STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019178	A. BUILDING: _____ B. WING _____	R-C 05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING MOUNT HOREB	104 LINCOLN CT MOUNT HOREB, WI 53572

(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 04/29/2025, with information gathered through 05/02/2025, Surveyor conducted a complaint investigation and verification visit. Six deficiencies were identified. Complaint was substantiated. One of 6 deficiencies, was a repeat violation (See Statement of Deficiency (SOD) NYMZ11). Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 12	{N 000}		
N 163	83.12(4)(a) Reporting when resident's whereabouts unknown A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time a resident ' s whereabouts are unknown, except those instances when a resident who is competent chooses not to disclose his or her whereabouts or location to the CBRF, the CBRF shall notify the local law enforcement authority immediately upon discovering that a resident is missing. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies or persons recovering from substance abuse. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the Department within 3 days when a resident's (Resident 4) whereabouts was unknown on 03/28/2025.	N 163		

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

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N 163	Continued From page 1 Findings include: On 04/08/2025, the Department received a concern alleging staff were unaware when a resident eloped from the facility and law enforcement was not contacted. On 04/29/2025, Surveyor reviewed Resident 4's record. Resident 4 moved into the facility 03/18/2025. Resident 4's record did not document diagnoses. Resident 4's record did not contain documentation related to the elopement. On 04/29/2025, at approximately 12:45 PM, Surveyor reviewed the police report s/he had received from the local law enforcement agency with Administrator H and House Manager J. The report documented that on 03/28/2025 at 7:20 PM officers were dispatched to a location where an elderly person had been found, confused and wandering the streets. Officers were able to determine the individual resided at VitaCare Living Mount Horeb and returned him/her to this location. Administrator H asked if a self-report had been submitted to the department, as s/he was not the administrator during this incident. Surveyor informed him/her that s/he had reviewed the department file and did not observe a self-written report. Administrator H stated s/he would submit a late report. On 05/02/2025, Surveyor reviewed the department file and determined a written report had not been submitted by the provider in 2025. Cross Reference: N0358 DHS 83.32(3)(n) Rights of Residents: Safe Environment	N 163		

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N 215	Continued From page 2	N 215		
N 215	83.15(3)(b) Administrator responsible for staff training The administrator shall be responsible for the training and competency of all employees. This Rule is not met as evidenced by: Based on record review and interview, the administrator did not ensure training and competency of all employees. Findings include: On 03/04/2025, the provider received a "Notice and Order" letter regarding Statement of Deficiency (SOD) NYMZ11, where it was documented: "Notice of Special Orders: 1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., the licensee shall develop (or review and revise) a written procedure addressing advanced directives, CPR (cardiopulmonary resuscitation), and DNR (do not resuscitate) orders to ensure the action and interventions taken by an employee at the time of the medical emergency is clear and consistent with a resident's wishes. All resident care staff, and managers will receive in-service training regarding the written procedure. Documentation of training will be maintained in personnel files and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. A copy of the procedure will be made available to department representatives upon request." On 04/29/2025, at approximately 12:45 PM, Surveyor interviewed Administrator H.	N 215		

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N 215	Continued From page 3 Administrator H explained that s/he had just been recently employed with the provider and was in the process of organizing the previous Administrator A's records. Administrator H stated previous Administrator A worked for the management company the provider had previously hired. There were concerns with previous Administrator A's oversight of the building and the management company was dismissed. Administrator H confirmed that there was limited documentation readily available. On 05/02/2025 at 8:16 AM, Surveyor emailed Administrator H and requested the training records that staff had received regarding advance directives and residents, since 12/09/2024, when a survey had been completed at the facility and concerns had been identified in staff training in this area. Surveyor requested the records be forwarded by 3:00 PM. On 05/02/2025 at 4:19 PM, Administrator H emailed Surveyor and stated s/he had not been able to locate the documentation and could not verify if staff had received additional training regarding advance directives and CPR.	N 215		
N 355	83.32(3)(k) Rights of Residents: Self-determination In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Self-determination. Make decisions relating to care, activities, daily routines and other aspects of life which enhance the resident ' s self reliance and support the resident ' s autonomy and decision making.	N 355		

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N 355	Continued From page 4 This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not support or promote the right of self-determination for 1 of 1 resident. Resident 4's cable box for basic tv service was not installed. Findings include: On 04/29/2025, at approximately 11:05 AM, Surveyor toured the facility and observed a resident room where his/her television was displaying "No Service." On 04/29/2025, at approximately 12:45 PM, Surveyor interviewed Administrator H and House Manager J. Administrator H stated s/he and House Manager J had just recently started employment with the provider, but s/he knew the basic cable package was provided to residents. If residents wanted an enhanced cable package, that would be the resident's responsibility. Administrator H stated Resident 4 should have the option to watch his/her television programming in his/her room, as that was part of his/her admission package. House Manager J stated Resident 4 did not have basic cable tv in his/her room. Administrator H stated s/he would contact maintenance and have the concern addressed. On 04/29/2025, Surveyor reviewed Resident 4's record. Resident 4 moved into the facility 03/18/2025. Resident 4's record did not have an admission agreement. On 04/29/2025, at approximately 12:55 PM, Surveyor interviewed Administrator H.	N 355		

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N 355	Continued From page 5 Administrator H stated s/he was unable to locate an admission agreement in Resident 4's record but could provide a blank admission agreement for review. Surveyor reviewed the blank admission agreement which documented: Exhibit A - Monthly Service Charge Listing - j. Basic Expanded cable TV in facility Exhibit B - Optional Services/Supplies Listing - d. Expanded cable TV On 04/30/2025, at approximately 10:48 AM, Surveyor interviewed Resident 4's Power of Attorney (POA) I. POA I stated Resident 4 had not had cable service for his/her television since his/her admission date, 03/18/2025. POA I stated, "This is a basic service that was to be provided and nobody can tell us when this service will be available."	N 355		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a safe environment for 1 of 1 resident. Resident 4 eloped from the facility and his/her	N 358		

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N 358	Continued From page 6	N 358		

whereabouts were unknown until resident was returned to the facility by law enforcement.

Findings include:

On 04/08/2025, the Department received a concern that a resident had eloped from the facility and staff were unaware.

On 04/29/2025, at approximately 11:30 AM, Surveyor interviewed House Manager J. House Manager J stated, "It is important to keep the residents entertained, so they do not get bored. If you have eyes on them and you are interacting with them, you would know if they are exit seeking. [Resident 4] loves to walk around, but [s/he] won't go outside if the weather is cold."

On 04/29/2025, at approximately 12:20 PM, Surveyor reviewed the police report with Administrator H, which documented:
"On March 28, 2025, at approximately 7:20 PM, I was notified [Communications Center] to respond to 109 S. Sixth Street, ... for a report of a found person ... an elderly [man/lady] who was confused and wandering the streets. The elderly [fe/male] was later identified as [Resident 4]. ...
I arrived on scene and identified myself as a police officer. [Resident 4] was confused and did not know where [s/he] was, [his/her] date of birth, or where [s/he] lived. ... [Resident 4] knew [his/her] name and knew [s/he] was from the area, but later was confused about whether [s/he] was in Blue Mounds or Mount Horeb. ...
I made contact with [concerned citizen] and ... [concerned citizen] reported that [s/he] was at [convenience store] on Springdale Street and 8th Street. [Concerned citizen] observed that [Resident 4] was standing with a "blank stare" by the gas pump. [Concerned citizen] left

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N 358	Continued From page 7 [convenience store], picked up food from a restaurant, and returned to the area. [Concerned citizen] was driving on E. Main Street near Sixth Street at the [church] and located [Resident 4] again. [Concerned citizen] reported that [Resident 4] appeared confused. [Concerned citizen] knows from [his/her] experience working at an assisted living facility with people who have dementia that this stare is a common sign of someone with dementia. [Concerned citizen] called police and continued to stand by with [Resident 4]. ... I transported [Resident 4] to [address last on file for him/her]. ... made contact with [Power of Attorney (POA) I. [POA I] reported that [Resident 4] had recently moved into VitaCare Assisted Living Mount Horeb and was extremely surprised that [Resident 4] was in the back of a police car. I transported [Resident 4] to VitaCare Assisted Living Mount Horeb and requested that [emergency medical services] respond to the scene to evaluate [Resident 4]. ... I rang the front doorbell to the Vita Care complex and made contact with [Caregiver K]. [Caregiver K] opened the door, and I asked [him/her] if [s/he] was missing anyone or looking for someone. [Caregiver K] reported that [s/he] was looking for [Resident 4]. [Caregiver K] informed me that [s/he] was going to call [his/her] manager. [Caregiver K] appeared frustrated. ... [Caregiver K] reported that [s/he] was working with [Resident 4] before 7:00 PM tonight and knew that [s/he] was still there. At approximately 7:00 PM tonight, [Caregiver K] was giving medications to all residents. When [Caregiver K] got to [Resident 4's] room to give [him/her] medications, [s/he] could not locate [him/her]. [Caregiver K] checked the entire facility but could not locate [Resident 4]. [Caregiver K] did not know for how long [s/he] had searched the facility and the time when [s/he] first noted that [Resident 4] was missing.	N 358		

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N 358	Continued From page 8 [Caregiver K] reported that there is no video camera footage inside Vita Care, but all of the doors upstairs are secured and require a code to be entered in order to unlock the door. [Caregiver K] was very confused about how [Resident 4] was found outside the facility and said multiple times that [s/he] believed someone must have let [him/her] out. No staff members or visitors left or entered the facility before 7:00 PM. It appears that no one left or entered except for [Resident 4]. [Caregiver K] reported that [Resident 4] likes to ride the elevator in the facility and that the downstairs doors do not have any locks. [Caregiver K] showed me the two exits downstairs, and I located the doors with normal handles. All upstairs doors appear to be electronic and require a code to exit. When someone attempts to exit without entering a code, it sets off an alarm. ... I encouraged [Caregiver K] to call police when [s/he] finds that a resident is not in the facility and missing. [Caregiver K] called [previous Executive Director (ED) L]. [ED L] was talking to [Caregiver K], and I heard [Caregiver K] report to [ED L] that there were no "alarms" going off, which would happen if someone attempted to open the door with an incorrect code or attempted to open the door without a code. [ED L] reported to me that [s/he] is filling in as the manager for this facility but normally supervises northern Vita Care Facilities. [ED L] did not know much about the situation. I explained to [him/her] that this incident was unacceptable, and [s/he] stated that Vita Care has to update their security protocol. ... I made contact with [Caregiver M], who reported that this is [his/her] first day working at Vitacare. [Caregiver M] did not know about the incident. [Caregiver M] and [Caregiver K] are the only two employees on scene and working tonight. From where Vita Care is located and where	N 358		

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[Resident 4] was found, [s/he] would have crossed 8th Street, also called State Highway 92, one of the busiest streets for vehicular traffic in the Village of Mount Horeb. During this incident, the temperature was approximately 74 degrees and sunny."

Surveyor determined it was approximately 0.5 mile to the convenience store from the providers location.

Administrator H stated s/he had never seen Resident 4 "play" on the elevators. The elevator was difficult to operate. Administrator H stated, "It is possible that [Resident 4] went out the front door, the alarm went off but then disengaged when the door was closed. Administrator H explained that him/her and House Manager J were new to the provider and would be conducting elopement drills with the staff, as this concern was unacceptable and should not have occurred.

On 04/29/2025, Surveyor reviewed Resident 4's record.
Resident 4 moved into the facility on 03/18/2025.
Resident 4's assessment, dated 03/18/2025, documented:
"Mobility Status: Monitor and Cue - Resident requires staff monitoring and/or reminders and cues when ambulating."
"Transferring: 1 person assist - Tenant requires staff assistance to complete transfers."
"Leisure Time Activities: Resident requires staff to offer activities and monitor participation."

On 04/29/2025, Surveyor reviewed the evacuation policy, dated April 2023, provided by House Manager J, which documented:
"Administrative and Organizational Issues:

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N 358	Continued From page 10 Emergency Planning & Disaster, Plan/Procedure for a Missing Resident: The designated ULP (unlicensed personnel) will communicate missing resident to all other facility staff on site. All staff will make a prompt and thorough search of the building(s) and premises. The designated ULP will notify the Executive Director or designee who will report to the building and take charge of the situation. The Executive Director or their designee will immediately notify the resident's responsible party, if any, and/or emergency contact person. The Executive Director or their designee will notify police by dialing 911. Provide the police with a description of the person and photo, if available." On 04/29/2025, at approximately 1:15 PM, Surveyor observed the elevator. The elevator did not have the 'typical' up/down button on the outside of the door that would signal the sliding doors to open. This elevator had a swinging door that would need to be operated from the inside. On 04/30/2025, at approximately 10:48 AM, Surveyor interviewed Resident 4's POA I. POA I stated, "I have been told so many different stories. One minute they are saying [s/he] exited from downstairs, via the elevator. [S/he] would not be playing on the elevator. Then another time someone let [him/her] out of the building. The next time it was because [s/he] got out a side door that was accessible through a vacant office. They don't know. How do staff not know where their residents are and then not to even care to call 911."	N 358		
N 432	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents	N 432		

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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, interviews and record review, the provider did not provide medication administration services to ensure Resident 4's and Resident 5's blood sugar (BS) levels were monitored individually through their blood glucose meters.

Findings include:

On 04/29/2025, Surveyor reviewed Resident 4's record.

Resident 4 moved into the facility, 03/18/2025, with diagnosis including diabetes.
Resident 4's March 2025 Medication Administration Record (MAR) documented: "Accu-Chek Kit Guide: Use as directed to test blood sugar twice daily. Scheduled at 8:00 AM and 8:00 PM. Start Date: 03/19/2025."
The MAR did not document BS levels on 03/26 and 03/28 at 8:00 PM.

On 04/29/2025, at approximately 12:20 PM, Surveyor interviewed Administrator H and House Manager J. Surveyor asked if s/he could review Resident 4's Accu-Check to determine if the BS

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N 432	Continued From page 12 levels had been taken and had not been recorded on the MAR. House Manager J stated there was only one Accu-Chek available between Resident 4 and Resident 5 but Resident 4's 8:00 PM reading could be identified, because Resident 5 only had AM readings. Surveyor and House Manager J observed the Accu-Chek glucose reader which did not identify any readings. House Manager J could not explain why there were no recorded readings on the Accu-Check. Administrator H stated each resident was to have their own Accu-Check and this concern would be addressed immediately. "Germs can live in blood. Never use fingerstick devices for more than one person. Assign blood glucose meters to a person unless the device is designed for use in professional settings and is cleaned and disinfected after every use. Never use fingerstick devices for more than one person. Do not share blood glucose meters. If you must share them in a healthcare or congregate setting, select a device designed for use in professional settings, not an over-the-counter device. Clean and disinfect blood glucose meters after every use, per the manufacturer's instructions. These recommendations apply in: Long-term care settings (e.g., nursing homes and assisted living facilities)." (Source: CDC (Center for Disease Control and Prevention) website, Considerations for Blood Glucose Monitoring and Insulin Administration, August 07, 2024, https://www.cdc.gov/injection-safety/hcp/infection-control/index.html#:~:text=Germs%20can%20live%20in%20blood,and%20disinfected%20after%20every%20use. (retrieval date - May 02, 2025).)	N 432		
{N 454}	83.42(1) Resident record maintained.	{N 454}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019178	A. BUILDING: _____ B. WING _____	R-C 05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING MOUNT HOREB	104 LINCOLN CT MOUNT HOREB, WI 53572

(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 454}	Continued From page 13 The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or	{N 454}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VITACARE LIVING MOUNT HOREB	104 LINCOLN CT MOUNT HOREB, WI 53572

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{N 454}	Continued From page 14 symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the records for 2 of 2 residents were maintained with all the required information. This is a repeat deficiency. See Statement of Deficiency (SOD) NYMZ11, dated 12/09/2024. Resident 4's record did not contain an admission agreement. Resident 5's record did not contain an individual service plan (ISP). Findings include:	{N 454}		

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{N 454}	Continued From page 15 On 04/29/2025, at approximately 12:45 PM, Surveyor interviewed Administrator H. Administrator H explained that s/he had just been recently employed with the provider and was in the process of organizing previous Administrator A's records. Administrator H stated previous Administrator A worked for the management company the provider had previously hired. There were concerns with previous Administrator A's oversight of the building and the management company was dismissed. Administrator H confirmed that there was limited documentation readily available, which was concerning since the provider utilized an electronic computer system for resident records. On 04/29/2025, Surveyor reviewed Resident 4's and Resident 5's record. Resident 4 moved into the facility on 03/18/2025 and was represented by Power of Attorney (POA) I. Resident 4's record did not contain an admission agreement. Resident 5 moved into the facility 01/30/2023. Resident 5's record did not contain a current ISP. On 05/02/2025 at 8:16 AM, Surveyor emailed Administrator H and requested Resident 4's admission agreement and Resident 5's current ISP with signature page. Surveyor requested the records be forwarded by 3:00 PM. On 05/02/2025 at 4:19 PM, Administrator H emailed Surveyor and stated s/he had not been able to locate the documentation.	{N 454}		