STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018759	A. BUILDING: _____ B. WING _____	R-C 11/26/2025

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VITACARE LIVING - ABBOTSFORD I	100 S 4TH AVE ABBOTSFORD, WI 54405

(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 10/24/2025, Surveyor conducted a complaint investigation, licensure survey, and verification visit. Data collection continued through 11/26/2025. Three of 4 complaints were substantiated. Twenty one deficiencies were identified. Two of 21 deficiencies were repeat violations. See Statement of Deficiencies (SOD) EHFE11, dated 11/16/2022. The deficiencies identified in SOD G7KO11 were corrected. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 9	{N 000}		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident's physician	N 169		

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

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N 169	Continued From page 1	N 169		

was immediately notified when there was an incident or injury to the resident, or a significant change in the resident's physical or mental condition.

Findings include:

On 10/24/2025 at approximately 12:30 PM, Surveyor interviewed Resident 2. Resident 2 stated a few weeks ago s/he had a heat pack applied to his/her shoulders and it burned the right side of his/her neck. Resident 2 stated s/he did not go in to be medically evaluated for the burn.

On 11/13/2025, Surveyor reviewed Resident 2's record.

The face sheet indicated Resident 2 was admitted on 10/18/2024 and had an activated power of attorney (POA). Diagnoses included in part prediabetes and impaired mobility and activities of daily living (ADLs).

Resident notes dated 09/01/2025 to 10/31/2025 indicated the following:

09/26/2025 written by Caregiver E - "Resident has 2 blisters on [his/her] right shoulder, I called [RD A] [s/he] says to monitor it, do not pop them, and to be sure heating pad is not to [sic] hot and is wrapped with a towel when you apply hot pad to [his/her] right shoulder."

Resident 2's record indicated s/he received a burn to his/her right shoulder on 09/26/2025 and there was no evidence indicating Resident 2's physician was updated about the injury. There was no incident report to review and no evidence indicating Resident 2 was medically evaluated for

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N 169	Continued From page 2 the burn. On 11/26/2025 at 1:00 PM, Surveyor interviewed Regional Director (RD) A, Nurse F, and Team Lead (TL) B. RD A stated staff initially messaged him/her about Resident 2's burn from the heat pack. RD A stated s/he followed-up weekly verbally with staff to see how the burn was doing. RD A stated s/he did not know if Resident 2's physician was updated after Resident 2 received the burn. The provider did not notify the resident's medical provider when there was an incident, injury, or significant change in condition. Cross reference: N0431 DHS 83.38(1)(g) Health Monitoring	N 169		
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 record review and interview, the provider and its operation did not comply with all laws governing the Community Based Residential Facility (CBRF). As a result of this licensure survey, 4 complaint surveys, and verification visit a total of 22 violations were issued and 3 of 4 complaints were substantiated. Two of the 22 violations were repeat deficiencies.	N 196		

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N 196	Continued From page 3 Findings include: This provider is licensed to care for up to 16 residents in the client groups of: advanced age, irreversible dementia/Alzheimer's disease, terminally ill, and physically disabled. On 10/24/2025, the facility census was 9. On 10/24/2025, Surveyor reviewed Department records for VitaCare Living Abbotsford I, licensed on 02/07/2022 with a probationary license. Since initial licensure the facility has had 1 substantiated complaint and a total of 9 deficiencies. The following information was reviewed: SOD EHFE11 was issued on 11/30/2022 and seven deficiencies were identified: 1. 83.17(2)(a) Employees Screened For Communicable Disease 2. 83.32(2)(a) Explanation Of Rights, Grievance Procedure 3. 83.37(3)(g) Medication Storage: Controlled Substances 4. 83.41(3)(b) Food Safety 5. 83.42(2) Resident Records Safeguarded 6. 83.43(1) Environment Safe, Clean, And Comfortable 7. 83.45(3) Toxic Substances. SOD EHFE12 was issued on 02/06/2023 and no deficiencies were identified. The deficiencies identified in SOD EHFE11 were corrected. SOD G7KO11 was issued on 06/17/2024. One of 1 complaint was substantiated and two deficiencies were identified: 1. 83.20(2)(a)-(d) Department-Approved Training Courses	N 196		

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N 196	Continued From page 4 2. 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake. On 06/17/2024, the Department issued a Notice and Order letter with SOD G7KO11. The Notice and Order letter included orders to comply with requirements and special orders. The special orders indicated the provider was to develop (review/revise) written procedures to address ensuring staffing patterns were sufficient to meet the needs of residents and providing sufficient staff on duty at all times when a resident required the assistance of two or more staff members. On 10/24/2025, Surveyor conducted a licensure survey, 4 complaints investigation, and verification visit at VitaCare Living Abbotsford I. Three of 4 complaints were substantiated, and 21 deficiencies were identified. Two of the 22 deficiencies were repeat violations (see SOD EHFE11, dated 11/16/2022). On 10/29/2025 at 11:54 AM, Surveyor received from Regional Director (RD) A two policies and procedures and reviewed them. The Maintenance of Current Written Staffing Schedule policy and procedure and the Sufficient Staffing and Documentation of staffing and Care Patterns policy and procedure both did not have an effective date or review date indicated. Both policies and procedures did not have staff signatures and dates on them indicating they were reviewed by management and staff. On 11/26/2025 at 1:00 PM, Surveyor interviewed RD A, Nurse F, and Team Lead (TL) B. RD A stated s/he had started in his/her current role at the beginning of the year and was also a nurse. RD A stated the provider was lacking a medication trainer for staff prior to him/her joining	N 196		

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N 196	Continued From page 5	N 196		

the company. RD A stated s/he was now responsible to make sure staff received their required training. RD A stated Licensee L visited the facility quarterly. RD A stated Nurse F and RD A visited the facility once per week. RD A stated Nurse F started his/her role in October 2025. RD A stated the previous TL's last day was on 10/08/2025. TL B stated s/he started overseeing this facility on 10/23/2025. RD A stated they have had multiple changes in TLs at the facility recently as the previous TL was only in his/her role for 1 month and the facility had one other previous TL and two previous directors prior to that. RD A indicated through this survey process s/he realized they had areas of improvement, which included staff documentation, staff notification to management, and need for a better monitoring and auditing processes. The team indicated they understood the concerns discussed and would work immediately to correct them.

The licensee did not ensure the administrator supervised the daily operation of the facility, programming, and personnel in a way that ensured residents received proper care and treatment. The licensee did not ensure compliance with DHS 83 was achieved and maintained when this survey resulted in 3 of 4 complaints substantiated and 22 deficiencies identified. The licensee did not ensure the special orders in SOD G7KO11 were followed.

Cross References:
N0169 DHS 83.12(5)(a) Notification: Incident, Injury, Changes
N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation
N0220 DHS 83.17(2)(a) Employees Screened For Communicable Disease
N0230 DHS 83.19 Orientation

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N 196	Continued From page 6 N0302 DHS 83.28(4)(a) Resident Health Screening And Documentation N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0392 DHS 83.35(4) Resident Satisfaction Evaluation N0393 DHS 83.35(5)(a) Initial Evaluation Of Evacuation Limitations N0394 DHS 83.35(5)(b) Annual Evaluation Of Evacuation Limits N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule N0416 DHS 83.37(2)(e) Other Administration Given Or Delegated By Rn N0425 DHS 83.38(1)(a) Personal Care N0427 DHS 83.38(1)(c) Leisure Time Activities N0431 DHS 83.38(1)(g) Health Monitoring N0488 DHS 83.44(1)(c) Clothes Dryers Enclosed And Vented N0499 DHS 83.45(3) Toxic Substances N0525 DHS 83.47(2)(d) Fire Drills N0526 DHS 83.47(2)(e) Other Evacuation Drills	N 196		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are	N 214		

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N 214	Continued From page 7 respected. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure an administrator supervised the daily operation of the facility, programming, and personnel in a way that ensured residents received proper care and treatment. Findings include: On 05/19/2025, 05/29/2025, 09/09/2025, and 10/09/2025, the Department received complaints regarding staffing concerns and resident care. This provider is licensed to care for up to 16 residents in the client groups of: advanced age, irreversible dementia/Alzheimer's disease, terminally ill, and physically disabled. On 10/24/2025 at 9:54 AM, Surveyor entered the facility and interviewed Caregiver C. Caregiver C stated s/he had been working at the facility as agency staff since August 2025. Caregiver C stated s/he reached out to Team Lead (TL) B upon Surveyor's arrival, and s/he would be coming today to assist with the survey. Caregiver C stated the previous TL had left his/her position. On 10/24/2025 at 10:24 AM, Surveyor observed TL B arrive at the facility and interviewed him/her. TL B stated s/he just took over as TL for this facility yesterday and would do his/her best to find what was needed for the survey. TL B stated the previous TL, and directors had left their positions 1 week ago. TL B stated s/he was now covering	N 214		

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N 214	Continued From page 8 both this facility and another facility about 30 minutes away. On 10/24/2025 at approximately 1:00 PM, TL B informed Surveyor s/he needed to leave for a training that afternoon. Surveyor requested if someone else from management could assist with the survey. TL B stated Regional Director (RD) A was unable to come due to being at another facility. TL B made a phone call and stated another management staff would be able to come, but they were new to their role as well. Surveyor declined additional management staff coming due to them not being familiar with their new role and this facility. Surveyor requested from TL B documentation, such as employee records, resident records, and safety inspections prior to him/her leaving. TL B was able to provide a state binder with some of the safety inspections and resident binders. TL B was unable to locate employee records. Surveyor worked out with TL B a plan to obtain further documentation via email, which would include employee records, additional resident records, policies and procedures, etc. Surveyor asked TL B which staff would be working the evening shift, and s/he responded Caregiver I and an agency staff. On 10/24/2025 at 2:47 PM, Surveyor interviewed Caregiver I and asked who was working the evening shift with him/her tonight as Caregiver C was still present. Caregiver I stated s/he did not know, but there were always 2 staff working. On 10/24/2025 at 3:11 PM, Surveyor observed Caregiver C sitting in his/her vehicle. Surveyor asked Caregiver C who was coming in to relieve him/her. Caregiver C stated s/he did not know but would stay until his/her replacement came.	N 214		

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N 214	Continued From page 9 On 10/24/2025, Surveyor reviewed Department records for VitaCare Living Abbotsford I, which indicated RD A was listed as the facility administrator. On 11/17/2025 at 1:58 PM, Surveyor received an email from RD A, which read in part after responses to questions about resident care, "I understand these are not an appropriate response, I do wish I had all the answers and could fix past issues faster but I am getting the right people in place to get better processes for resident care and staff success." On 11/26/2025 at 1:00 PM, Surveyor interviewed RD A, Nurse F, and TL B. RD A stated Nurse F and s/he visited the facility once per week. RD A stated they have had multiple changes in management at the facility recently. RD A stated the previous TL's last day had been 10/08/2025. TL B stated s/he was now responsible for the daily operation of the facility. TL B stated s/he was splitting his/her time at this facility in the afternoon and another facility in the morning. RD A stated multiple times through the survey process s/he did not know what the previous TL's processes were and struggled to find documentation. The team indicated they understood the concerns discussed and would work immediately to correct them. Three of 4 complaints were substantiated, and the following issues were identified during the survey: - Resident's physician was not notified after an injury. - Communicable disease screening for staff was not completed prior to hire. - Orientation for staff was not completed prior to assuming job responsibilities.	N 214		

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N 214	Continued From page 10 - Communicable disease screening for residents was not completed within 90 days or 7 days after admission. - Residents did not receive medications as ordered. - Resident did not have a comprehensive ISP up to 30 days after admission. - Resident ISPs were not updated. - Resident satisfaction evaluations were not completed - Residents were not evaluated for evacuation capabilities within 3 days of admission. - Residents were not evaluated annually for evacuation capabilities. - Accurate staff schedules were not maintained. - Staff did not have medication delegation. - Residents did not receive adequate and appropriate care within the capacity of the facility. - The resident was not offered a daily activity program. - Residents did not receive adequate health monitoring of skin changes. - Dryer vent material was not ridged. - Toxic substances were not secured. - Quarterly fire drills were not documented as required. - Safety drills (other than fire) were not completed semi-annually as required. Cross reference: N0169 DHS 83.12(5)(a) Notification: Incident, Injury, Changes N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0220 DHS 83.17(2)(a) Employees Screened For Communicable Disease N0230 DHS 83.19 Orientation N0302 DHS 83.28(4)(a) Resident Health Screening And Documentation N0352 DHS 83.32(3)(h) Rights Of Residents:	N 214		

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N 214	Continued From page 11 Receive Medication N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0392 DHS 83.35(4) Resident Satisfaction Evaluation N0393 DHS 83.35(5)(a) Initial Evaluation Of Evacuation Limitations N0394 DHS 83.35(5)(b) Annual Evaluation Of Evacuation Limits N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule N0416 DHS 83.37(2)(e) Other Administration Given Or Delegated By Rn N0425 DHS 83.38(1)(a) Personal Care N0427 DHS 83.38(1)(c) Leisure Time Activities N0431 DHS 83.38(1)(g) Health Monitoring N0488 DHS 83.44(1)(c) Clothes Dryers Enclosed And Vented N0499 DHS 83.45(3) Toxic Substances N0525 DHS 83.47(2)(d) Fire Drills N0526 DHS 83.47(2)(e) Other Evacuation Drills.	N 214		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the	N 220		

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N 220	Continued From page 12 screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 5 employees reviewed had obtained documentation from a physician, physician assistant, clinical nurse practitioner, or a licensed registered nurse, indicating they had been screened within 90 days before the start of employment for clinically apparent communicable disease, including tuberculosis (TB). The record for Caregiver C did not contain evidence from a physician, physician assistant, clinical nurse practitioner, or a licensed registered nurse, indicating they had been screened within 90 days before the start of employment for clinically apparent communicable disease. Records for Caregiver H, Caregiver I, and Caregiver K contained a communicable disease screening but the screenings did not include the date signed and signature from a qualified screener that conducted the assessment. Caregiver H's record contained a TB test administered over 1 month after his/her hire date. This is a repeat deficiency. See Statement of Deficiencies (SOD) EHFE11, dated 11/16/2022. Findings include: On 11/13/2025, Surveyor conducted a review of 5 employees. Surveyor requested communicable disease screenings and TB tests from Regional Director (RD) A.	N 220		

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N 220	Continued From page 13 Caregiver C was hired in August 2025 as agency staff; exact hire/start date unknown. Caregiver C's record did not contain evidence from a physician, physician assistant, clinical nurse practitioner, or a licensed registered nurse, indicating s/he had been screened within 90 days before the start of employment for clinically apparent communicable disease. Caregiver H was hired on 10/01/2025. Caregiver H's record indicated s/he did not receive a TB test in the last year and RD A administered a TB test on 10/27/2025; over 1 month after hire. Caregiver H's record contained a communicable disease screening dated 09/17/2025, but the date and signature from the screener was cut off. Caregiver I was hired on 10/13/2025. Caregiver I's record contained a communicable disease screening dated 10/09/2025, but the date and signature from the screener was cut off. Caregiver K was hired on 12/20/2024. Caregiver K's record contained an undated communicable disease screening without the screener's signature. On 11/26/2025 at 1:00 PM, Surveyor interviewed RD A, Nurse F, and Team Lead (TL) B. RD A stated their hire process included a 2-step TB test and was done upon the staff's availability. RD A stated s/he or Nurse F would conduct the communicable disease screening for staff and the plan was for Nurse F to fully take over this task.	N 220		
N 230	83.19 Orientation Before an employee performs any job duties, the	N 230		

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N 230	Continued From page 14 CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 5 staff (Caregiver H, Caregiver I and Caregiver C) completed orientation training prior to assuming job responsibilities. Findings include: On 11/13/2025, Surveyor reviewed employee records. Caregiver H was hired on 10/01/2025. Caregiver H's record did not include evidence of orientation training. Caregiver I was hired on 10/13/2025. Caregiver I's record did not include evidence of orientation training. Caregiver C was hired in August 2025 as agency staff; exact hire/start date unknown. Caregiver C's record did not include evidence of orientation training.	N 230		

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N 230	Continued From page 15 On 11/26/2025 at 1:00 PM, Surveyor interviewed Regional Director (RD) A, Nurse F, and Team Lead (TL) B. RD A stated s/he was not sure what previous management did for documenting staff orientation training. TL B stated all staff were to use and complete an orientation form with the staff training them. TL B stated agency staff were given an overview of the facility, and s/he was unsure if this orientation was documented. Surveyor requested the documentation by the end of the day. As of 5:00 PM on 11/26/2025, Surveyor did not receive evidence of documented orientation training for Caregiver H, Caregiver I, and Caregiver C.	N 230		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record.	N 302		

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N 302	Continued From page 16 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 residents admitted were screened for clinically apparent communicable disease, including tuberculosis (TB) within 90 days before or 7 days after admission. Findings include: This provider is licensed to care for up to 16 residents in the client groups of: advanced age, irreversible dementia/Alzheimer's disease, terminally ill, and physically disabled. On 11/13/2025, Surveyor requested to review Resident 9's record. Resident 9's face sheet had an admission date of 05/30/2025. The record did not have evidence Resident 9 was screened for clinically apparent communicable disease, including TB upon admission. On 11/26/2025 at 1:00 PM, Surveyor interviewed Regional Director (RD) A, Nurse F, and Team Lead (TL) B. RD A stated Resident 9's record should have had a communicable disease screening and TB test, because they requested one prior to his/her admission from the hospital. Surveyor requested the documentation by the end of the day. As of 5:00 PM on 11/26/2025, Surveyor did not receive evidence of a communicable disease screening or TB test for Resident 9.	N 302		
N 352	83.32(3)(h) Rights of Residents: Receive medication	N 352		

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N 352	Continued From page 17 In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 2 of 2 residents reviewed (Resident 2 and Resident 8) received their medications as ordered in August through October 2025. Findings include: On 10/09/2025, the department received a complaint alleging medications were not administered as ordered. This provider is licensed to care for up to 16 residents in the client groups of: advanced age, irreversible dementia/Alzheimer's disease, terminally ill, and physically disabled. On 10/24/2025 at approximately 11:30 AM, Surveyor was observing Caregiver C during medication pass and asked if s/he had any concerns regarding medications being available in the facility for residents. Caregiver C stated at times because not all staff knew how to reorder medications. Resident 2: On 10/24/2025 at approximately 12:30 PM, Surveyor interviewed Resident 2. Resident 2 stated s/he was out of his/her medications frequently.	N 352		

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N 352	Continued From page 18 On 11/13/2025, Surveyor reviewed Resident 2's record. The face sheet indicated Resident 2 was admitted on 10/18/2024 and had an activated power of attorney (POA). Diagnoses included in part candidiasis, chronic back pain, fecal incontinence, overactive bladder, urinary incontinence, prediabetes, and impaired mobility and activities of daily living (ADLs). The individual service plan (ISP) was last updated on 05/07/2025 and indicated the provider managed Resident 2's medications. Surveyor reviewed Resident 2's medication administration records (MARs) for August through October 2025, which indicated the following: Resident 2 had an order for both scheduled tramadol HCL 50 mg to be given half a tablet 3 times daily and PRN (as needed) tramadol 50 mg to be given 1 tablet every 4 hours. The MAR indicated Resident 2 did not receive his/her scheduled tramadol at 8:00 AM on 09/04/2025, 09/05/2025, and 09/08/2025. Resident 2 did not receive his/her scheduled tramadol at 2:00 PM on 09/02/2025, 09/03/2025, 09/04/2025, 09/05/2025, and 09/08/2025. Resident 2 did not receive his/her scheduled tramadol at 8:00 PM on 09/01/2025 through 09/05/2025. Staff notes on 09/01/2025, 09/03/2025, 09/04/2025, indicated staff gave Resident 2 a PRN dose of tramadol due to the scheduled tramadol not being available. Staff notes on 09/02/2025 indicated scheduled tramadol needed to be reordered. A staff note on 09/06/2025 indicated Resident 2 had received his/her scheduled tramadol again.	N 352		

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N 352	Continued From page 19 Cavilon 1.3% cream - apply topically to lower back and buttocks 4 times daily to prevent skin breakdown. Staff notes in the MAR from August through October 2025 indicated this medication was not available for administration on the following dates: 08/07/2025 08/09/2025 08/10/2025 08/13/2025 08/15/2025 08/18/2025 08/25/2025 09/04/2025 09/08/2025 09/09/2025 09/17/2025 09/23/2025 09/25/2025. Desitin 40% paste - apply to affected area twice daily after washing with warm soapy water. Staff notes in the MAR from August through October 2025 indicated this medication was not available for administration on the following dates: 08/18/2025 08/19/2025 08/20/2025 08/21/2025 08/25/2025 08/26/2025 10/24/2025. An email received from RD A on 10/24/2025 at 11:54 AM, indicated Resident 2 had not had any medication errors in the past few months. On 11/26/2025 at 1:00 PM, Surveyor interviewed Regional Director (RD) A, Nurse F, and Team Lead (TL) B. RD A stated they had issues with a	N 352		

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few of Resident 2's medications including waiting for physicians to renew prescriptions and frequent medication order changes for tramadol. RD A stated some of Resident 2's prescriptions were ordered by different physicians, which made getting updated orders for medications more complicated. TL B stated sometimes Resident 2 refused his/her prescribed creams.

Resident 2 was out of scheduled tramadol from 09/01/2025 through 09/05/2025; for 4 days. Resident 2 did not have his/her cavilon and desitin creams available to administer multiple days in August through October 2025.

Resident 8:

On 11/13/2025, Surveyor reviewed Resident 8's record.

The face sheet indicated Resident 8 was admitted on 02/08/2024 and had a guardian. Diagnoses included in part dementia with behavioral disturbance, major depressive disorder, anxiety disorder, and chronic obstructive pulmonary disease (COPD).

An assessment dated 09/23/2024 indicated the provider managed Resident 8's medications. The assessment indicated Resident 8 was a risk for elopement and wandering and had a wander guard. The assessment indicated Resident 8 had a PRN medication for anxiety and read in part, "utilized in moments wherein [s/he] attempts to elope and is not easily redirected."

Surveyor reviewed the service notes from 08/06/2025 to 10/30/2025 and found the following:

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N 352	Continued From page 21 08/26/2025 - "Resident went out the door several times with staff running behind [him/her] to bring [him/her] back inside the house ...[His/Her] PRN (as needed) med was destroyed, do to being expired and not replaced yet, was ordered". 08/28/2025 - "Resident has been eloping today according to am shift 3 to 4 times." 09/01/2025 - "Yesterday, this resident went out the door several times and staff had to go after [him/her] ...[S/He] does not have [his/her] PRN med., as it was destroyed, due to being expired and Pharmacy still has not sent it. Today this resident has went out the door twice already as staff went after [him/her] each time, as [his/her] alarm sounded." 09/03/2025 - "resident was trying to exit seek but didn't leave the building." 09/04/2025 - " ...Resident also went out the door a couple times, has a wander guard on, was redirected by staff, brought back inside ..." 09/23/2025 - "Resident went outside 3 times today and staff had to redirect [him/her] and bring [him/her] back inside ...Resident eloped today at 3:30, writer sate with [him/her] for a few minutes and then other staff came out to assist ...Resident has been trying to leave the property since 3pm [sic] when [s/he] woke up. So far about 10 attempts. Writer looked for prn [sic] which there is one listed but currently out." 09/24/2025 - "Resident walked out the front door but stayed in the parking lot area." 09/26/2024 - "Resident has tried to elope 10-15 times this shift. [S/He] is getting harder to	N 352		

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redirect."

09/27/2025 - "Resident went out the outside door and had to be brought back in by staff ..."

09/30/2025 - "Resident left the building a couple times, staff went after [him/her], brought [him/her] back into the building ..."

10/30/2025 - "Resident walked out the front door but stayed in the parking lot.".

On 11/26/2025 at 1:00 PM, Surveyor interviewed RD A, Nurse F, and TL B. RD A stated Resident 8's PRN hydroxyzine did not always help with his/her anxiety. RD A stated when the medication was not available in August and September 2025, they were waiting on a physician for a new order request to get the medication refilled. Surveyor requested Resident 8's MARs for August through October 2025.

On 11/26/2025 at 2:50 PM, Surveyor received Resident 8's September and October 2025 MARs from the provider. Surveyor reviewed Resident 8's MARs for September and October 2025 and found the following:

Hydroxyzine 25 mg tablet - take 1 tablet 4 times daily as needed for anxiety. Resident 8 did not receive this medication in September and October 2025.

Triamcinolone 0.1% cream - apply topically to neck and back twice daily for rash. The October 2025 MAR indicated Resident 8 did not receive this medication at 8:00 AM on 10/19/2025 and 10/21/2025 through 10/31/2025. The MAR indicated Resident 8 did not receive this medication at 8:00 PM on 10/19/2025,

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N 352	Continued From page 23 10/21/2025, and 10/23/2025 through 10/31/2025. Staff notes on 10/20/2025 and 10/21/2025 indicated the medication was out. Staff notes on 10/22/2025 indicated the medication was reordered and continued to be reordered multiple times through the end of the month. Resident 8 did not have his/her PRN hydroxyzine available to be administered from at least 08/26/2025 to 09/23/2025. Three times staff documented behaviors where they would have administered PRN hydroxyzine to Resident 8 but were unable to due to the medication being unavailable. Resident 8 did not have his/her Triamcinolone cream available to be administered from approximately 10/19/2025 through 10/31/2025. Resident 2 and Resident 8 did not receive multiple medications as ordered in August through October 2025. Cross Reference N0431 DHS 83.38(1)(g) Health Monitoring	N 352		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify	N 386		

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N 386	Continued From page 24 methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 residents sampled (Resident 9) had a comprehensive individualized service plan (ISP). Findings include: On 05/29/2025 and 10/09/2025, the department received complaints alleging resident care plans were not comprehensive. This provider is licensed to care for up to 16 residents in the client groups of: advanced age, irreversible dementia/Alzheimer's disease, terminally ill, and physically disabled. On 10/28/2025 at 11:00 AM via email, Surveyor requested a sample of resident records to review, including the comprehensive ISP and current ISP on file. Resident 9 had an admission date of 05/30/2025. Surveyor found a pre-admission assessment and admission assessment dated 05/30/2025. Surveyor did not find a comprehensive ISP that included Resident 9's needs and desired outcomes, frequency of program services, and measurable goals in his/her record up to 30 days after his/her admission. On 11/26/2025 at 1:00 PM, Surveyor interviewed RD A, Nurse F, and TL B. RD A stated they would	N 386		

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N 386	Continued From page 25 have to look for Resident 9's comprehensive ISP done after admission. RD A states s/he was unsure if it was done, and this was now a priority focus for them to get ISPs updated and comprehensive. Surveyor requested documentation by the end of the day. As of 5:00 PM on 11/26/2025, Surveyor had not received a comprehensive ISP for Resident 9. The provider did not ensure Resident 9 had a comprehensive ISP completed and on record after admission.	N 386		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or 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 ensure Resident 2's individual service plan (ISP) was updated to identify services, frequency, approaches provided by the provider, or specify methods for delivering	N 389		

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needed care, and identify who was responsible for delivering care for his/her new skin breakdown and burn injury. The provider did not identify services and frequency of facial shaving in Resident 3's ISP. The provider did not make sure Resident 8's ISP was updated annually.

Findings include:

On 05/29/2025 and 10/09/2025, the department received a complaint alleging resident care plans were not up to date.

This provider is licensed to care for up to 16 residents in the client groups of: advanced age, irreversible dementia/Alzheimer's disease, terminally ill, and physically disabled.

Resident 2:
On 10/24/2025 at approximately 12:30 PM, Surveyor interviewed Resident 2. Resident 2 stated a few weeks ago s/he had a heat pack applied to his/her shoulders and it burned the right side of his/her neck. Resident 2 stated s/he did not go in to be medically evaluated for the burn. Resident 2 indicated staff had popped the blister that formed, which was the size of a dime.

On 11/13/2025, Surveyor reviewed Resident 2's record.

The face sheet indicated Resident 2 was admitted on 10/18/2024 and had an activated power of attorney (POA). Diagnoses included in part candidiasis, chronic back pain, fecal incontinence, overactive bladder, urinary incontinence, prediabetes, and impaired mobility and activities of daily living (ADLs).

Resident notes dated 09/01/2025 to 10/31/2025

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N 389	Continued From page 27 indicated the following: 09/18/2025 written by Caregiver C - "Resident has a wound on [his/her] butt that is beginning to open again. Writer cleaned with wound cleaner, dried it and covered with a 4x4 bordered gauze with adhesive border until nurse can look at it." 09/26/2025 written by Caregiver E - "Resident has 2 blisters on [his/her] right shoulder, I called [RD A] [s/he] says to monitor it, do not pop them, and to be sure heating pad is not to [sic] hot and is wrapped with a towel when you apply hot pad to [his/her] right shoulder." The ISP was last updated on 05/07/2025 and did not address Resident 2's skin breakdown and burn wound. Resident 3: Resident 3 had an admission date of 08/29/2024. An assessment dated 09/16/2024, indicated Resident 3 was independent with personal cares such as grooming and hygiene, but required reminders from staff to complete these tasks. Resident 3's care coordination notes dated 02/01/2025 to 05/22/2025, indicated the following for documentation related to facial hair shaving: 04/01/2025 - "Staff shaved facial hair ...". The ISP was last updated on 04/18/2025 and indicated Resident 3 required full assistance with hygiene and grooming. The ISP indicated grooming cares included washing, drying, hair care, oral care, and applying deodorant and fragrances. The ISP did not address Resident 3's shaving of facial hair or his/her noncompliance	N 389		

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with cares.

On 11/17/2025 at 1:58 PM, Surveyor received an email from RD A. Surveyor had asked RD A what the expectation was for staff with shaving resident's facial hair. RD A responded in part, " ...The previous manager didn't have processes and expectations in place for documentation of showers, shaving, refusals, and shift to shift communication. We have no [sic] in place a communication binder for shift to shift, documentation requirements for refusals and for completed tasks, and overall expectations of the staff is enforced with auditing of charting."

On 11/26/2025 at 1:00 PM, Surveyor interviewed RD A, Nurse F, and TL B. RD A stated Resident 3 refused cares frequently and staff made frequent attempts. RD A stated there was not a lot of documentation from previous staff for Resident 3's cares and staff's reattempts.

Resident 8:
On 11/13/2025, Surveyor reviewed Resident 8's record.

The face sheet indicated Resident 8 was admitted on 02/08/2024 and had a guardian. Diagnoses included in part dementia with behavioral disturbance, major depressive disorder, anxiety disorder, and chronic obstructive pulmonary disease (COPD).

Resident 8 had an ISP last updated on 09/23/2024.

On 11/26/2025 at 1:00 PM, Surveyor interviewed Regional Director (RD) A, Nurse F, and Team Lead (TL) B. RD A stated s/he did not believe Resident 2's ISP was updated after s/he

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N 389	Continued From page 29 developed skin breakdown to his/her buttocks and a burn wound in September 2025. Nurse F stated s/he did a clinical update in November 2025. RD A stated they did not find an updated ISP since 09/23/2024 for Resident 8. Resident 2's ISP had not been updated with services, frequency, approaches provided by the provider, or specify methods for delivering needed care, and identify who was responsible for delivering care Resident 2 had skin breakdown to his/her buttocks and s/he experienced a burn wound on his/her neck from a heat pack in September 2025. Resident 3's ISP did not identify services and frequency of facial shaving. Resident 8's ISP was not updated annually. Cross Reference N0431 DHS 83.38(1)(g) Health Monitoring	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 interview, the provider did not provide the resident and the resident's legal representative the opportunity to complete an evaluation, at least annually, of the resident's level of satisfaction with the provider's services, for 2 of 2 (Resident 2 and Resident 7)	N 392		

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N 392	Continued From page 30 residents reviewed Findings include: On 11/13/2025, Surveyor reviewed the records of Resident 2 and Resident 7. Resident 2 was admitted to the facility on 10/18/2024. Resident 2's record did not contain evidence to show a satisfaction survey was sent to Resident 2 or Resident 2's representative in 2025. Resident 7 was admitted to the facility on 05/09/2019. Resident 7's record did not contain evidence to show a satisfaction survey was sent to Resident 7 or Resident 7's representative at least annually. On 11/26/2025 at 1:00 PM, Surveyor interviewed Regional Director (RD) A, Nurse F, and Team Lead (TL) B. TL B stated s/he was working on the satisfaction surveys for this year and sent some out already. RD A stated the expectation was satisfaction surveys were done annually. Surveyor requested documentation by the end of the day. As of 5:00 PM on 11/26/2025, Surveyor did not receive satisfaction surveys for Resident 2 or Resident 7.	N 392		
N 393	83.35(5)(a) Initial evaluation of evacuation limitations. Initial evaluation. The CBRF shall evaluate each resident within 3 days of the resident ' s admission to determine whether the resident is able to evacuate the CBRF within 2 minutes in an	N 393		

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unsprinklered CBRF and 4 minutes in a sprinklered CBRF without any help or verbal or physical prompting, and what type of limitations that resident may have that prevent the resident from evacuating the CBRF within the applicable period of time. A form provided by the department shall be used for the evaluation. The resident ' s evaluation shall be retained in the resident ' s record.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 1 of 4 residents were evaluated within 3 days of the resident's admission for evacuation capabilities.

Findings include:

This provider is licensed to care for up to 16 residents in the client groups of: advanced age, irreversible dementia/Alzheimer's disease, terminally ill, and physically disabled.

On 11/13/2025, Surveyor reviewed the record of Resident 2.

Resident 2 was admitted on 10/18/2024. Resident 2 had diagnoses that included cerebrovascular accident (CVA) and impaired mobility and activities of daily living (ADLs).

An assessment dated 05/07/2025, indicated Resident 2 was unable to ambulate and required 2 staff assistance with transfers via a sit-to-stand.

Surveyor reviewed an evacuation assessment dated 11/01/2024, 14 days after admission.

On 11/26/2025 at 1:00 PM, Surveyor interviewed

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N 393	Continued From page 32 Regional Director (RD) A, Nurse F, and Team Lead (TL) B. TL B stated s/he did not know why Resident 2's initial evacuation assessment was done 14 days after admission. TL B stated s/he now did the initial evacuation assessment upon resident admission as part of their admission process.	N 393		
N 394	83.35(5)(b) Annual evaluation of evacuation limits Evaluation update. The CBRF shall evaluate each resident ' s mental or physical capability to respond to a fire alarm at least annually or when there is a change in the resident ' s mental or physical capability to respond to a fire alarm. This Rule is not met as evidenced by: Based on record review and interview, the provider did not complete 1 of 2 resident's reviewed (Resident 7) annual evacuation assessment in 2025. Findings include: This provider is licensed to care for up to 16 residents in the client groups of: advanced age, irreversible dementia/Alzheimer's disease, terminally ill, and physically disabled. On 11/13/2025, Surveyor reviewed the record of Resident 7. Resident 7 was admitted on 05/09/2019. Resident 7 had diagnoses that included bilateral knee osteoarthritis, gait disorder multifactorial, neurogenic claudication secondary to central spine canal stenosis, patchy mild cognitive dysfunction likely vascular, and obesity.	N 394		

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N 394	Continued From page 33 Assessments dated 04/23/2025 and 09/17/2025, read in part, "pivot transfer with a GAIT BELT on good days - depends on mood, Order for a SIT-TO-STAND or HOYER is in place as needed for bad days - depending on mood." Surveyor reviewed an annual evacuation assessment for Resident 7 dated 09/17/2024, but did not see an annual evacuation assessment for 2025. On 10/28/2025 at 11:00 AM, Surveyor requested via email, Resident 7's annual evacuation assessment for 2025. As of 11/26/2025, Surveyor did not receive a 2025 annual evacuation assessment for Resident 7. On 11/26/2025 at 1:00 PM, Surveyor interviewed Regional Director (RD) A, Nurse F, and Team Lead (TL) B. TL B stated s/he did not know where the 2025 annual evacuation assessment for Resident 7 was and would look for it. Surveyor requested documentation by the end of the day. As of 11/26/2025 at 5:00 PM, Surveyor did not receive a 2025 annual evacuation assessment for Resident 7.	N 394		
N 399	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked.	N 399		

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N 399	Continued From page 34 This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain an accurate staffing schedule. Findings include: This provider is licensed to care for up to 16 residents in the client groups of: advanced age, irreversible dementia/Alzheimer's disease, terminally ill, and physically disabled. On 10/24/2025 at 10:00 AM, Surveyor interviewed Caregiver D. Caregiver D stated there were 2 staff scheduled per shift. On 10/24/2025 at approximately 10:10 AM, Surveyor interviewed Caregiver C. Caregiver C indicated s/he was an agency staff and passing medications for this shift. On 10/24/2025 at 10:24 AM, Surveyor interviewed Team Lead (TL) B. TL B stated s/he just took over as lead of the facility yesterday as the previous lead had left his/her position. TL B stated s/he would be the lead for this facility and another facility within the company. On 10/24/2025, Surveyor requested and reviewed the staff schedule from May 2025 to present from TL B. The September 2025 and October 2025 staff schedules indicated agency staff were working shifts. The staff schedule did not indicate the agency staff's full name. The staff schedule indicated the shift the agency staff worked, but did not include a specific time worked. The staff schedules did not indicate the staff's full name, which staff was the shift's designated medication passer, and the hours worked during the shift. The staff schedules also did not indicate which	N 399		

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N 399	Continued From page 35 shifts management picked up and their normal work hours. The provider's Maintenance of Current Written Staffing policy and procedure read in part, "The schedule must clearly include: -Names of all staff scheduled to work -Job titles or roles (e.g., caregiver, med passer, cook) -Shift times and dates -On-call staff when applicable." On 11/26/2025 at 1:00 PM, Surveyor interviewed Regional Director (RD) A, Nurse F, and TL B. RD A stated they were implementing a different staff scheduling system that would include more detail. TL B stated s/he had filled in for shifts as a caregiver at the facility several times. Surveyor reviewed the staff schedules again and did not see TL B's name listed on the schedules. TL B stated s/he was currently working at the other facility in the morning and coming to this facility in the afternoon during the week. The provider did not maintain an accurate staffing schedule that included each employee's full name, job assignment and time worked.	N 399		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3).	N 416		

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N 416	Continued From page 36 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure medication delegation of injectables, nebulizer, stomal and enternal medications, treatments or preparations delivered vaginally or rectally for 1 of 6 caregivers reviewed. Findings include: This provider is licensed to care for up to 16 residents in the client groups of: advanced age, irreversible dementia/Alzheimer's disease, terminally ill, and physically disabled. On 10/24/2025 at 2:47 PM, Surveyor interviewed Caregiver I. Caregiver I indicated s/he had his/her medication training and delegation. On 11/13/2025, Surveyor reviewed Caregiver I's record. Caregiver I was hired on 10/13/2025. Caregiver I had a skill competency document signed off by Regional Director (RD) A on 10/27/2025 for vaginal medication administration. On 11/13/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 10/18/2024. Resident 2 had diagnoses that included cerebral vascular accident (CVA), chronic systolic heart failure, and vaginal atrophy. According to the medication administration record (MAR) for October 2025, Resident 2 was prescribed estradiol 0.1mg/gm vaginal cream to be given twice weekly on Wednesday and Sunday. The MAR indicated 1 gram of medication was to be inserted vaginally. The MAR indicated Caregiver I administered estradiol on 10/19/2025 at 7:29 PM and 10/26/2025 at 7:15 PM to Resident 2.	N 416		

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N 416	Continued From page 37 On 11/26/2025 at 1:00 PM, Surveyor interviewed Regional Director (RD) A, Nurse F, and Team Lead (TL) B. RD A stated s/he had started in his/her current role at the beginning of the year and was also a nurse. RD A stated s/he had done medication delegation for all current employees passing medications. RD A stated prior to his/her employment the facility was lacking a medication trainer and now s/he was responsible to make sure employees were trained prior to assuming their duties. RD A stated Nurse F had just started his/her role in October 2025. The provider did not ensure medication delegation for Caregiver I was completed prior to him/her administering medication vaginally to Resident 2 twice in October 2025.	N 416		
N 425	83.38(1)(a) Personal care. 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: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence.	N 425		

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This Rule is not met as evidenced by:
Based on interview and record review, the provider did not provide personal care services adequate to meet the needs of Resident 2 and Resident 3.

Findings include:

On 05/29/2025 and 06/02/2025, the department received complaints regarding resident care.

This provider is licensed to care for up to 16 residents in the client groups of: advanced age, irreversible dementia/Alzheimer's disease, terminally ill, and physically disabled.

On 10/24/2025 at approximately 10:00 AM, Surveyor interviewed Caregiver C and asked if there had been any resident care concerns. Caregiver C stated resident's getting their showers as scheduled had been a concern.

Example 1

On 10/24/2025 at approximately 12:30 PM, Surveyor interviewed Resident 2. Resident 2 stated s/he was showered once per week and would like it to be twice per week. Resident 2 stated his/her shower was scheduled at night but s/he would like it done right before bed. Resident 2 stated sometimes staff were busy and would chart s/he declined his/her shower instead of giving him/her one. Resident 2 stated s/he went 1 month without a shower last month.

Surveyor reviewed Resident 2's record. Resident 2 was admitted on 10/18/2024. Resident 2 had diagnoses that included chronic systolic heart failure, candidiasis, cerebrovascular accident (CVA) chronic back pain, fecal incontinence,

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overactive bladder, rotator cuff impingement syndrome of right shoulder, urinary incontinence, recurrent urinary tract infection (UTI), impaired mobility and activities of daily living (ADLs), and prediabetes.

The planned services dated 05/07/2025, indicated Resident 2 was to receive a shower weekly on Friday evenings with staff assistance.

An assessment dated 05/07/2025, indicated Resident 2 required moderate assistance with showering and 2 staff to assist with sit-to-stand transfers.

Surveyor reviewed the resident notes for September and October 2025 and found the following related to showering for Resident 2:
09/05/2025 - refused
09/16/2025 - "Resident told staff [s/he] has not had a shower in 3 weeks. [S/He] asked staff if [s/he] could get one forsure [sic] this Friday September 19th ..."
09/18/2025 -showered
09/26/2025 - refused
10/03/2025 - refused and was asked by two different staff
10/31/2025 -showered.

Surveyor reviewed the shower service documentation for September and October 2025 and found the following:
09/19/2025 - showered
09/26/2025 - refused
10/03/2025 - refused
10/07/2025 -showered.

Resident 2 did not have a documented shower from 09/20/2025 to 10/06/2025; 17 days.

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N 425	Continued From page 40 On 11/26/2025 at 1:00 PM, Surveyor interviewed Regional Director (RD) A, Nurse F, and Team Lead (TL) B. RD A stated Resident 2 liked to refuse showers. TL B stated s/he was now notified by staff if a resident refused a shower and TL B would speak to the resident via phone. TL B stated this conversation with the resident would be documented. RD A stated Resident 2 would change his/her mind frequently regarding his/her shower schedule. Example 2 Surveyor reviewed Resident 3's record. Resident 3 was admitted on 08/29/2024 and had a guardian. Resident 3 had diagnoses that included major depressive disorder, dorsalgia, transient ischemic attack (TIA), cerebral infarction without residual deficits, type 2 diabetes mellitus, and chronic obstructive pulmonary disease (COPD). An assessment dated 09/16/2024, indicated Resident 3 was protectively placed and needed one staff assistance to shower. The staff would aid with getting in and out of the shower, adjusting water temperature, and helping to wash hard to reach places. An assessment dated 04/18/2025, indicated Resident 3 needed full assistance with all aspects of showering. Surveyor reviewed the resident notes for February 2025 to May 2025 and found the following related to showering for Resident 3: 03/20/2025 - showered 03/27/2025 - "Shower will be done tomorrow" 04/05/2025 - " ...refuses cares" 04/06/2025 - refused cares 04/11/2025 - refused to get dressed	N 425		

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N 425	Continued From page 41 05/01/2025 - showered 05/02/2025 - refused to get dressed 05/06/2025 - refused to get dressed 05/18/2025 - refused to get dressed 05/19/2025 - refused to get dressed 05/21/2025 - admitted to hospital. Resident 3 did not have a documented shower from 03/21/2025 to 04/30/2025; 41 days. Resident 3 did not have a documented shower from 05/02/2025 to 05/21/2025; 20 days. On 11/17/2025 at 1:58 PM, Surveyor received an email response from RD A. Surveyor asked if RD A could speak to Resident 3 not having a documented shower between 03/20/2025 to 05/01/2025 and how they addressed his/her noncompliance with cares. RD A responded, "unfortunately [sic] I cannot. The previous manager didn't have processes and expectations in place for documentation of showers, shaving, refusals, and shift to shift communication. We have no [sic] in place a communication binder for shift, documentation requirements for refusals and for completed tasks, and overall expectations of the staff is enforced with auditing of charting." On 11/26/2025 at 1:00 PM, Surveyor interviewed RD A, Nurse F, and TL B. RD A stated Resident 3 refused cares frequently and staff made frequent attempts. RD A stated there was not a lot of documentation from previous staff for Resident 3's cares and staff's reattempts. The provider did not provide personal care services adequate to meet the needs of Resident 2 and Resident 3, when staff documentation indicated Resident 2 and Resident 3 went over 2 weeks without showers in 2025.	N 425		

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N 425	Continued From page 42 Cross Reference N0431 DHS 83.38(1)(g) Health Monitoring	N 425		
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 to meet the interests and capabilities of the residents. Findings include: On 10/24/2025 at approximately 10:00 AM, Surveyor interviewed Caregiver D and inquired if there was an activity calendar posted. Caregiver D stated there was no activity calendar currently posted. Caregiver D stated residents were to do independent activities or socialize with each other. Caregiver D stated s/he tried to do an activity recently, but no residents participated. On 10/24/2025 at approximately 10:45 AM,	N 427		

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N 427	Continued From page 43 Surveyor interviewed Team Lead (TL) B. TL B stated they had previous activity calendars and gave Surveyor the October 2025 activity calendar to review. For 10/24/2025, the activity calendar listed the following activities: 10:00 AM Snacks 11:30 AM Daily Chronicles 2:00 PM Bowling 3:00 PM Music (linked senior). On 10/24/2025 at approximately 12:30 PM, Surveyor interviewed Resident 2. Resident 2 stated there were no activities offered, and s/he would like to do crafts. Resident 2 stated s/he needed help to do activities due to his/her arm being paralyzed. On 10/24/2025 at 2:03 PM, Surveyor interviewed Resident 4. Resident 4 stated there were no group activities offered, and s/he bought his/her own colors and crafts. On 10/24/2025 at 2:12 PM, Surveyor interviewed Resident 1. Resident 1 stated s/he had not observed any activities conducted at the facility. On 10/24/2025 at 2:27 PM, Surveyor interviewed Resident 5. Resident 5 stated s/he would like exercise to be offered as an activity. On 10/24/2025 at 2:36 PM, Surveyor interviewed Resident 6. Resident 6 stated staff offered bingo occasionally. Surveyor did not observe an activity calendar posted in the facility or any activities taking place during the duration of the survey on 10/24/2025 from 9:54 AM to 3:11 PM. On 11/26/2025 at 1:00 PM, Surveyor interviewed	N 427		

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N 427	Continued From page 44 Regional Director (RD) A and TL B. RD A stated they did have an activity calendar and encouraged residents to participate. RD A stated there was a puzzle table for residents and they had board games and crafts available. RD A stated staff offered activities daily to residents, but many residents preferred not to participate.	N 427		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.	N 431		

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N 431	Continued From page 45 This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide health monitoring of Resident 2 and Resident 3 related to changes in their skin. The provider did not adequately document monitoring and assessments of Resident 2's and Resident 3's skin changes in his/her record. Findings include: On 05/29/2025 and 10/09/2025, the department received a complaint alleging health monitoring concerns. Example 1 On 10/24/2025 at approximately 12:30 PM, Surveyor interviewed Resident 2. Resident 2 stated a few weeks ago s/he had a heat pack applied to his/her shoulders and it burned the right side of his/her neck. Resident 2 stated s/he did not go in to be medically evaluated for the burn. Resident 2 indicated staff had popped the blister that formed, which was the size of a dime. Resident 2 stated s/he wanted it drained at the hospital. On 11/13/2025, Surveyor reviewed Resident 2's record. The face sheet indicated Resident 2 was admitted on 10/18/2024 and had an activated power of attorney (POA). Diagnoses included in part candidiasis, chronic back pain, fecal incontinence, overactive bladder, urinary incontinence, prediabetes, and impaired mobility and activities of daily living (ADLs). A planned services document dated 05/07/2025,	N 431		

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indicated under bathing assistance staff were to report skin concerns to the nurse.

An assessment dated 05/07/2025, indicated under toileting needs, "[Resident 2] hesitates to 'bother' staff so will often sit in [his/her] soiled bottoms and not ask for help. A toileting schedule is in place in an effort to prevent this." The assessment indicated Resident 2 had no skin issues. The assessment indicated Resident 2 had pain in his/her right shoulder and lower back constantly. The assessment indicated Resident 2 had nystatin and barrier cream to apply as needed, but did not indicate where to apply. The assessment indicated Resident 2 would occasionally refuse to be toileted and cleaned up by staff.

Resident notes dated 09/01/2025 to 10/31/2025 indicated the following:

09/18/2025 written by Caregiver C - "Resident has a wound on [his/her] butt that is beginning to open again. Writer cleaned with wound cleaner, dried it and covered with a 4x4 bordered gauze with adhesive border until nurse can look at it."

09/26/2025 written by Caregiver E - "Resident has 2 blisters on [his/her] right shoulder, I called [RD A] [s/he] says to monitor it, do not pop them, and to be sure heating pad is not to [sic] hot and is wrapped with a towel when you apply hot pad to [his/her] right shoulder."

10/29/2025 written by Nurse F - "Writer observed a small open are [sic] to right shoulder area. Measures 0.4cm x 0.1cm x <0.1cm. Wound bed is moist, and pink. Scant bloody drainage present. Peri-wound: no edema, redness, or warmth noted. Cleanse daily with warm soapy

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water, pat dry, and cover with dry dressing until resolved."

Surveyor received an email from Regional Director (RD) A on 11/24/2025 at 11:54 AM, which read in part, "The heating pad was [his/her] own that [s/he] applied to [his/her] skin without us knowing [s/he] had it. Once the incident occurred we have acquired a heating pack with a cover to protect [his/her] skin and did education on the proper way to use it."

Resident 2's record contained only one note about his/her skin breakdown to his/her buttocks and no charting indicating it was monitored or assessed. Resident 2's record indicated s/he received a burn to his/her right shoulder on 09/26/2025. The burn was not physically assessed by a nurse until 10/29/2025; over 1 month later.

Example 2

On 11/13/2025, Surveyor reviewed Resident 3's record.

The face sheet indicated Resident 3 was admitted on 08/29/2024 and had a guardian. Diagnoses included in part type II diabetes mellitus and major depressive disorder. Resident 3 was protectively placed at the facility.

An assessment dated 09/16/2024, indicated Resident 3 was independent with personal cares. The assessment indicated Resident 3 had skin excoriation near his/her left chest and was treated.

Resident 3's care coordination notes dated 02/01/2025 to 05/22/2025, indicated the following:

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N 431	Continued From page 48 02/13/2025 - "Red groin: Resident was given a shower and staff noted that [his/her] groin area on both sides. Nystatin powder was applied after area was clean and dried." 03/20/2025 - "Nystatin applied to armpits due to being red, nurse notified." 03/27/2025 - "Resident has redness under belly fold applied nystatin powder." 04/09/2025 - "Staff came down and resident said [his/her] armpits hurt. Staff looked and [his/her] armpit on left arm is really raw and sore redness and yeasty smell. Staff washed [his/her] armpits dried them and applied nystatin powder to them. [His/Her] right one was just a slight red so applied nystatin to both." 05/01/2025 - "Resident is very red and sore under belly fold. This staff applied nystatin powder under belly fold." 05/13/2025 - "Nurse Note: Team showed RN adbdominal [sic] folds red and odor present. Resident history of yeast to abdominal folds. Advised to wash with soap and water, apply nystatin and Viva papertowels [sic]. PCP updated." An assessment dated 04/18/2025, indicated Resident 3 required full assistance from staff with bathing and hygiene. The assessment indicated Resident 3 needed assistance with toileting. The assessment indicated Resident 3 would get frequent redness on his/her chest and groin areas. The assessment also indicated Resident 3 would get intermittent moisture yeast and redness to his/her bilateral axilla and abdominal folds.	N 431		

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Staff were to apply nystatin powder and cream as needed.

Resident 3's skin breakdown to his/her groin was first noted by staff on 02/13/2025 and Resident 3's skin breakdown to his/her axilla and abdominal folds was first noted by staff on 03/20/2025 and 03/27/2025. The first assessment noting skin breakdown in these areas by a nurse was documented on 04/18/2025; over 2 months later. A follow-up nurse assessment was done one month later on 05/13/2025, but there was no charting indicating it was monitored or assessed more often by staff or the nurse.

On 11/17/2025 at 1:58 PM, Surveyor received an email response from RD A. Surveyor asked if RD A could speak to how Resident 3's skin breakdown was addressed and monitored from February 2025 to May 2025. RD A responded, "no [sic] skin issues were reported to nursing for this time period. We now have this added to the communication expectation of the team to nursing on a weekly basis."

On 11/26/2025 at 1:00 PM, Surveyor interviewed RD A, Nurse F, and Team Lead (TL) B. RD A stated staff initially messaged him/her about Resident 2's burn from the heat pack. RD A stated s/he followed-up weekly verbally with staff to see how the burn was doing. RD A stated staff were instructed to not pop the blister and keep the burn covered and then to leave it open to air as it healed. RD A stated s/he was unable to physically be at the facility during that time, did not physically assess the burn, and did not document monitoring of the burn adequately. When Surveyor asked RD A about Resident 2's skin breakdown on his/her bottom, RD A stated

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N 431	Continued From page 50 s/he was not aware of the wound on his/her buttocks. Nurse F stated staff had also not made him/her aware of the wound on Resident 2's buttocks. RD A stated s/he assessed Resident 3's skin in May 2025. Nurse F stated s/he was currently working on educating staff about the notification of skin breakdown and would be improving the nurse's charting of skin breakdown monitoring and assessing. The provider did not provide adequate health monitoring related to changes in Resident 2's and Resident 3's skin and document changes in their records. Cross Reference N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0425 DHS 83.38(1)(a) Personal Care	N 431		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the dryer vent tubing was of rigid material. Findings include:	N 488		

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N 488	Continued From page 51 This provider is licensed to care for up to 16 residents in the client groups of: advanced age, irreversible dementia/Alzheimer's disease, terminally ill, and physically disabled. On 10/24/2025 at 1:02 PM, Surveyor observed the laundry room and found the interior dryer vent tubing was of semi-rigid flexible material. "An estimated 2,900 clothes dryer fires in residential buildings are reported to U.S. fire departments each year and cause an estimated 5 deaths, 100 injuries, and $35 million in property loss...Flexible transition ducts used to connect the dryer to the exhaust duct system are required to be not longer than eight feet, not concealed within construction, and listed and labeled in accordance with Underwriters Laboratories (UL) 2158A." (Source: U.S. Fire Administration website,Topical Fire Report Series: Clothes Dryer Fires in Residential Buildings (2008-2010), August 2012, https://www.usfa.fema.gov/downloads/pdf/statistics/v13i7.pdf (retrieval date - 12/12/2025).) On 11/26/2025 at 1:00 PM, Surveyor interviewed Regional Director (RD) A, Nurse F, and Team Lead (TL) B. RD A stated s/he was unsure if the vent had been replaced and would call maintenance to correct immediately.	N 488		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area.	N 499		

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N 499	Continued From page 52 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure toxic substances were securely stored. This is a repeat deficiency. See Statement of Deficiency (SOD) EHFE11, dated 11/16/2022. Findings include: This provider is licensed to care for up to 16 residents in the client groups of: advanced age, irreversible dementia/Alzheimer's disease, terminally ill, and physically disabled. On 10/24/2025 at 10:19 AM, Surveyor observed in the south public bathroom a wall cabinet that contained glass cleaner and disinfectant. On 10/24/2025 at 11:42 AM, Surveyor interviewed Caregiver D. Caregiver D stated the kitchen door was left open during the day shift due to staff going in and out frequently. Surveyor observed toxic substances unsecured under the kitchen sink cabinet. On 10/24/2025 at 2:11 PM, Surveyor observed the kitchen door was left open for anyone to access. On 10/24/2025 at 3:09 PM, Surveyor observed the kitchen door still open and observed the following toxic substances unsecured under the kitchen sink cabinet: -disinfectant -glass cleaner -bleach -rinse aide.	N 499		

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N 499	Continued From page 53 On 11/26/2025 at 1:00 PM, Surveyor interviewed Regional Director (RD) A, Nurse F, and Team Lead (TL) B. RD A acknowledged the concerns related to the storage of toxic chemicals and would correct it immediately.	N 499		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire drill documentation included the total evacuation time and did not record residents having an evacuation time greater than the time allowed under s. DHS 83.35(5), and the type of assistance needed for evacuation in 2024 and 2025. Findings include:	N 525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018759	A. BUILDING: _____ B. WING _____	R-C 11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - ABBOTSFORD I	100 S 4TH AVE ABBOTSFORD, WI 54405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 525	Continued From page 54 This provider is licensed to care for up to 16 residents in the client groups of: advanced age, irreversible dementia/Alzheimer's disease, terminally ill, and physically disabled. On 10/24/2025, Surveyor reviewed the provider's safety reports. Fire drill documentation showed the time of day the drill was conducted but did not specify the total evacuation time and did not record residents having an evacuation time greater than the time allowed under s. DHS 83.35(5), and the type of assistance needed for evacuation. On 11/26/2025 at 1:00 PM, Surveyor interviewed Regional Director (RD) A, Nurse F, and Team Lead (TL) B. RD A stated they had a resident point of rescue (POR) list and were working with their local fire department. RD A stated the form used to document fire drills would be updated to document the required information.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct tornado, flooding, or other emergency or disaster evacuation drills at least semi-annually in 2024 and 2025. Findings include: This provider is licensed to care for up to 16	N 526		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018759	A. BUILDING: _____ B. WING _____	R-C 11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - ABBOTSFORD I	100 S 4TH AVE ABBOTSFORD, WI 54405

(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 55 residents in the client groups of: advanced age, irreversible dementia/Alzheimer's disease, terminally ill, and physically disabled. On 10/24/2025, Surveyor reviewed the provider's safety reports. The provider conducted only one emergency drill in 2024 and two emergency drills on the same day in 2025. On 05/21/2024, the provider conducted a tornado drill at 7:00 PM. On 09/24/2025, the provider conducted an elopement drill and tornado drill. On 11/26/2025 at 1:00 PM, Surveyor interviewed Regional Director (RD) A, Nurse F, and Team Lead (TL) B. RD A confirmed those were the only emergency drills they had on record for 2024 and 2025 and would be correcting this moving forward.	N 526		