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 _____	C 01/30/2026

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 01/20/2026, with information gathered through 01/30/2026, Surveyors conducted a complaint investigation at VitaCare Living Mount Horeb. Two deficiencies were identified. One of 2 cites are a repeat deficiency (see Statement of Deficiency (SOD) NYMZ12). Complaint was substantiated. Census: 12	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, record review and interview, the provider did not ensure 1 of 1 resident received appropriate medication administration. This is a repeat deficiency. See Statement of Deficiency (SOD) NYMZ12, dated 05/02/2025. Resident 1 was prescribed Clozapine (psychiatric medication), Valbenazine (medication for	N 432		

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

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involuntary movements) and Venlafaxine (antidepressant) which were not administered as prescribed.

Findings include:

On 12/29/2025, the department received a concern alleging residents did not receive prescribed medications.

On 01/20/2026, Surveyors reviewed Resident 1's record.

Resident 1 moved into the facility 08/12/2025 with diagnosis including schizophrenia.

Resident 1's progress notes documented:
12/15/2025 - [Resident 1] return back to the facility at 10:30 AM from the [medical facility].
12/27/2025 - Writer (Licensed Practical Nurse (LPN) B) received call from staff stating that resident was not feeling well that [his/her] eyes were blinking more or twitching more than normal. Writer asked if [s/he] wanted to be sent out. After talking to resident for a bit, resident stated yes, that [s/he] did want to be sent out to the ER (emergency room) to be evaluated.
12/28/2025 - Around 7:00 AM, Sunday December 28th resident in the room 12:00 call 911 so they can transport [him/her] back to the emergency room [s/he] was seeking some type of medical treatment that has something to do with an ejection that's all the information that I have Administration and the LPN has been notified.
01/02/2026 - Writer (Assistant Executive Director A) reach out to [medical facility] for an update on how [Resident 1] was doing, response was that [s/he] should be ready for discharge next week and that they are trying to get [him/her] back to baseline.

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N 432	Continued From page 2 Surveyors observed Resident 1 returned to the facility on 01/20/2025 during the survey process. Resident 1's "Medication Error/Near Miss" report, dated 12/29/2025, documented: Resident wanted to be seen in the ER (emergency room) to be evaluated as s/he felt s/he was having a medication reaction/side effect. Resident went on 12/27/2025 in the morning and returned to the facility and again wanted to be sent out to the ER on 12/28/2025 for the same symptoms. ... [LPN B] and [Assistant Executive Director A] were notified of the medication situation on 12/29/2025 morning around 11:55 AM. [Managed Care Organization (MCO) Registered Nurse C] had called to ask about [Resident 1's] current medications and what s/he had been taking and when. LPN B had placed all cycle/refill medications into the medication cart on 12/04/2025 for [Resident 1] which included all AM, Noon, PM and Bedtime medications. Resident 1 was admitted to the hospital on 12/02/2025 and discharged on 12/15/2025. Resident was given all bedtime medication on 12/15/2025 and 12/16/2025. Sometime between 12/05/2025 and 12/29/2025 Resident 1's bedtime medications were placed in the medication office by staff. ... Writer (LPN B) and other staff were searching the medication cart to see if they may have been destroyed or misplaced. Writer went back to the medication office and was looking for the destruction book and found the medications on the shelving which had not been seen there prior to 12/29/2025. Resident 1's Medication Administration Record (MAR), dated 12/15/2025 to 12/27/2025, documented: -Clozapine Tab 100 MG (milligram). Take 1 ½	N 432		

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tablets (150 MG) by mouth at bedtime for schizophrenia.
The MAR documented 8 out of 13 opportunities that the medication was not available; 1 out of 13 opportunities that resident was hospitalized; 1 out of 13 opportunities that resident declined; and 3 out of 13 opportunities the medication was administered.
-Valbenazine (Ingrezza) 80 MG - Take 1 capsule by mouth at bedtime for movement disorder.
The MAR documented 4 out of 13 opportunities that the medication was not available; 1 out of 13 opportunities that resident was hospitalized; 1 out of 13 opportunities that resident declined; and 7 out of 13 opportunities the medication was administered.
-Venlafaxine (Effexor) Cap (capsule) 150 MG ER (extended release). Take 2 capsules (300 MG) by mouth at bedtime for mood.
The MAR documented 6 out of 13 opportunities that the medication was not available; 1 out of 13 opportunities that resident was hospitalized; 1 out of 13 opportunities that resident declined; and 5 out of 13 opportunities the medication was administered.

On 01/20/2026, at approximately 1:45 PM, Surveyors interviewed Assistant Executive Director A and LPN B. Surveyors asked for clarification on what happened with the availability of Resident 1's medications and how staff had documented administration when the medication had been documented as not available. LPN B stated there was a breakdown in communication between staff and s/he was unsure who placed the medication in his/her office. LPN B explained that Resident 1 had returned to the facility after hospitalization on 12/15/2025 and received doses on 12/15/2025 and 12/16/2025. Somewhere during the process of checking in medication,

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Resident 1's new blister cards of Clozapine and Venlafaxine had been removed from the med cart and placed in LPN B's office. Surveyors commented that the medication error was not recognized until Resident 1 was hospitalized again on 12/28/2025. LPN B stated that the medication error was on them and that new processes were being implemented. LPN B stated that staff would be re-educated on proper medication administration documentation and to ensure that one only document medication they have administered.

On 01/26/2026, Surveyor reviewed Resident 1's medical documentation submitted by his/her hospital provider which stated:
"12/29/2025 14:38 (2:38 PM) - LOCAL TITLE: MH (mental health) INPATIENT STAFFING & TREATMENT PLAN OF CARE - ADMITTED: 12/28/2025 17:04 (5:04 PM).
Staff Attending Addendum: I have reviewed the History and Physical Examination and the admission work-up and concur. ... This treatment plan was developed with the collaboration of the patient during this patient staffing meeting. Members of the interdisciplinary treatment team who have signed below have reviewed the plan and concur. ... From all accounts appears [Resident 1] has been OFF clozapine and venlafaxine inadvertently since 12/17/25 due to med admin (administration) error at ALF (assisted living facility). [S/He] developed increased anxiety, poor sleep and c/o (complained of) EPS (extrapyramidal symptoms [involuntary movement and muscle stiffness] "jaw pain/dystonia" over the last week or so, [s/he] is not a reliable historian but notes from [peer support] on 12/22/2025 indicate [s/he] appeared tremulous and was not sleeping well. [S/He] was in ED (emergency department) 2x (times) in last 2 days w/ (with) c/o

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involuntary movements and distress asking as [s/he] often does for Artane injections. On my eval (evaluation) [s/he] looks very similar to past admissions when [s/he] is off clozapine - anxious, perseverative on jaw/tongue stiffness and need for Artane IM, very reluctant to take clozapine or other psych meds. ... Summary of med admin per collateral gathered at this point is as follows: Clozapine - none since 12/17, Venlafaxine - none since 12/17, ... Mental Status Exam: 1. General (appearance, grooming, cooperation): appears somewhat disheveled 2. Orientation: fully 3. Gait: using walker, a bit stiff 4. Speech: nl (normal) rate/vol when distracted, at times dysarthric w/ tongue seeming dystonic, but not consistent 5. Psychomotor: slowed 6. Abnormal movements: neck muscles are tight, possibly dystonic, jax [sic: jaw] is slightly open, tongue protruding, but later when distracted this resolves ...
ASSESSMENT: 80 yo (year old) w/ Schizophrenia, previously stable on clozapine, recent discharge from [medical facility], now w/ acute psychiatric decompensation and possible rebound EPS (episode) off clozapine x 12 days inadvertently due to med admin error at ALF. The somatic experience and exam findings that are often variable when this has happened in past. Suspect [his/her] fixation on dystonia is both genuine physiologic EPS having abruptly stopped clozapine + anxious distress about any dystonic somatic experience; additionally, the perceived jaw dystonia has also been proposed in past to itself be a somatic delusion. Regardless, agenda for tx (treatment) is to get [him/her] back on therapeutic dose of clozapine as soon as can be safely done and manage dystonic sx (symptoms) with [his/her] preferred med Artane. Monitoring closely for anticholinergic SE (side effects)."

On 01/26/2026, Surveyor reviewed mental health

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notes submitted by mental health provided which stated:
"12/29/2025 10:26 AM - Please see [emergency department] notes from two separate ED visits, one on 12/27/25 to address complaints of excessive blinking), and another on 12/28/25 to address complaints of abnormal jaw movements. ... Phone call to [Assistant Executive Director A and LPN B] - Noted that I had e-mailed [Assistant Executive Director A] last week on 12/23/25 regarding [Resident 1's] expressed concerns about poor sleep and my request for ALF staff to ensure that [s/he] is getting prescribed Clozapine. I did not hear back. Informed ALF staff that after being treated in ED on 12/28/25 for complaints of abnormal jaw movements, that upon discharge, [Resident 1] attempted to take full bottle of #30 Artane tabs. Initially [Assistant Executive Director A and LPN B] were under assumption that staff was providing all of [his/her] medications (i.e. They checked ALF MAR and informed me that all medications including Clozapine were signed for as being dispensed by ALF staff who provide medications). Discussed my concerns about sleep disturbance and question if [Resident 1] was getting prescribed/very sedating Clozapine. When asked to check their supply of Clozapine, [Assistant Executive Director A and LPN B] could not locate any supply and opted to call [Pharmacy] to research last medication delivery. Also agreed that they would call the staff that dispensed meds to ensure that they observed [Resident 1] take [his/her] HS (bedtime) medications. I too call [pharmacist] who verified that Clozapine supply for 12/4/25-12/31/25 had been delivered/signed for by ALF staff. Also noted that another supply of medication for 1/1/26-1/28/26 was to be delivered today. Spoke to [Assistant Executive Director A and LPN B] who in the meantime located vet's 'missing'

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N 432	Continued From page 7 12/4-12/31 PM med supplies in [LPN B's] office. After much discourse, it sounds as though during [Resident 1's] 12/2-12/15/25 inpatient stay at [medical facility], the PM ALF medication dispensing staff removed his PM medications for 12/4-12/31 from the ALF's med cart (i.e. this is standard practice if [resident] is inpatient at another facility), and put them in ALF's LPN's office without telling [him/her]. When [Resident 1] was discharged from [medical facility] back to ALF on 12/15, the PM med dispensers used an 'old' 2 day supply of PM meds for 12/15 and 12/16, but from 12/17/25 on the dispensers apparently could not locate a supply of PM meds (including Clozapine), and did not inform [Assistant Executive Director A and LPN B] that they were out of meds. Instead, PM ALF med dispensers marked medications on ALF's MAR as "unavailable", resulting in [Resident 1] not getting [his/her] PM medications (i.e. Clozapine, Venlafaxine, Valbenazine), for 12/17-12/27/25. ... Later phone conversation with [Assistant Executive Director A and LPN B] who were understandably upset and sorry about the medication error and agreed to provide a written documentation of how the error occurred. Explained to them that this will be very helpful in finding/rectifying the weaknesses in their system to try to ensure that this does not happen again. On 01/26/2026 at 4:20 PM, Surveyor emailed Regional Director D and Regional Director E a summary of the findings as requested. As of 01/30/2026 at 5:00 PM, Surveyor did not receive a response. "Do not suddenly stop taking this medicine (Venlafaxine) without checking first with your doctor. Your doctor may want you to gradually	N 432		

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reduce the amount you are taking before stopping it completely. This will decrease the chance of side effects, including agitation, anxiety, blurred vision, confusion, diarrhea, dizziness, fast or irregular heartbeat, headache, irritability, nausea or vomiting, numbness or tingling feeling, restlessness, seizures, sweating, thoughts of hurting yourself or others, trouble sleeping, unusual dreams, or unusual drowsiness, tiredness, or weakness." (Source: Mayo Clinic website, Venlafaxine (oral route), January 01, 2026, https://www.mayoclinic.org/drugs-supplements/venlafaxine-oral-route/description/drg-20067379 (retrieval date - January 22, 2026).)

"Clozapine discontinuation should be done under the guidance of a psychiatrist. The dose should be gradually tapered, not stopped suddenly." (Source: National Library of Medicine website, Stopping and switching antipsychotic drugs, October 2019, https://pmc.ncbi.nlm.nih.gov/articles/PMC6787301/#:~:text=should%20be%20formulated.-,Clozapine,for%20example%2C%20agranulocytosis%20has%20occurred. (retrieval date - January 22, 2026).)

"Do not stop taking Valbenazine or change your dose without talking to your health care provider first." (Source: National Alliance on Mental Illness (NAMI) website, Valbenazine (Ingrezza), February 2024, https://www.nami.org/treatments-and-approaches/mental-health-medications/types-of-medication/valbenazine-ingrezza/#:~:text=Only%20your%20health%20care%20provider,concerns%20about%20valbenazine%20and%20pregnancy?. (retrieval date - January 22, 2026).)

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N 435	83.38(1)(k) Transportation. 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: Transportation. The CBRF shall provide or arrange for transportation when needed for medical appointments, work, educational or training programs, religious services and for a reasonable number of community activities of interest. CBRFs that transport residents shall develop and implement written policies addressing the safe and secure transportation of residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure transportation was arranged or provided for a reasonable number of community activities of interest for residents. Resident 2, who was represented by a managed care organization (MCO), was not provided with transportation for banking purposes. Findings include: The provider is licensed as a class CNA (non-ambulatory) CBRF (community-based residential facility) able to serve up to 23 residents in the following client groups: physically disabled, advanced aged, and irreversible dementia/Alzheimer's.	N 435		

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N 435	Continued From page 10 On 01/20/2026, at approximately 11:15 AM, Surveyor interviewed Resident 2. Resident 2 wanted to express to Surveyor his/her concern that there are no transportation options available at the facility. Resident 2 stated, "There are no community events. We are not provided with transportation to go to the store or the bank, even just once a month. I went to the bank about a month ago and I had to pay an uber, who turned out to be one of the caregivers." On 01/20/2026, at approximately 11:25 AM, Surveyor interviewed Resident 3. Resident 3 expressed that the residents never leave the facility. Resident 3 stated, "I am not allowed to go anywhere." On 01/20/2026, Surveyor reviewed Resident 2's "CBRF Residency and Services Agreement," dated 08/19/2025, which documented: "Transportation: Facility will provide or arrange for transportation for Resident when needed for medical appointments, work, educational or training programs, religious services and for a reasonable number of community activities of interest." On 01/26/2026, Surveyor reviewed the provider's contract with Resident 2's MCO, provided by the MCO, which documented: "Community-Based Residential Facility (CBRF). A residential facility for elders or persons with physical/developmental/intellectual disabilities where 5 or more adults who are not related to the operator or administrator reside and receive care, treatment, support, supervision, and training. Services include supportive home care, personal care, medication support, health monitoring, supervision, behavior and social supports, daily	N 435		

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living skills training, transportation, and nursing as defined by Department of Health Services (DHS) 83."
"10. Transportation-regular and routine transportation needs are arranged by, provided by, and paid for by the residential provider. Providers may choose to transport members in provider-owned vehicles, through subcontracting with a transportation provider, through the purchase of cab coupons/taxi tickets, or through other safe and effective means. Providers are responsible for ensuring that subcontracted providers are in compliance with DHS requirements for transportation providers.
a. Regular and routine transportation includes but is not limited to transportation to and from:
i. medical and/or mental health appointments and/or services
ii. day services, day care, and/or other programming
iii. work programs and/or competitive integrated employment (CIE)
iv. community events, services, and/or activities*
v. social, educational and/or hobby activities
vi. religious and/or spiritual services
vii. visits to family and/or other natural supports

On 01/26/2026 at 4:20 PM, Surveyor emailed Regional Director C and Regional Director D outlining the transportation concern.

As of 01/30/2026 at 5:00 PM, Surveyor did not receive a response.