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 02/24/2026

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 02/18/2026, Surveyor completed 2 complaint investigations and a verification visit. Data collected through 02/24/2026. Two of 2 complaints were substantiated. Four deficiences were identified. Two of 4 were repeat deficiencies. See Statement of Deficiency (SOD) QLT611, dated 05/17/2023 and SOD QTL614, dated 09/15/2025. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 12	{N 000}		
{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 Resident 1 received his/her medication (Olanzapine) as prescribed in January and February of 2026. This is a repeat deficiency. See Statement of Deficiency (SOD) QLT611, dated 05/17/2023 and SOD QTL614, dated 09/15/2025. Findings include:	{N 352}		

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
	0018750	A. BUILDING: _____ B. WING _____	R-C 02/24/2026

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 352}	Continued From page 1 On 02/18/2025 at 9:35 AM, Surveyor requested Resident 1's January and February 2026 medication administration record (MAR) Resident 1 was admitted to the facility on 04/21/2025 with diagnoses that included: amnesia, aphasia, and dementia ... moderate with psychotic disturbance. Resident 1 had an order for Olanzapine. Olanzapine was scheduled daily at 8 PM. The order read: "Dissolve ½ tablet (2.5mg) by mouth at bedtime." Resident 1's January 2026 MAR showed that the medication was not given on the 1st through 8th, 19th through 25th, 27th, 30th, and 31st. The medication was charted "not in house." Resident 1's February 2026 MAR showed the medication was not given on the 1st, 2nd, 4th, 6th, 10th, 12-15th, and 18th. The medication was charted "not in house." On 02/23/2026 at approximately 1:17 PM, Surveyor interviewed Interim Regional Director (IRD) A and Executive Director (ED) B regarding Resident 1's medications being out of stock. IRD A stated that s/he would do some digging and find out why the medication was out of stock. IRD A stated if the medication was a cycle medication, it should have always been re-ordered and in stock. Surveyor requested any clarifying information to be sent by end of day. At 4:40 PM, Surveyor received an e-mail from ED B that stated Resident 1's Olanzapine was not a cycle medication and did need to be ordered. Surveyor asked if there was evidence that the medications were being properly re-ordered on	{N 352}		

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 02/24/2026

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 352}	Continued From page 2 time. ED B stated that medications were not ordered, and s/he would be putting different processes into place immediately.	{N 352}		
N 400	83.37(1)(a) Written order for medications, supplements. Practitioner ' s order. There shall be a written practitioner ' s order in the resident ' s record for any prescription medication, over-the-counter medication or dietary supplements administered to a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain written orders for medications administered to residents. Resident 3's record did not include written orders for Acetaminophen-Codeine #4. Findings include: On 2/18/2025 at 9:35 AM, Surveyor requested Resident 3's record. Resident 3 was admitted to the facility on 06/19/2025. Resident 3 had diagnosis that included: paranoid schizophrenia, chronic pain, and age-related cataracts. At 2:30 PM, Surveyor reviewed Resident 3's MAR (medication administration record) for January and February of 2026. Resident 3's MAR showed the only scheduled medication s/he had was Acetaminophen-Codeine #4. Take 1 tablet my	N 400		

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 02/24/2026

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 400	Continued From page 3 mouth 4 times a day. The January 2026 MAR showed Resident 3 received this medication on 01/07/2026 at 12 PM, 01/09/2026 at 8 AM, and 01/12/2026 at 12 PM. On all other documented dates and times, the medication was charted as: "not in house," "don't have," "med out of stock," or "refused." The February 2026 MAR showed Resident 3 received this medication on 02/05/2026 at 12 PM and 02/11/2026 at 8 AM. On all other documented dates and times, the medication was charted as: "med out of stock," "not in house," "refused," or "resident only has PRN (as needed) meds." On 02/23/2026 at approximately 1:17 PM, Surveyor interviewed Interim Regional Director (IRD) A and Executive Director (ED) B regarding Resident 3's medication being administered only 5 times from 01/01/2026 to 02/18/2026. IRD A stated s/he had to do a little digging and would get back to Surveyor by the end of the day with additional information. At 4:40 PM, Surveyor received an e-mail from ED B that stated, "...see attached MD (medical doctor) order for [Resident 3] stating that the Tylenol with Codeine was as needed." Surveyor reviewed the order for Resident 3 that was dated 11/13/2025. The order read, "Acetaminophen 300mg-codeine 60mg tablet. Take 1 tablet oral four times a day as needed while awake 8am-!2[sic]pm-4pm-10pm 30 days ... start on November 13th, 2025, end on December 12th, 2025." Surveyor requested any additional orders for Resident 3, as that order ended on 12/12/2025. ED B stated that it was the only order they had for Resident 3. S/he stated they would reach out to pharmacy. ED B stated staff were following the expired order as it was the last one	N 400		

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 02/24/2026

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 400	Continued From page 4 entered in the MAR. ED B stated, "I will be putting different processes in place effective immediately." On 02/24/2026, at approximately 8:23 AM, Surveyor received an e-mail from ED B stating s/he was going to reach out to the pharmacy today to see if they had a more recent order. Surveyor asked ED B if the medication was still in house even though the order was discontinued as it appeared Resident 3 received 5 doses of this medication from 01/01/2026 to 2/18/2026. ED B stated at 9:21 AM, that yes, there was still a bubble pack of Tylenol with Codeine for Resident 3 in the medication cart. ED B stated that the order had been incorrectly entered into the MAR, resulting in staff giving it as scheduled medication. Surveyor asked if the medication was continuing to be refilled, or if it was leftover medication from the original order. ED B stated that it was leftover medication. The provider did not ensure there were written orders for all medications administered to Resident 3, when s/he received 5 doses of Acetaminophen 300mg-codeine 60mg tablet after the order was discontinued.	N 400		
{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.	{N 410}		

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 02/24/2026

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 5 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 interview and record review, the provider did not report all errors in the administration of medication to a licensed practitioner, supervising nurse or pharmacist immediately. This is a repeat deficiency. See Statement of Deficiency (SOD) QLT611, dated 05/17/2023 and SOD QTL614, dated 09/15/2025. Findings include: Resident 1 was admitted to the facility on 04/21/2025 with diagnoses that include: amnesia, aphasia, and dementia ... moderate with psychotic disturbance. According to Drugs.com, "Olanzapine (brand name Zyprexa) is an atypical antipsychotic that may be used to treat adults and adolescents aged 13 and older with schizophrenia or bipolar I disorder." On 02/18/2025 at 9:35 AM, Surveyor requested Resident 1's January and February 2026 medication administration record (MAR). Surveyor reviewed Resident 1's MAR's and found that his/her Olanzapine was not given 18 of 31 days in January and 10 of the 18 days in	{N 410}		

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 02/24/2026

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 6 February. On 02/23/2026 at approximately 1:17 PM, Surveyor interviewed Interim Regional Director (IRD) A and Executive Director (ED) B regarding notification to Resident 1's physician regarding multiple missed doses of his/her Olanzapine in both January and February. IRD A stated they were going to investigate the issue and would send any provider documentation to Surveyor. On 02/24/2026 at approximately 10 AM, Surveyor followed up with ED B who stated they were unable to find any communication to the provider. Cross reference N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication	{N 410}		
N 431	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid	N 431		

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 02/24/2026

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 431	Continued From page 7	N 431		

intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not monitor the health and/or make arrangements for physical health services when a change of condition occurred.

The provider did not adequately document monitoring and assessments of Resident 2's skin changes in his/her record.

Findings include:

On 10/20/2025 and 12/05/2025, the department received complaints regarding resident care concerns.

On 02/18/2026 at 9:35 AM, Surveyor requested Resident 2's record.

At 3:00 PM, Surveyor reviewed Resident 2's record.

Resident 2 was admitted to the facility on 09/09/2025. Resident 2 had diagnoses that included: bipolar disorder, chronic heart disease, chronic kidney disease, fibromyalgia, osteoporosis, dementia, and vitamin D deficiency.

Surveyor reviewed the Resident 2's notes from

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 02/24/2026

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 431	Continued From page 8 admission through discharge and noted the following documentation related to skin concerns. -09/17/2025 at 12:12 PM, A nurse visit note, "Writer visited facility today ... resident denies and [sic] outstanding health concerns or new health concerns, denies any new skin concerns, none observed by writer or reported by staff." -09/24/2025 at 3:58 PM, A nurse visit note, "Writer visited with resident today. Resident voiced no new health concerns or skin concerns. Staff voice no new health concerns or skin concerns for this resident." -09/26/2025 at 1:13 PM, "[Resident 2's] ... told staff [s/he] had some pain in [his/her] back, the lesion on [his/her] bottom is looking okay." -10/04/2025 at 9:32 PM ,"When it was time for bed ... they wiped off [his/her] old cream on [his/her] sore on [his/her] butt and reapplied new cream." -10/05/2025 at 8:41 PM, "[S/he] also got a shower and [his/her] wound on [his/her] butt was cleaned up and reapplied with [sic] cream and a border Pad." -10/06/2025 at 1:39 PM, " ... [s/he] has a new blister looking bump on [his/her] intergluteal cleft on the top right. Staff applied some zinc oxide cream and a new bandage." -10/06/2025 at 9:31 PM, "[His/her] wound was cleaned up and new ointment was applied along with a new border pad." -10/11/2025 at 12:30 PM "Staff has been applying cream to [his/her] bottom as [s/he] has a wound on [his/her] bottom." -10/12/2025 at 1:32 PM, "[His/her] bottom looks good." -10/15/2025 at 1:21 PM, "[His/her] bottom still has a sore on it." -10/16/2025 at 12:38 PM, "The sore on [his/her] bottom is now quite large"	N 431		

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 02/24/2026

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 431	Continued From page 9 -10/16/2025 at 6:53 PM, "Writer and staff member have been having [him/her] lay on [his/her] side to keep [him/her] off of [his/her] sore bottom. We did put a meplex [sic] bandage on there to give it some cushion if [s/he] is on [his/her] back. -10/17/2025 at 2:42 PM, A nurses note read, "Nurse updated today that resident has an open area on [his/her] buttocks. Writer assessed area and it is an unstageable pressure ulcer, it is mainly to the left buttock/gluteal fold. It measures approx. (approximately) 5*2.7 cm, irregular in shape, somewhat oval/rectangular. The wound base and edges have swelling. The area has undermining/tunneling to 9'o clock approx. (approximately) 2.7cm depth and 1 cm diameter. The area has a pink base with yellow/loose slough material and scant purulent drainage. The surrounding tissues are WNL (within normal limits). Resident does report discomfort to the area at rest and with assessment ... writer called EMS (emergency medical services) for transport. Writer called report to RN (registered nurse) ... paperwork sent with EMS. -10/17/2025 at 3:04 PM, A nurse's note read, "ER (emergency room) nurse, called, [sic] wanted more info (information) on when wound started and progression. In agreement this is likely considered a DTI (deep tissue injury) ... the area may need surgical consult and debridement." -10/23/2025 at 5:05 PM, a nurses note read, "MCO (managed care organization) rep (representative) and building admin (administration) had [sic] conference call today ... looking for more information on resident wound history, care history, reporting change in condition process and expectations, and staff education. Provided information as requested." At 4 PM, Surveyor reviewed all incident reports	N 431		

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 02/24/2026

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 431	Continued From page 10	N 431		

for Resident 2. The only incident report regarding skin concerns was dated 10/17/2025 at 1:15 PM. The incident/injury description section of the report read, "On 10/16 staff witnessed an open wound between [his/her] buttock. Nurse came to assess it on 10/17 after supervisor was notified." Under Action taken to prevent recurrence of injury/incident the report read, "Inclusa was notified. Hospital update today was that [Resident 2] may need a would vac placed to help heal this wound and upon return to this facility would need a special mattress to assist with making sure this does not happen again. Inclusa to assist with getting a broda [sic] chair and hospital bed."

On 02/19/2026 at 8 AM, Surveyor reviewed Resident 2's pre-admission assessment, dated 08/25/2025. Resident 2's pre-admission assessment did not indicate that Resident 2 had any wounds or skin concerns.

On 02/19/2026 at 8:15 AM, Surveyor reviewed Resident 2's wound care assessments. There was only 1 wound care assessment, dated 10/17/2025, the day Resident 2 was sent to the ER for his/her unstageable pressure ulcer.

On 02/23/2026 at 12:30 PM, Surveyor reviewed a self-report form that was submitted to the department on 10/20/2025. The documentation reiterated the wound findings noted in the 10/17/2025 nursing note above and included additional information on the timeline of the wound progression. The report stated that "staff notes show that the area had been documented on 09/26/2025, and not reported to director or nursing ... staff noted a few other times from 09/26/2025-10/17/2025 on wound, but did not report ...staff education [sic] provided at facility staff meeting 10/17/2025 on residents right to

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 02/24/2026

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 431	Continued From page 11 care [sic] and not delaying treatmenr [sic] and need to report any changes in condition to director and/or nurse immediately [sic] and to file an incident report within 24 hours." On 02/23/2026 at approximately 1:39 PM, Surveyor interviewed Interim Regional Director (IRD) A and Executive Director (ED) B regarding Resident 2's wound progression and lack of timely intervention or monitoring. IRD A stated s/he cannot really say much regarding the situation since they were not employed at the facility during the time this incident happened. IRD A stated they understand the need for timely follow up and documentation regarding skin and wound concerns. S/he stated they will be implementing new processes in the future to avoid these unfortunate circumstances in the future. On 02/24/2026 at 11:48 PM, Surveyor interviewed Case Manager (CM) C. CM C stated they were first notified of Resident 2's wound on 10/18/2025. CM C stated on 10/20/2025 Resident 2 had I&D (Incision & Drainage) of wound and wound vac placement due to the severity of the wound. CM C stated that Resident 2 remained hospitalized until 11/6/2025 and was discharged to a SNF (skilled nursing facility) on hospice.	N 431		