STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018750	A. BUILDING: _____ B. WING _____	R-C 09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MENOMONIE II	1902 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, the Department conducted a complaint investigation and verification visit at Vitacare Living - Menomonie II. Data was collected through 09/15/2025. Two of 2 complaints were substantiated. Five violations were identified. Five of 5 violations were repeat deficiencies. See Statement of Deficiencies (SOD) QLT613, dated 03/28/2025; QLT611, dated 05/17/2023; and CN9L11, dated 11/11/2022. 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) QLT611, 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 4 complaints at the facility and issued 22 deficiencies since the provider was licensed on 03/01/2022. On 05/22/2025, the Department issued SOD QLT613 with enforcement orders that read: "Effective immediately, the licensee shall ... provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. WITHIN 45 DAYS of receipt of this notice, the licensee shall develop and implement a written procedure 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, leisure time activities), 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 ... - Assigned staff will be separate and have distinct duties related to the care and services for residents at VitaCare Living - Menomonie II. The assigned staff will not be shared with other programs ... All managers and resident care staff (as appropriate) will receive training regarding the licensee's written procedure required by Order	N 196		

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N 196	Continued From page 2 #1. 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 procedure will be made 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 substantiated both complaints. The investigation found the provider did not provide prompt and adequate care to a resident (Resident 1) and did not provide medications to a resident (Resident 2) as prescribed. The Department also identified the following concerns during the survey: - The facility was not staffed with a sufficient number of employees to meet resident needs. - Medication administration was not accurately documented and errors were not reported. - Individual service plans were not updated when residents experienced a significant change in condition. All deficiencies identified during this survey were repeat deficiencies. 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	N 196		

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N 196	Continued From page 3 have enough staff to meet resident needs. Surveyor requested evidence from Director A that the provider completed their enforcement orders issued on 05/22/2025. 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. The licensee did not complete Department orders issued on 05/22/2025. Cross references: N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0396 DHS 83.36 (1)(a) Adequate Staff to Meet Resident Needs N0410 DHS 83.37(1)(k) Medication Error Or Adverse Reaction	N 196		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 1 of 1 resident reviewed (Resident 2) received his/her medication	N 352		

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N 352	Continued From page 4	N 352		

(Imbruvica) as prescribed for 10 days in June 2025.

This is a repeat deficiency. See Statement of Deficiency (SOD) QLT611, dated 05/17/2023.

Findings include:

The Department received a complaint related to the provider's medication management services. The complaint was substantiated.

On 09/09/2025 at 9:20 AM, Surveyor interviewed Director A. Director A discussed Resident 2's needs and condition. Director A indicated Resident 2 had leukemia and was treated with Imbruvica, a medication administered at the facility. Resident 2's team recently decided to end treatments, and Imbruvica was discontinued on 09/03/2025.

Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 12/12/2023 with a diagnosis of chronic lymphocytic leukemia. According to Resident 2's Master Care Plan (updated on 08/24/2025) Resident 2 had specialty medications that needed to be ordered by the director.

Resident 2's June 2025 medication administration record (MAR) indicated Resident 2 was prescribed Imbruvica 140 mg capsule, take 1 capsule by mouth on Monday, Wednesday, and Friday. On 06/20/2025, Staff documented Resident 2's Imbruvica was out. Staff documented the medication was still out on 06/30/2025.

On 09/11/2025 at 3:00 PM, Surveyor interviewed Director A, Administrator B, Registered Nurse

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N 352	Continued From page 5 (RN) D, and Regional Director (RD) E. Director A stated Resident 2's Imbruvica was out for 10 days in June because the previous director, Director C, did not know s/he needed to place a separate order for it through a specialty pharmacy. Director A stated s/he was re-assigned to another location during this time, but staff contacted Director A after the medication had been out for a few days. Director A instructed the caregiver to refill the medication by calling the specialty pharmacy. RN D said staff were trained to reorder medication when there was 7 days left in the supply.	N 352		
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 1 of 1 resident reviewed (Resident 1's) individual service plan (ISP) was updated when Resident 1 experienced a significant change in condition.	N 389		

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N 389	Continued From page 6 This is a repeat deficiency. See Statement of Deficiency (SOD) QLT611, dated 05/17/2023. Findings include: On 09/09/2025 at approximately 9:15 AM, Surveyor observed Director A and Lead Caregiver (LC) G assist Resident 1 via pivot transfer from a wheelchair to a vehicle. At 9:20 AM, Surveyor interviewed Director A. Director A stated Resident 1 required assistance of 2 staff because s/he recently underwent hip surgery. 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 reviewed and signed by a resident's care team and guardian. The second was a document titled Master Care Plan (MCP) which included a resident's needs and abilities. At approximately 12:40 PM, Surveyor interviewed LC G. LC G stated Resident 1 recently had hip surgery and did not understand s/he needed help to walk and transfer. LC G stated Resident 1 needed to be in line-of-sight when s/he was awake because s/he would try to get out of his/her wheelchair. LC G said Resident 1 recently got a bed and chair alarm to alert staff when s/he attempted to get up on his/her own. On 09/09/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 04/21/2025 with diagnoses that included dementia with psychotic disturbances, aphasia, and chronic pain.	N 389		

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N 389	Continued From page 7 Resident 1's record included evidence of 3 unwitnessed falls between the dates 07/27/2025 and 08/07/2025. The first fall was believed to have occurred during the overnight hours between 07/26/2025 and 07/27/2025. Resident 1 expressed significant pain throughout the day on 07/27/2025 and told staff s/he slipped on the floor during the night. S/he was sent to the emergency department on 07/27/2025 and was diagnosed with a hip fracture. Resident 1 underwent hip surgery and returned to the facility on 08/04/2025. The incident report for this fall read, "Actions taken to prevent future falls: Reminders on using [his/her] call light and to call for assistance when needed. Checking [his/her] room regularly to make sure any spills are cleaned up right away." The second fall occurred on 08/06/2025 at 9:30 PM. The incident report read, "Resident was found on the floor next to [his/her] door to [his/her] room. [S/he] told staff [s/he] was trying to sit in [his/her] chair. [S/he] had [his/her] chair turned. [His/her] floor was clean and [s/he] had [his/her] shoes on ...Actions taken to prevent future falls: Resident is on 30 minute checks." The third fall occurred on 08/07/2025 at 4:45 PM. The incident report read, "Resident was served dinner and both staff went to do other things. About 20 minutes after giving resident [his/her] dinner staff heard [him/her] screaming. Staff found resident with [his/her] head in [his/her] garbage can between [his/her] recliner and [his/her] bed. [S/he] has [sic] [his/her] dinner all around the floor. [His/her] walker was in front of [his/her] wheelchair which was blocking the bathroom door and full of bags and packages of depends. [S/he] was wearing [his/her] shoes as well ...Actions taken to prevent future falls: 30	N 389		

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N 389	Continued From page 8	N 389		

minute checks were already in place. Awaiting bed and chair alarms ...Night staff were instructed to leave [his/her] bedroom door open all night and take turns sitting down by [his/her] room and to enter when they hear any movement or sounds made by resident."

Resident 1's Planned Services (updated 5/21/2025) and MCP (updated 08/24/2025) did not indicate Resident 1 needed mobility devices (walker or wheelchair) and did not indicate Resident 1 required any transfer assistance, increased safety monitoring (i.e. 30-minute checks), or fall interventions (i.e. alarms). The MCP read:
"Mobility - Transfer ... Independent - no assistance needed with transferring ...
No wheelchair in use ...
Toileting Needs ... Independent - no assistance needed with toileting ...
Resident is at risk of falling."

On 09/11/2025 at 3:00 PM, Surveyor interviewed Director A, Administrator B, Registered Nurse (RN) D, and Regional Director (RD) E. Surveyor asked for a summary of the changes Resident 1 experienced since his/her fall in July. Director A stated Resident 1 returned from the hospital needling 2-hour toileting and full-assistance with all care tasks. Director A said Resident 1 was considered non-ambulatory, used a wheelchair, had bed and chair alarms, and was working with physical therapy. Surveyor asked if Resident 1 was assessed since s/he returned from the hospital on 08/04/2025; Director A stated, "I can't answer that." RD E reviewed Resident 1's record and stated the previous director, Director C, completed a clinical assessment on 07/30/2025; however, the document did not reflect Resident 1's changes in condition. RD E stated it was the

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N 389	Continued From page 9 director's responsibility to complete resident assessments and ISP updates. RD E reviewed Resident 1's ISP and confirmed it was not updated when Resident 1's needs and condition changed.	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 QLT613, dated 03/28/2025. 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: - Resident 1 required 2 staff for transfers. - Resident 2 required 2 staff for transfers via	{N 396}		

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{N 396}	Continued From page 10	{N 396}		

sit-to-stand.
- Resident 3 required 2 staff for transfers via sit-to-stand.
- Resident 4 (resided at the neighboring facility) required 2 staff for transfers.
- Resident 5 (resided at the neighboring facility) required 2 staff for all cares and transfers.
- Resident 6 (resided at the neighboring facility) required 2 staff for transfers via sit-to-stand.
- Resident 7 (resided at the neighboring facility) required 2 staff for transfers via pivot or mechanical lift, depending on his/her strength.
- Resident 8 (resided at the neighboring facility) required 2 staff for cares and transfers due to his/her behavior.

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 2025 to help assist with resident

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{N 396}	Continued From page 11 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 410	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. 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 2's) record included medication omissions. The provider did not immediately notify Resident 2's physician or the supervising nurse when Resident 2's medication was out. This is a repeat deficiency. See Statement of Deficiency (SOD) QLT611, dated 05/17/2023. Findings include: On 09/09/2025, Surveyor reviewed Resident 2's	N 410		

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record. Resident 2 was admitted to the facility on 12/12/2023 with a diagnosis of chronic lymphocytic leukemia.

According to Drugs.com, chronic lymphocytic leukemia can be treated with Imbruvica, a medication used to help slow cancer progression.

Resident 2's June 2025 medication administration record (MAR) indicated Resident 2 was prescribed Imbruvica 140 mg capsule, take 1 capsule by mouth on Monday, Wednesday, and Friday. Resident 2's MAR for dates 06/20/2025 through 06/30/2025 indicated the following:
- 06/20/2025 at 8:34 AM, "Imbruvica 140 Mg Capsule- Do not have"
- 06/23/2025 at 8:03 AM, Caregiver I documented Imbruvica was successfully administered.
- 06/25/2025 at 7:36 AM, "Imbruvica 140 Mg Capsule- not in house"
- 06/27/2025 at 8:19 AM, Caregiver I documented Imbruvica was successfully administered.
- 06/30/2025 at 8:16 AM, "Imbruvica 140 Mg Capsule- Not in house"

Surveyor reviewed Resident 2's notes and did not find evidence that Resident 2's physician was notified of the medication error (i.e. omitted medication).

On 09/11/2025 at 3:00 PM, Surveyor interviewed Director A, Administrator B, Registered Nurse (RN) D, and Regional Director (RD) E. Director A stated Resident 2's Imbruvica was out for 10 days in June; Resident 2 did not receive Imbruvica on 06/23/2025 or 06/27/2025.

Administrator B and RN D were unaware of the medication issue prior to the discussion on 09/11/2025. RN D stated staff were supposed to

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MENOMONIE II	1902 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 410	Continued From page 13 complete daily medication administration checks at the end of their shift. RN D stated if they had done this, they would have caught the documentation error and the medication supply error. Director A stated if Resident 2's physician was contacted, it would have been documented in Resident 2's notes. Administrator B stated Director C should have immediately communicated the concern to RN D, Administrator B, and Resident 2's physician. Administrator B stated Director C's lack of communication contributed to his/her termination. Cross reference N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication	N 410		