STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 08/29/2025, Surveyor conducted a complaint investigation at VitaCare Living - Medford II. The complaint was substantiated. One deficiency was identified. Census: 17	N 000		
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 record review and interview, the provider did not ensure there were sufficient numbers of employees on a 24-hour basis to meet the needs of all residents. Resident 1 required the assist of 2 staff members to transfer safely. The provider did not schedule 2 staff on a 24-hour basis. Findings include: On 04/29/2025, the Department received a complaint that alleged there was not enough staff. On 08/29/2025 at approximately 10:15 a.m., Surveyor interviewed Caregiver C and asked what the staffing pattern was. Caregiver C told Surveyor there were 2 staff members scheduled for the day and evening shifts, and there was 1 staff member scheduled for the overnight shift. Caregiver C said they had residents with high behaviors and "it would be nice to have 2 staff on	N 396		

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
	0018754	A. BUILDING: _____ B. WING _____	C 08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 396	Continued From page 1	N 396		

overnights." Surveyor asked if any of the residents required 2 staff to assist. Caregiver C said Resident 1 required 2 staff with the use of a mechanical lift, called a "sit to stand," to transfer.

At approximately 10:30 a.m., Surveyor observed a white board with staff names written on it. The board identified 2 staff for the day shift, 2 staff for the evening shift and 1 staff for the overnight shift.

On 08/29/2025, Surveyor reviewed Resident 1's record.

Resident 1 was admitted to the provider on 11/29/2024. S/he had a diagnosis of Lewy body dementia and was on hospice.

Resident 1's individual service plan (ISP), updated by Administrator A on 08/14/2025, read, in part: "Needs assistance with transferring, specify: - Note: 2 person assist due to history of falls and being weak .... 2 person assist to help getting in and out of wheelchair ...Decreased endurance/strength due to Lewy body dementia ..."

Resident 1's services for the overnight shift included: "Change incontinence pad and provide peri care." This task was to be completed at 11:00 p.m., 1:00 a.m., 3:00 a.m., and 5:00 a.m.

On 08/04/2025 at 9:08 p.m., staff documented: "When staff got resident out of bed before supper and had to change [him/her] [sic] resident would not cooperate. It took both staff. [S/he] didn't want to sit up in bed, when [s/he] got [his/her] sling on and [s/he] didn't want to hold onto the lift ..."

On 08/05/2025 at 3:58 a.m., staff documented:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 396	Continued From page 2	N 396		

"When staff went to check on resident around 3am (3:00 a.m.), resident was almost halfway off the bed with [his/her] blankets all off and [his/her] call button thrown at the end of the bed. Staff assisted with getting resident back in bed correctly again ... Also noting that while changing resident earlier in the night, resident was resistive to turning on [his/her] side."

On 08/09/2025 at 1:54 a.m., staff documented, in part: "Resident went in for rounds at 115am (1:15 a.m.) and found resident laying [sic] in bed with depends [sic] off and blankets thrown off. The bed was soaked. Staff cleaned up the mess and did a bed change. Resident would not roll to help staff with changing, staff assisted a lot for repositioning during the change. Resident then was covered up to go to bed."

On 08/15/2025 at 5:34 a.m., staff documented: "When resident needed to be changed around 1am (1:00 a.m.), resident was tense and not cooperating. After a couple minutes of staff telling resident that [s/he] needs to help at least a little bit as staff can't do it alone, [s/he] loosened up and helped a little bit. This has become quite common at night and is making it hard for one person alone."

On 08/29/2025, Surveyor reviewed Resident 1's hospice record.

On 04/22/2025, Resident 1's hospice physician documented a note that read, in part: "[RESIDENT 1] NOW REQUIRES THE ASSISTANCE OF 1 TO 2 PEOPLE FOR 5 OF 6 ADLS (activities of daily living). [S/HE] IS ABLE TO FEED [HIM/HERSELF] AFTER SET UP. [S/HE] TRANSFERS WITH A SIT-TO-STAND AND THE ASSISTANCE OF 2 PEOPLE. [S/HE]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018754	A. BUILDING: _____ B. WING _____	C 08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - MEDFORD II	955 E ALLMAN ST MEDFORD, WI 54451

(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 396	Continued From page 3 IS NO LONGER AMBULATORY ... [S/HE] IS INCONTINENT OF BOWEL AND BLADDER ..." On 02/07/2025, the hospice registered nurse documented, in part: "Weakness requiring 2 c (with) sit to stand for transfers." On 08/29/2025, Surveyor reviewed the employee schedule. The August schedule indicated there was only 1 staff scheduled to work the overnight shift. On 08/29/2025 at approximately 3:00 p.m., Surveyor interviewed Administrator A and Director B. Surveyor asked when they began scheduling only 1 staff on the overnight shift. Administrator A said this started approximately a month ago. S/he said now that the census was up, they were going to start scheduling 2 staff on the overnight shift. Surveyor explained they cannot base staffing levels on census alone, they must also staff based on resident needs. Resident 1 required 2 staff to assist, they must have 2 staff on at all times. Administrator A told Surveyor s/he would ensure the corporate office was aware. The provider did not ensure there was adequate staff to meet the needs of Resident 1 on a 24-hour basis.	N 396		