confirmed that 1 staff was typically scheduled for each shift in the facility. RD A stated s/he had gotten complaints from staff about staffing. RD A stated that if a staff member had to shower a resident or a situation arose where the staff member needed more help, they would call the nearby CBRF for assistance. At approximately 10:50 AM, Caregiver B stated there were no residents that required a 2-person assist. At approximately 1:05 PM, Surveyor interviewed Resident 2, who stated that when s/he fell, 2 staff members were needed to pick him/her up off the floor. Resident 2 stated that whenever s/he fell, staff would call for help from the other provider. Resident 2 stated his/her condition required 2 people and s/he did not believe there were enough staff working at the facility to care for him/her. At approximately 1:20 PM, Surveyor interviewed Caregiver B, who stated that staff from the other provider would come over to this provider to help with Resident 1's behaviors. Caregiver B stated Resident 2 fell a lot, and that staff called for help to get Resident 2 up whenever s/he fell. Caregiver B stated Resident 2 required 2 people to assist. At approximately 2:30 PM, Surveyor observed Caregiver D respond to an alarm for Resident 4. Resident 4 was on the floor in his/her room after having fallen. Caregiver D was unable to assist Resident 4 up alone, and requested assistance	N 396		

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N 396	Continued From page 6 from RD A, who was on-site due to the survey. On 08/14/2025, Surveyors reviewed resident records, which included the following: - A note regarding Resident 1's behaviors, dated 04/11/2025, which read, "...[Resident 1] was lying on the floor...Call was made to [nearby CBRF] for assistance with picking [Resident 1] up off the floor..." - A note regarding Resident 1's behaviors, dated 04/15/2025, which read, "...writer informed [Resident 1] that [s/he] would need to wait from [sic] support from the other building for help..." - A note regarding Resident 1's behaviors, dated 02/22/2025, which read, "...[Resident 1] was found face down on [his/her] bed with [his/her] legs hanging off and [his/her] pants still around [his/her] ankles. [S/he] was unable to be moved by writer without screaming, so another staff was called from the other building to assist..." - A note regarding Resident 1's behaviors, dated 04/23/2025, which read, "...Staff from the other building was sent up to assist with resident cares while writer stayed 1:1 with [Resident 1]..." - A fall incident report for Resident 2, dated 05/15/2025, which read, "...Staff from other building came to assist with transfer from the floor..." - A fall incident for Resident 4, dated 06/22/2025, which read, "...I then tried to lift [him/her] up but was unable to so I called Building 1 right next door to us and someone...came over with in [sic] 2 minutes of me calling..." The provider did not ensure there were employees in sufficient numbers on a 24-hour basis to meet the needs of the residents.	N 396		

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N 427	Continued From page 7	N 427		
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: Based on observation and interview, the provider did not provide a daily activity program for residents. Findings include: The provider is licensed to care for 15 residents in the client groups advanced age, physically disabled, irreversible dementia/Alzheimer's disease, and terminally ill. On 08/14/2025, from approximately 10:35 AM to 3:55 PM, Surveyors did not observe any activities being done. At approximately 11:00 AM, Surveyors reviewed the facility activity calendar. According to the calendar, "Daily Chronicles" was scheduled for 11:00 AM, and bingo was scheduled for 2:00 PM. Surveyors observed neither of these activities	N 427		

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N 427	Continued From page 8 being completed at any point from 11:00 AM to 3:55 PM. At approximately 1:20 PM, Surveyor interviewed Caregiver B, who stated residents were able to color with supplies on the tables, but that there was no time for other activities. Caregiver B stated s/he did not follow the activity calendar as there was no time. Caregiver B stated s/he would stick to impromptu activities. At approximately 2:15 PM, Surveyor interviewed Resident 3, who stated s/he liked to keep busy. Resident 3 stated there were no activities, and did not know about an activity calendar. On 08/20/2025, at approximately 12:14 PM, Surveyors interviewed Regional Director (RD) A, who stated activities should be getting done. The provider did not ensure a daily activity program was provided for residents.	N 427		