STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018747	A. BUILDING: _____ B. WING _____	C 04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - LADYSMITH II	**1105 BAKER AVE LADYSMITH, WI 54848**

(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 04/08/2025, Surveyor conducted 2 complaint investigations and a standard licensure survey at VitaCare Living - Ladysmith II. Data was collected through 04/09/2025. Two of 2 complaints were unsubstantiated. Six deficiencies were identified. One of 6 deficiencies was a repeat deficiency. See Statement of Deficiency 7EER11, dated 10/13/2022. Census: 16	N 000		
N 432	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure staff provided medication administration to meet the needs of each resident. Insulin pens stored in the medication cart were not all labeled with an open or use by date.	N 432		

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

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N 432	Continued From page 1	N 432		

Resident 3 did not receive adequate medication administration services when his/her medication was no longer available to administer.

Findings include:

INSULIN STORAGE

The Food and Drug Administration (FDA) label indicates how long the insulin can be stored once opened as follows:
Lantus (SoloStar) - "Only use your pen for up to 28 days after its first use. Throw away the LANTUS SoloStar pen you are using after 28 days, even if it still has insulin left in it."
(Retrieved 04/09/2025 from: https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/021081s078s079lbl.pdf).

Semglee - "The pen that you are using should be thrown away 28 days after removing it from the refrigerator, even if the pen has insulin left in it."
(Retrieved 04/09/2025 from: https://www.accessdata.fda.gov/drugsatfda_docs/label/2020/210605s000lbl.pdf).

On 04/08/2025 at approximately 10:45 a.m., Surveyor observed the medication cart with Caregiver D. Resident 4 had a Lantus insulin pen with no date on it. Resident 2 had a Semglee insulin pen with no date on it. Caregiver D told Surveyor staff were to date the insulin pens when they remove them from the refrigerator. The insulin pens had stickers on them for staff to document the open date.

On 04/08/2025 at approximately 4:30 p.m., Surveyor interviewed Registered Nurse (RN) C. RN C told Surveyor s/he would be auditing the

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N 432	Continued From page 2	N 432		

medication carts on a regular basis to ensure all medications that required open dates were dated.

RESIDENT 3

On 04/08/2025, Surveyor reviewed Resident 3's record.

Resident 3 was admitted to the facility on 06/05/2024. She had multiple diagnoses, including: hemiplegia and hemiparesis affecting the right side, unspecified dementia, anxiety, major depressive disorder, fibromyalgia, and opioid dependence.

Resident 3's medication administration record (MAR) for February, March, and April 2025 indicated Resident 3 had an order for duloxetine DR (delayed release), 40 milligrams, 2 times a day for muscle/bone pain and depression. From 02/12/2025 - 02/28/2025, staff documented 25 doses as missed due to the medication not being available. From 02/12/2025 - 02/28/2025, staff documented 7 doses were administered. In March 2025, staff documented 57 doses as missed due to the medication not being available. In March 2025, staff documented 5 doses were administered. From 04/01/2025 - 04/07/2025, staff documented 12 doses as missed due to the medication not being available. From 04/01/2025 - 04/07/2025, staff documented 2 doses were administered.

On 04/08/2025 at approximately 4:00 p.m., Surveyor interviewed Director A, Assistant Director (AD) B, and Registered Nurse (RN) C. Surveyor asked why Resident 3 did not receive his/her prescribed duloxetine. Director A was not sure. AD B called the pharmacy to ask why Resident 3's duloxetine was not delivered. AD B

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N 432	Continued From page 3 told Surveyor the pharmacist said it was not delivered due to waiting for prior authorization since the medication was ordered 2 times a day. AD B said the pharmacist told him/her the duloxetine was delivered on 04/07/2025. RN C reviewed Resident 3's orders and found an order from Resident 3's hospice provider, dated 03/13/2025. This order discontinued the duloxetine and ordered amitriptyline. The amitriptyline was added to Resident 3's MAR, but the duloxetine was not discontinued from the MAR. RN C said s/he was going to contact Resident 3's hospice provider to get an updated list of all of Resident 3's prescribed medications to reconcile with Resident 3's MAR. The provider did not ensure Resident 3 received services for medication administration. Staff did not communicate to management when Resident 3 no longer had a medication available to administer. Some staff documented the medication was administered as prescribed, even though other staff stated it was not available.	N 432		
N 490	83.44(2)(b) Toilet and bathing area. All toilet and bathing areas, facilities and fixtures shall be clean and in good working order. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure all toilet and bathing areas were maintained in good working order. Findings include: On 04/08/2025 at 9:40 a.m., Surveyor interviewed Resident 1 in his/her room. Resident 1 told	N 490		

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N 490	Continued From page 4 Surveyor the shower was leaking and dripping in his/her bathroom. Surveyor observed the shower, which was dripping into a foot basin. On 04/08/2025, Surveyor reviewed Resident 1's Resident Satisfaction Evaluation, dated and signed by Resident 1 on 10/15/2023. Question 22 read: "Any other comments regarding this facility you would like to make?" Resident 1 included the following comment: "I would like my shower fixed." On 04/08/2025 at approximately 10:20 a.m., Surveyor observed Resident 2's bathroom. The toilet paper holder was broken off the wall. On 04/08/2025 at approximately 4:00 p.m., Surveyor interviewed Director A and explained the observations of Resident 1's shower leaking and Resident 2's toilet paper holder. Director A told Surveyor they recently hired a new maintenance person, and s/he would add this to his/her list of things to fix.	N 490		
N 504	83.46(1)(c) Heating system maintenance. Heating. The CBRF shall maintain the heating system in a safe and properly functioning condition. The CBRF shall ensure that a heating contractor or local utility company completes all of the following maintenance and makes available to the facility documentation of the maintenance performed: 1. An oil furnace shall be serviced at least once each year. 2. A gas furnace shall be serviced at least once every 3 years. 3. The CBRF shall have a chimney inspected at intervals corresponding with the heating system service under subd. 1. or 2.	N 504		

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N 504	Continued From page 5 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a heating contractor or local utility company completed maintenance service on the gas furnace at least every 3 years. Findings include: On 04/08/2025, Surveyor reviewed the provider's safety binder. Surveyor did not locate a furnace inspection. On 04/08/2025 at approximately 4:30 p.m., Surveyor interviewed Director A. Director A told Surveyor s/he could not locate documentation of the last furnace inspection. Director A said s/he would contact the contractor to obtain this documentation. On 04/09/2025 at approximately 1:00 p.m., Surveyor interviewed Director A on the phone and asked if s/he received documentation of the furnace inspection. Director A said s/he found a copy of the last furnace inspection, which was completed in 2020. S/he said s/he called the contractor, and they would be there on Friday (04/11/2025) to inspect the furnaces.	N 504		
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.	N 525		

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N 525	Continued From page 6 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 conduct at least one fire evacuation drill in 2023 and 2024 that simulated the conditions during normal sleeping hours. Findings include: On 04/08/2025, Surveyor reviewed the provider's safety binder for fire drills conducted in 2023 and 2024. None of the fire drills reviewed indicated they were conducted or simulated during normal sleeping hours. On 04/08/2025 at approximately 4:30 p.m., Surveyor interviewed Director A. Director A said s/he could not locate any documentation to indicate the fire drills included a drill conducted or simulated during normal sleeping hours.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills	N 526		

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N 526	Continued From page 7 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 an "other" (other than fire) evacuation drill (i.e., tornado, flood, or disaster evacuation drill) at least semi-annually. This is a repeat deficiency. See Statement of Deficiency 7EER11, dated 10/13/2022. Findings include: On 04/08/2025, Surveyor reviewed the provider's safety binder for "other" evacuation drills conducted in 2023 and 2024. There was a severe weather evacuation drill conducted April 2024. There were no other evacuation drills documented, in addition to fire drills, in 2023 and 2024. On 04/08/2025 at approximately 4:30 p.m., Surveyor interviewed Director A. Director A said s/he could not locate any other documentation of "other" evacuation drills conducted in 2023 and 2024.	N 526		
N 669	83.60(2) Insect-proof screens on openable windows Screens. All required openable windows shall have insect-proof screens. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure all screens were insect-proof. Resident 1's window screen had holes in it.	N 669		

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N 669	Continued From page 8 Findings include: On 04/08/2025 at 9:40 a.m., Surveyor interviewed Resident 1 in his/her room. Surveyor observed holes in the window screen in Resident 1's room. Resident 1 told Surveyor the holes had been there for 2 years. On 04/08/2025, Surveyor reviewed Resident 1's Resident Satisfaction Evaluation, dated and signed by Resident 1 on 10/15/2023. Question 22 reads: "Any other comments regarding this facility you would like to make?" Resident 1 included the following comment: "A new screen for my window."	N 669		