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 03/09/2026

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 03/04/2026, Surveyor completed a complaint investigation and 2 verification visits at Vitacare Living Menomonie I for Statement of Deficiency (SOD) KO5311, dated 09/02/2025; and SOD O2Q314, dated 09/15/2025. Data collected through 03/09/2026. Seven deficiencies were identified. Four of 7 were repeat deficiencies. See Statement of Deficiency (SOD) 949Y11, dated 06/22/2022; SOD EL5R11, dated 11/08/2022; and SOD O2Q311, dated 05/17/2023; and SOD O2Q314, dated 09/15/2025. The complaint was substantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 9	{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	{N 196}		

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

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 03/09/2026

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 196}	Continued From page 1 and SOD O2Q314, dated 09/15/2025. Findings include: The licensee has displayed a pattern of noncompliance evidenced by their survey history. As of 03/09/2026, the Department substantiated 7 complaints at the facility and issued 49 deficiencies since the provider was licensed on 03/01/2022. On 12/18/2025, the provider entered a Stipulated Settlement Agreement with the Department of Health Services. The Stipulated Agreement read in part, "10. In exchange for the Departments actions stated in Paragraph 9 of this Agreement, Petitioner agrees to: ... c. Ensure all citations listed in SOD No. O2Q314 are corrected." The current survey, conducted between 03/04/2026 and 03/09/2026, was prompted by a complaint and 2 verification visits. The facility did not ensure all citations were corrected from SOD O2Q314. The following issues were identified; the items identified with an asterisk (*) were repeat deficiencies from SOD O2Q314. -*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. -Resident personal funds of more than $200 were kept at the facility. -Resident funds were not distributed within 14 days of discharge. -Residents were not adequately supervised. -Residents were not provided a daily activity program. On 03/04/2026 at approximately 12:13 PM,	{N 196}		

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 03/09/2026

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 196}	Continued From page 2 Surveyor interviewed Interim Regional Director (IRD) A and Director B. IRD A acknowledged that individual service plans (ISPs) were not accurately updated to reflect resident needs. IRD A also acknowledged that the ISPs lacked required signatures documenting the residents' involvement and agreement with the plan. IRD A was able to locate a file folder containing signed ISPs, which appeared to be completed after the issue was previously identified. However, it was evident that after the initial correction, the process was not consistently maintained as the ISPs continued to be updated. IRD A stated they would get the ISPs updated and signed right away. Cross Reference: N0370 DHS 83.34(3) More Than $200 Personal Funds From Resident N0371 DHS 83.34(4) Provide Written Final Accounting N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0426 DHS 83.38(1)(b) Supervision N0427 DHS 83.38(1)(c)Leisure Time Activities.	{N 196}		
N 370	83.34(3) More than $200 personal funds from resident Funds in excess of $200. A CBRF receiving more than $200 of personal funds from a resident shall deposit funds in excess of $200 in an interest-bearing account in the resident ' s name in a savings institution insured by an agency of, or a corporation chartered by, this state or the United States. This Rule is not met as evidenced by:	N 370		

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 03/09/2026

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 370	Continued From page 3 Based on record review and interview, the provider did not ensure resident funds in excess of $200 were placed in an interest-bearing account. Findings include: On 12/15/2025, the department received a complaint regarding concerns with resident funds. On 03/04/2026 at approximately 10:40 AM, Surveyor requested Resident 2's resident funds log. Director B stated s/he knew that Resident 2 still had money in the lock box. On 03/04/2026 at approximately 11:40 AM, Surveyor reviewed Resident 2's resident funds log. The following balances over $200 were noted: -10/10/2025, $303.49 -10/15/2025, $266.31 -11/12/2025, $213.91 -12/22/2025, $563.91 Surveyor interviewed Interim Regional Director (IRD) A and Director B about resident funds. Director B stated that the maximum amount they can manage for a resident was $200. Surveyor asked where resident funds were kept after they exceeded $200. Director B stated at this time, the providers' current process involved keeping money in lock box at the facility, but they were looking for ways to improve the process on managing resident funds. Director B acknowledged that Resident 2's account exceeded $200 on multiple occasions. The provider did not ensure resident accounts did not have a balance over $200.	N 370		

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 03/09/2026

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 371	Continued From page 4	N 371		
N 371	83.34(4) Provide written final accounting Final accounting. Within 14 days after a resident is discharged, the CBRF shall provide to the resident or the resident ' s legal representative a written final accounting of all the resident ' s funds held by the CBRF and shall disburse any remaining money to the resident or to the resident ' s legal representative. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that any remaining money was disbursed to the resident or resident's legal representative within 14 days of discharge. Findings include: On 12/15/2025, the department received a complaint regarding concerns with resident funds. On 03/04/2026 at approximately 10:40 AM, Surveyor requested Resident 2's resident funds log. Director B stated s/he knew that Resident 2 still had money in the lock box. Resident 2 was admitted to the facility on 03/25/2025. Resident 2 was discharged on 02/09/2026. At 11:40 AM, Surveyor reviewed the "Record of Financial Transactions - Personal Allowance Funds" for Resident 2. The last transaction on 12/22/2025 showed that Resident 2 had requested $400, which left a balance of $163.91. The bottom of the "Record of Financial Transactions - Personal Allowance Funds" read: "A final accounting and return of personal funds	N 371		

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 03/09/2026

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 371	Continued From page 5 will be done within 10 days after discharge." At 11:47 AM, Surveyor interviewed Interim Regional Director (IRD) A and Director B. Director B stated that Resident 2 still had money at the facility that was not given to him/her at the time of discharge. Director B stated that Resident 2 had been discharged the same day s/he started his/her job at the facility, 02/09/2025. Director B stated that Lead Caregiver (LC) E oversaw resident funds. LC E quit on 02/24/2026. Director B stated after that date was when s/he got into the lock box and noticed that Resident 2 still had money at the facility. Director B stated s/he needed to find the facility Resident 2 was discharged to and get him/her the remaining money. The provider did not ensure Resident 2 received his/her remaining money within 14 days of discharge when the provider still had his/her money on 03/04/2026, 23 days after Resident 2 had discharged from the facility.	N 371		
{N 387}	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the 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	{N 387}		

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 03/09/2026

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 387}	Continued From page 6 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 his/her involvement in and agreement with the plan. This is a repeat deficiency. See Statement of Deficiency (SOD) O2Q314, dated 09/15/2025. Findings include: On 03/04/2026 at approximately 9:50 AM, Surveyor requested Resident 1's record from Director B. 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 Master Care Plan (MCP) was dated 03/01/2026 and did not include evidence that it was reviewed or signed by Resident 1. At 12:07 PM, Surveyor interviewed Interim Regional Director (IRD) A and Director B. Director B stated they were unable to locate a signed MCP for Resident 1. IRD A was able to find a signed MCP, dated 11/13/2025 for Resident 1 in a filing folder that contained signed MCPs for all	{N 387}		

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 03/09/2026

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 387}	Continued From page 7 residents after this same issue was noted on a previous survey. However, Director B reported that Resident 1's MCP was updated on 12/31/2025, 01/28/2026, and 03/01/2026 and none of those updated MCP's were signed by Resident 1. IRD A stated they would get Resident 1's MCP signed today.	{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. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure Resident 1's individual service plan (ISP) was accurate to his/her condition and needs. This is a repeat deficiency. See Statement of Deficiency (SOD) O2Q314, dated 09/15/2025. Findings include: On 03/04/2026, at approximately 9:40 AM,	{N 389}		

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 03/09/2026

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 389}	Continued From page 8 Surveyor interviewed Resident 1. Resident 1 stated that s/he used a walker to pivot to the commode. Resident 1 stated that there were always 2 staff in the room to help him/her get to the commode. Surveyor observed a commode next to Resident 1's recliner as well as a walker. Surveyor observed an oxygen machine in Resident 1's room. Surveyor also observed a nebulizer machine. Resident 1 stated that s/he used oxygen all the time. S/he stated that s/he was on 4 L(liters) of oxygen. Surveyor asked Resident 1 if s/he used a nebulizer as well. Resident 1 stated that they were having a hard time getting the medication for his/her nebulizer, so s/he had not used it in over a couple weeks. At 10:30 AM, Surveyor interviewed Caregiver D. Caregiver D stated that Resident 1 was a 2-assist transfer and was also on oxygen. At 10:47 AM, Surveyor interviewed Caregiver C. Caregiver C stated that Resident 1 was a 2-assist transfer, sometimes even 3. Caregiver C stated that when Resident 1 moved in s/he was a 1-assist but had been a 2-assist for over a few months now. Caregiver C stated that Resident 2 pivoted to the commode. Caregiver C stated that Resident 2 had been on oxygen since at least January and had the nebulizer machine for about a month. 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. Director A provided Surveyor with a copy of Resident 1's Master Care Plan (MCP). Director A explained that the MCP was the document the	{N 389}		

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 03/09/2026

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 389}	Continued From page 9 facility used for an ISP. The MCP, dated 03/01/2026; read: -Mobility- Transfer "Needs assistance with transferring ...needs assist of 1 sometimes 2 to get out of the recliner." -Respiratory Equipment "No respiratory equipment in use - Note: Resident does not use oxygen equipment such as nebulizer, CPAP, BiPap, or other respiratory equipment" -Toileting Needs "Needs assistance with toileting ...asks for assistance with using the bathroom ... currently using a catheter for urine output. Will alert staff when assistance is needed for bowel." The MCP did not match Resident 1's needs as s/he was always a 2-assist transfer, used oxygen consistently, a nebulizer as needed, and a commode for toileting needs. At 12:13 PM, Surveyor interviewed Interim Regional Director (IRD) A and Director B. IRD A acknowledged that the information did not accurately reflect Resident 1's condition and needs and confirmed that it was an issue. S/he stated that they will make the changes immediately to accurately reflect Resident 1's needs.	{N 389}		
N 426	83.38(1)(b) Supervision. 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	N 426		

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 03/09/2026

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 426	Continued From page 10 services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure the residents were adequately supervised when Resident 3 eloped 3 times in 1 day. This is a repeat deficiency. See Statement of Deficiencies (SOD) 949Y11, dated 06/22/2022; EL5R11, dated 11/08/2022; and SOD O2Q311, dated 05/17/2023. Findings include: On 12/15/2025, the Department received a complaint related to supervision concerns. Resident 2 was admitted to the facility on 03/25/2025. Resident 2 had diagnoses that included: Change in mental status, alcoholism, decline cognitive, depression, homelessness, loss hearing sensorineural bilateral, syncope, and stroke. At approximately 11 AM, Surveyor reviewed Resident 2's incident reports. A Missing Resident report dated 09/21/2025 at 2:30 PM stated that staff watched Resident 2 walk out of the building at 2:15 PM and when they realized s/he hadn't come back at 3:15 PM they called 911. Staff thought Resident 2 was going for his/her normal walk. When staff called 911, the	N 426		

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 03/09/2026

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 426	Continued From page 11	N 426		

operator stated that they had just gotten a call from a state trooper saying they had Resident 2. It was stated that Resident 2 was found by state troopers walking along I-94 in the ditch. On the missing resident form under actions taken to prevent incident from occurring again it read, "Looking into medications to help with aggression."

Another Missing Resident form dated 09/21/2025 at 4:05 PM stated that Resident 2 left at 4 PM and returned around 4:30 PM. The form stated that staff watched him/her leave the building. The description of the incident read, "[Resident 2] went to [his/her] room for a little bit before coming out to the dining room and took [his/her] bundle of things from behind the counter since staff wasn't able to put it in [Director F's] office right away. [Resident 2] said that [s/he] couldn't promise that [s/he] was or wasn't going to run away ...we were doing what the [Director E] told us to do. [Resident 2] said [sic] 'Then I'm going to run away again' and walked out the building. (Staff Member) followed [Resident 2], asking [Resident 2] to come back inside and [sic] Staff will get [him/her] some coffee. [Resident 2] continued to walk and ignore staff. (Staff Member) realized that [s/he] was off the property at this point and went to go talk to the shift lead ...called 911 ... after the phone call ended around 4:30 pm, [Resident 2] came back into the building." Under Actions taken to prevent incident from occurring again it read, "Meeting [Resident 2] where [s/he] is in [his/her] mental state. A care team meeting was held on Monday 09/22/25 ...we talked about getting [him/her] a walking pad ... and getting some medication changes."

A third missing resident report dated 09/21/2025 at 6:00 PM, stated that Resident 2 was walking

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 03/09/2026

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 426	Continued From page 12	N 426		

away from the facility at 6:00 PM and staff followed. Staff followed Resident 2 all the way to I-94. Director F met staff and Resident 2 on the side of the road on the overpass of I-94. Director F could not re-direct Resident 2, so they called the police and EMT (emergency medical technicians). Under Actions taken to prevent incident from occurring again it read, "Care team meeting did occur on 9/22/25 ...having [Resident 2] evaluated for medications to assist with [his/her] aggression ...a walking pad for in [his/her] room. We talked about [his/her] past and that the aggression is not a new thing although we here at Vitacare have not seen this side of [Resident 2]."

No immediate actions were taken between elopements to prevent Resident 2 from eloping again.

According to the Wisconsin Department of Transportation, "I-94 by Menomonie, WI (Wisconsin), is a major 4-lane east-west rural interstate corridor passing north of the city. The speed limit on I-94 near Menomonie, WI is generally 70 mph."

On 03/09/2026 at 3:22 PM, Surveyor interviewed Case Manager (CM) H. CM H stated that this was the first facility placement for Resident 2. However, it was known that if Resident 2 did not get what s/he wanted that s/he would take off and do what s/he wanted. CM H also stated that Resident 2 had some behavior issues including anger.

On 03/09/2026 at 11:00 AM, Surveyor reviewed Resident 2's Master Care Plan (MCP), dated 07/23/25. The MCP read, "Vulnerability... 24-hour supervision with 24-hour awake staff." It did not

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 03/09/2026

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 426	Continued From page 13 indicate that Resident 2 had a history of elopements which was later noted in the 09/24/2025 MCP. At 11:10 AM, Surveyor reviewed Resident 2's MCP dated 09/24/2025. The MCP read, "Safety -- Elopement Risk... History of Elopement, specify: Note: 9/21/2025 first occurrence. Care team states that [s/he] does have a history of this." At 12:22 PM, Surveyor interviewed Nurse Practitioner (NP) G. NP stated that Resident 2 was not independent, meaning s/he would not be able to safely leave the facility and self-supervise. S/he also stated that Resident 2 could not pass a mini-mental test (a test screening for cognitive impairment) which paired with his/her history made leaving the facility and taking walks alone a risk. At approximately 12:45 PM, Surveyor interviewed Interim Regional Director (IRD A) and Director B. IRD A acknowledged that this was an unfortunate situation and that interventions should have been in place to prevent 3 elopements in 1 day. IRD A stated that while s/he and Director B were not employed at the facility when this took place, s/he told Surveyor they would have immediately taken action to prevent further elopements. The provider did not ensure Resident 2 was supervised when s/he eloped 3 times in 1 day and was found located near I-94 on 2 different occasions.	N 426		
N 427	83.38(1)(c) Leisure time activities. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the	N 427		

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 03/09/2026

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 427	Continued From page 14 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 12/15/2025, the Department received a complaint that the facility was not providing activities for residents. On 03/04/2026 at approximately 9:35 AM, Surveyor toured the facility and did not observe an activity schedule posted. At 9:47 AM, Surveyor interviewed Caregiver C. Caregiver C stated that someone came in on Fridays to do Bingo with the residents, but they did not have daily activities. S/he stated that they tried to do activities if there was any free time. Surveyor asked Caregiver C if there was an activity calendar. Caregiver C stated there typically was one posted, but it did not look like there was one currently.	N 427		

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 03/09/2026

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 427	Continued From page 15 At 10:30 AM Surveyor interviewed Caregiver D. Caregiver D stated that since starting employment about a week and a half ago, there had not been activities performed. S/he stated the residents often asked, and it would be nice if there were activities. S/he stated that on Friday someone came in to play Bingo. Caregiver D stated that there was no activity schedule that s/he was aware of. At 10:33 AM, Surveyor interviewed Resident 3 about activities. Resident 3 stated that they get to play Bingo on Fridays, otherwise there were not any other activities that happened. At 11:27 AM, Surveyor interviewed Resident 4 about activities. Resident 4 stated that once in a great while they might have an activity. S/he stated that they do sometimes have Bingo. At approximately 12 PM, Surveyor interviewed Interim Regional Director (IRD A) and Director B about activities provided at the facility. IRD A showed Surveyor a March activity schedule and stated it should be posted. The activity schedule showed the activities were 10 AM snack and 11:30 AM Daily Chronicles. Surveyor inquired about snacks being an activity. IRD A stated s/he agreed that snack was not an activity. Surveyor also noted that while s/he was at the facility no activites had taken place. IRD A stated that activities were something they were actively working on revamping. IRD A noted the importance of activities and noted some additional ways they planned to execute activities moving forward.	N 427		