STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018756	A. BUILDING: _____ B. WING _____	R-C 09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MENOMONIE I	1916 TALEN STREET MENOMONIE, WI 54751

(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 09/09/2025, Surveyor conducted a complaint investigation and verification visit at Vitacare Living - Menomonie I. Data was collected through 09/15/2025. Two of 2 complaints were unsubstantiated. Five violations were identified. Three of 5 violations were repeat deficiencies. See Statement of Deficiencies (SOD) O2Q313, dated 03/19/2025; O2Q311, dated 05/17/2023; and EL5R11, dated 11/08/2022. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 14	{N 000}		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on interview and record review, the licensee did not ensure the Community Based Residential Facility (CBRF) and its operation complied with laws governing the program. The licensee did not follow Department orders and maintain regulatory compliance. This is a repeat violation. See Statement of Deficiencies (SOD) O2Q311, dated 05/17/2023. Findings include:	N 196		

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

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N 196	Continued From page 1 The licensee has displayed a pattern of noncompliance evidenced by their survey history. As of 05/22/2025, the Department substantiated 5 complaints at the facility and issued 43 deficiencies since the provider was licensed on 03/01/2022. On 05/15/2025, the Department issued SOD O2Q313 with enforcement orders that read: "...effective immediately, the licensee will comply with requirements specified by Wis. Admin. Code § DHS 83.36(1)(a) and shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. The facility will develop (or review/revise) written procedures to ensure: - Staffing patterns will be sufficient to meet the personal care needs of residents, to ensure needed supervision, to provide needed services (e.g., toileting, bathing, medication management, interventions to prevent falls, personal cares, meals), and to facilitate a safe evacuation of the building in the event of an emergency. - When a resident or residents (as a group) require the assistance of two or more staff members to address care and service needs, to provide supervision, or to evacuate the building in an emergency, the licensee will ensure sufficient, qualified staff members are on duty, present and available to assist residents at all times. - Written staff schedules will be current and shall include each employee's full name, job assignment and time worked. Records will be amended, as necessary, to ensure an accurate and complete record of time worked by all facility employees, and/or employees of contract agencies providing routine services to facility residents.	N 196		

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N 196	Continued From page 2 Additionally: - All managers and resident care staff (as appropriate) will receive in-service training regarding new written procedures... - Training will be documented in employee 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 written procedures and all documentation as evidence of meeting the requirements ... will be made available to department representatives upon request... Within 7 days of receipt of this notice, the CBRF will provide each resident's legal representative and case manager (if any), with a copy of ... O2Q313 and a copy of this Notice and Order letter. The licensee shall retain documentation, acceptable to the Department, to verify compliance ... The documentation required ... will be available to department representatives upon request." The current survey, conducted between 09/09/2025 and 09/15/2025, was prompted by 2 complaints and a verification visit. The Department found that the provider did not follow special orders issued on 05/15/2025. The following issues were identified; the items identified with an asterisk (*) were repeat deficiencies: - Residents who were their own decisions makers were not involved in the development of their care plans. - Resident individual service plans (ISP) were not updated with changes in condition. - *Residents were not provided staff in adequate numbers to meet their needs. - *Staff did not follow standards of practice for	N 196		

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N 196	Continued From page 3 hand hygiene. On 09/09/2025 at approximately 9:20 AM, Surveyor interviewed Director A. Director A indicated there were multiple residents at the facility and the provider's neighboring facility that required assistance of 2 staff for transfer and care. Director A indicated the provider staffed both facilities with 1 employee and a float caregiver between the hours of 10:00 PM and 6:00 AM (NOC shift). When the float caregiver was at the neighboring facility, the CBRF did not have enough staff to meet resident needs. Surveyor requested evidence from Director A that the provider completed their enforcement orders issued on 05/15/2025. At 1:18 PM, Surveyor interviewed Administrator B and Director A. Administrator B indicated s/he could not locate a written policy on staffing patterns or evidence employees were trained on an updated staffing procedure. Administrator B stated they did not have evidence that the SOD or notice and order letter was sent to case managers or legal representatives. Cross references: N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan N0396 DHS 83.36 (1)(a) Adequate Staff to Meet Resident Needs N0441 DHS 83.39(3) Hand Washing	N 196		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the	N 387		

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N 387	Continued From page 4 resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident reviewed (Resident 1) was involved in the development of his/her individual service plan (ISP). Resident 1 did not sign his/her ISP to acknowledge their involvement in and agreement with the plan. Findings include: On 09/09/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 06/26/2025. Resident 1's record did not indicate s/he had a guardian or power of attorney. Resident 1's Planned Services document was undated and did not include evidence that it was reviewed or signed by anyone. Resident 1's Master Care Plan (MCP), dated 8/14/2025, did not include evidence that it was reviewed or signed by Resident 1.	N 387		

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N 387	Continued From page 5 On 09/09/2025 at 11:16 AM, Surveyor interviewed Director A. Director A stated the previous director (Director C) was responsible for completing Resident 1's ISP. Director A confirmed Resident 1 was his/her own decision maker. Surveyor asked if anyone had reviewed the ISP with Resident 1. Director A stated they had not. On 09/09/2025 at 11:55 AM, Director A explained that the provider's ISPs were comprised of 2 documents. The first was a document titled Planned Services which included a list of scheduled services and desired outcomes. The Planned Services document was typically what was reviewed and signed by a resident, their care team, and legal representatives. The second was a document titled Master Care Plan (MCP) which included a resident's needs and abilities.	N 387		
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.	N 389		

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N 389	Continued From page 6 This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 1 of 1 resident reviewed (Resident 1's) individual service plan (ISP) was accurate to Resident 1's condition and needs. Findings include: On 09/09/2025 at approximately 8:20 AM, Surveyor observed Caregiver F and Caregiver G complete Resident 1's morning personal care tasks. Resident 1 was resting in his/her recliner with only an incontinent brief and blanket on. Staff assisted Resident 1 by wiping his/her skin folds, applying topical treatments, putting on clothes, and changing his/her incontinence brief. Resident 1 transferred from his/her recliner to his/her wheelchair via physical assistance of 2 staff and a guided pivot turn. Surveyor did not observe a walker in Resident 1's room. On 09/09/2025 at 9:20 AM, Surveyor interviewed Director A. Director A provided a list of residents who required assistance of 2 staff for transfers. Resident 1 was included on this list. Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 06/26/2025. Resident 1's pre-admission assessment, dated 05/30/2025, and Master Care Plan (MCP), dated 08/14/2025, read: "Needs an assistive device to ambulate: Wheeled walker... using a walker as a chair and propelling... Needs assistance with transferring, specify: Resident at times needs more than stand by assistance. [S/he] is sleeping in r/c (recliner) at this time. Needs help out of it to [his/her] walker."	N 389		

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N 389	Continued From page 7 Resident 1's Planned Services (undated) read: "Staff to provide stand by assist while ambulating with walker for short distances. [Resident 1] sits on wheeled walker and self propels backwards... Staff to provide stand by assist for all transfers and while ambulating for safety." Resident 1's Planned Services included another resident's name (Resident 2) within it: "Staff to offer and encourage [Resident 2] to drink a full glass of water with each med pass and offer choice of hydration with each meal and in between meals to promote hydration... Staff to prompt and encourage [Resident 2] to attend scheduled meals. [Resident 2] enjoys most foods. Staff to notify ED/AED (executive director/assistant executive director) if meal percentage is below 50% for 2 consecutive meals. DOCUMENT PERCENT EATEN." These services did not appear to match Resident 1's needs as his/her MCP indicated Resident 1 was independent and required no assistance with eating or drinking. On 09/09/2025 at 11:16 AM, Surveyor interviewed Director A. Director A stated the previous director (Director C) was responsible for completing Resident 1's ISP. Director A reviewed Resident 1's Planned Services document and confirmed the document was not accurate to Resident 1's needs, noting that the document switched between scheduled services for Resident 1 to scheduled services for Resident 2. On 09/09/2025 at 11:55 AM, Director A explained that the provider's ISPs were comprised of 2 documents. The first was a document titled	N 389		

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N 389	Continued From page 8 Planned Services which included a list of scheduled services and desired outcomes. The Planned Services document was typically what was reviewed and signed by a resident, their care team, and legal representatives. The second was a document titled Master Care Plan (MCP) which included a resident's needs and abilities.	N 389		
{N 396}	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on interview and record review, the provider did not provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This is a repeat deficiency. See Statement of Deficiency (SOD) SOD O2Q13, dated 03/19/2025 and O2Q311, dated 05/17/2023. Findings include: The provider is licensed to care for 16 residents in the client groups physically disabled, advanced aged, terminally ill, and irreversible dementia/Alzheimer's disease. The facility is located next to a facility of equal size that is licensed to the same licensee. On 09/09/2025 at 9:20 AM, Surveyor interviewed Director A. Director A stated s/he was the director for both facilities. Director A said both facilities had multiple residents that required assistance of 2 staff:	{N 396}		

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{N 396}	Continued From page 9 - Resident 1 required 2 staff for transfers. - Resident 3 required 2 staff for all cares and transfers. - Resident 5 required 2 staff for transfers via sit-to-stand. - Resident 6 required 2 staff for transfers via pivot or mechanical lift, depending on his/her strength. - Resident 7 required 2 staff for cares and transfers due to his/her behavior. - Resident 8 (resided at the neighboring facility) required 2 staff for transfers. - Resident 9 (resided at the neighboring facility) required 2 staff for transfers. - Resident 10 (resided at the neighboring facility) required 2 staff for transfers. On 09/09/2025, Surveyor reviewed the June, August, and September 2025 staff schedules for both facilities. The schedules indicated there was 1 staff scheduled at each facility between the hours of 10:00 PM and 6:00 AM daily. The provider also scheduled 1 float staff during this shift. The float staff was available to both facilities. On 09/09/2025 at 11:55 AM, Surveyor interviewed Director A. Director A confirmed the provider scheduled 1 staff at the facility between 10:00 PM and 6:00 AM daily, and a float staff was available to assist as needed. Surveyor discussed concern that the staffing pattern left each facility understaffed. On 09/15/2025 at 10:25 AM, Surveyor received a call from the Menomonie Fire Chief, Chief H. Chief H stated s/he had concerns about the provider's staffing patterns. Chief H stated the Menomonie Fire Department had responded to the provider's Menomonie locations over 100 times in the year 2025 to help assist with resident	{N 396}		

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{N 396}	Continued From page 10 transfers. Chief H stated there were times when staff were pulled from the facility to assist with the neighboring facility, leaving the facility without any staff.	{N 396}		
N 441	83.39(3) Hand washing. Employees shall follow hand washing procedures according to centers for disease control and prevention standards. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure caregiver followed standard hand hygiene guidelines. Caregiver F did not perform hand hygiene as recommended by the Centers of Disease Control and Prevention (CDC) on 09/09/2025. This is a repeat violation. See Statement of Deficiencies (SOD) SOD EL5R11, dated 11/08/2022. Findings include: The CDC recommends performing hand hygiene immediately before touching a patient, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or patient's surroundings, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal. (Retrieved 09/15/2025 from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html). On 09/09/2025 between 8:00 AM and 9:00 AM, Surveyor observed Caregiver F don gloves and apply a topical treatment to Resident 3. Caregiver	N 441		

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N 441	Continued From page 11 F removed the gloves and did not perform hand hygiene until after s/he went to the director's office and the medication cart. Caregiver touched multiple surfaces prior to performing hand hygiene. Caregiver F went to Resident 1's room and performed morning cares which included wiping his/her skin folds, applying 2 topical treatments, and assisting Resident 1 with dressing, grooming, and transferring. Caregiver F applied gloves for the tasks and removed them, but did not perform hand hygiene. Caregiver F moved to Resident 4 to complete a blood glucose check. Caregiver F donned gloves, performed the test, and doffed his/her gloves. Caregiver F returned to the medication cart and sanitized his/her hands. At approximately 9:00 AM, Surveyor interviewed Caregiver F. Caregiver F stated s/he forgot to wash or sanitize his/her hands multiple times during the observation.	N 441		