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	0019178	A. BUILDING: _____ B. WING _____	C 07/16/2025

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(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 07/11/2025, with information gathered through 07/16/2025, Surveyor conducted 2 complaint investigations at VitaCare Living Mount Horeb. Ten deficiencies were identified. Two of 2 complaints were substantiated. Census: 13	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 observation, record review, and interview, the provider did not administer medications in the intervals prescribed by a practitioner for 3 of 4 residents. Resident 3's Docusate, Eliquis, Simvastatin, and acetaminophen were not administered as prescribed. Resident 5's Levetiraceta (seizure medication), Fluvoxamine (medication for obsessive compulsive disorder (OCD), Famotidine (acid reducer medication), Divalproex (seizure medication), Atorvastatin (cholesterol medication), acetaminophen, and Areds 2 Eye (vitamin supplement) were not administered as prescribed. Resident 7's acetaminophen and Pravastatin (cholesterol medication) were not administered	N 352		

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

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N 352	Continued From page 1 as prescribed. Findings Include: On 06/13/2025, a concern was filed with the department alleging residents did not receive proper medication administration. Example 1: Resident 3 On 07/11/2025, at approximately 1:00 PM, Surveyor and Med Passer C, who was agency staff, observed Resident 3's medications in the medication cart. Surveyor observed Resident 3's 2:00 PM blister card of acetaminophen, dispensed on 06/11/2025, that contained the tablet for 07/01/2025. Surveyor observed Resident 3's Bedtime blister cards of Docusate, Eliquis, Simvastatin, and acetaminophen, dispensed on 06/11/2025, that contained the tablet(s) for 07/04/2025. Surveyor verified with Med Passer C that medications were dispensed out of the blister card on the number that correlated with the date of the month; the med cycle had started on 06/16/2025. On 07/11/2025, Surveyor reviewed Resident 3's record. Resident 3 admitted into the facility on 10/12/2019. Resident 3's Medication Administration Records (MARs), dated 06/16/2025 to 07/11/2025, documented: Acetaminophen 500 MG (milligram) caplet - Take 2 tablets by mouth 3 times daily in the morning, afternoon and at bedtime Docusate 100 MG soft gel - Take 1 capsule by mouth twice daily	N 352		

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Eliquis 2.5 MG tablet - Take 1 tablet by mouth every 12 hours in the morning and at bedtime
Simvastatin 20 MG tablet - Take 1 tablet by mouth at bedtime for hyperlipidemia
The MARs documented all meds had been administered on 07/01/2025 and 07/04/2025.

On 07/11/2025, at approximately 5:00 PM, Surveyor interviewed Executive Director A and Assistant Executive Director B. Executive Director A and Assistant Executive Director B did not have a response as to why the medications had not been administered as prescribed.

Example 2: Resident 5

On 07/11/2025, at approximately 1:00 PM, Surveyor and Med Passer C observed Resident 5's medications in the medication cart. Surveyor observed Resident 5's Bedtime blister cards of Levetiraceta, Fluvoxamine, Famotidine, Divalproex, Atorvastatin, and acetaminophen dispensed on 06/11/2025, that contained the medication for 07/04/2025. Surveyor observed Resident 5's Bedtime blister card of Areds 2 Eye, labeled July 2025, that contained the tablet(s) for 07/01/2025 and 07/04/2025. Surveyor verified with Med Passer C that medications were dispensed out of the blister card on the number that correlated with the date of the month; the med cycle had started on 06/16/2025.

On 07/11/2025, Surveyor reviewed Resident 5's record.

Resident 5 admitted into the facility on 12/03/2024.

Resident 5's MARs, dated 06/16/2025 to 07/11/2025, documented:

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Levetiraceta 750 MG - Take 2 tablets by mouth twice daily
Fluvoxamine 100 MG - Take 1 tablet by mouth once daily at bedtime
Famotidine 20 MG - Take 1 tablet by mouth once daily
Divalproex 250 MG - Take 3 tablets by mouth once daily in the evening for seizure disorder
Atorvastatin 20 MG - Take 1 tablet by mouth once daily at bedtime
Acetaminophen 500 MG - Take 2 tablets by mouth 3 times daily
The MARs documented all meds had been administered on 07/01/2025 and 07/04/2025.

On 07/11/2025, at approximately 5:00 PM, Surveyor interviewed Executive Director A and Assistant Executive Director B. Executive Director A and Assistant Executive Director B did not have a response as to why the medications had not been administered as prescribed.

Example 3: Resident 7

On 07/11/2025, at approximately 1:00 PM, Surveyor and Med Passer C observed Resident 7's medications in the medication cart. Surveyor observed Resident 7's Bedtime blister cards of acetaminophen and Pravastatin, dispensed on 06/11/2025, that contained the medication for 07/04/2025. Surveyor verified with Med Passer C that medications were dispensed out of the blister card on the number that correlated with the date of the month; the med cycle had started on 06/16/2025.

On 07/11/2025, Surveyor reviewed Resident 7's record.

Resident 7 admitted into the facility on

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N 352	Continued From page 4 02/01/2025. Resident 7's MAR, dated 06/16/2025 to 07/11/2025, documented: Acetaminophen 500 MG - Take 2 tablets by mouth twice daily Pravastatin 20 MG - Take 1 tablet by mouth once daily at bedtime The MARs documented all meds had been administered on 07/04/2025. On 07/11/2025, at approximately 5:00 PM, Surveyor interviewed Executive Director A and Assistant Executive Director B. Executive Director A and Assistant Executive Director B did not have a response as to why the medications had not been administered as prescribed.	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	N 389		

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interview, the provider did not ensure 2 of 2 Individual Service Plans (ISP) were reviewed when the resident experienced a change of condition.

Resident 5's ISP did not document his/her aggressive behaviors and his/her refusal of medications.
Resident 7's ISP did not reflect that s/he utilized bedrails and a scooped mattress.

Findings include:

Example 1: Resident 5

On 07/11/2025, at approximately 12:10 PM, Surveyor interviewed Resident 4's Family Member (FM) F. FM F stated Resident 4 gets tired of listening to the residents fighting or yelling at each other.

On 07/11/2025, at approximately 3:55 PM, Surveyor observed Resident 5 yelling at Resident 1 because s/he had walked into the kitchen.

On 07/11/2025, Surveyor reviewed Resident 5's record.

Resident 5 admitted into the facility, 12/03/2024, with diagnoses including obsessive compulsive disorder (OCD), seizure disorder and agitation.

Resident 5's progress notes, dated 06/01/2025 to 07/11/2025, documented:
06/01/2025 - Resident crying at the breakfast table with other residents present. Resident had a very small episode of crying, but redirection was successful.
06/06/2025 - Writer reached out to [doctor name] via fax to let them know that resident refused the

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scheduled Diclofenac gel 1 % on 5/30 at 8a.m./4p.m./8p.m. as well as on 6/2 at 8 am and noon.
06/06/2025 - [Resident 5] had a seizure at 1:24 pm sitting at the dining room table in a up right position for about five min, after [s/he] had settle down from the seizure caregiver [Caregiver I] and [Caregiver J] push [him/her] back to [him/her] room so that [s/he] can lay down staff ask was [s/he] in any pain [s/he] said the lower abdominal was hurting a little. vital was done BP (blood pressure)145/95 P (pulse) 81T (temperature) 97.8 R (respirations)18 PCP (primary care physician) was notified and give order to monitor [him/her] one to two hour, waiting on family to call back. Family give writer a call back to inform family that [Resident 5] had a seizure in the dining room.
06/08/2025 - at 1:25 pm [Resident 5] decided to come in the dining room when [s/he] entered the room [s/he] was yelling at [Resident 1] to move out of [him/her] chair I told [him/her] that there is no specific setting as I was telling [him/her] [s/he] raised [him/her] hand to hit [Resident 1] and I told [him/her] if [s/he] hit [s/he] was going to be in a world of trouble I will be calling [name] [s/he] told me that I don't know [name] I told [him/her] I will call [name] as well. [Resident 1] finally got up and started walking and [s/he] got [him/her] set
06/09/2025 - Staff noted that resident refused [him/her] schedule 8 a.m. Diclofenac Gel 1 % / Systane Ultra 0.4-0.3% Soln (solution)/Fluticasone 50 mcg (microgram) Nasal Spray Primary care physician was notified of refusals
06/17/2025 - Resident refused [him/her] scheduled 8 am/12 p.m. Diclofenac Gel 1 % on this date. Will notify PCP in the morning.
06/19/2025 - Resident refused scheduled 12 p.m. Diclofenac Gel 1 %today.

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N 389	Continued From page 7 06/26/2025 - Resident continues to refuse [his/her] scheduled Diclofenac Gel 1 % 06/27/2025 - Resident refused [his/her] scheduled 8 am Diclofenac 1 % gel on this date 06/28/2025 - Resident refused [his/her] scheduled 12 pm Diclofenac Gel 1 % on 6/27 /25 06/29/2025 - Writer received a call from care specialist. [Med Passer H] informed me that [Power of Attorney (POA) K] has called to say [Resident 5] reported to [him/her] that [s/he] has had several brain seizures throughout the weekend. writer told staff that I will get in touch with [POA K] to discuss that [Resident 5] has not had any seizure. Writer put a call out to [POA K] to discuss about [him/her] having seizures. Also received a call back from [POA K] to let [him/her] know that [Resident 5] has not had any seizures. [S/he] is concerned about a [sister/brother] that [s/he] hasn't seen in six or seven months who [s/he] referred to and say [s/he] is too busy to come see [him/her]. [Resident 5] has been on emotionally in tears, the next five minutes [him/her] sister [POA K] called I also informed [him/her] that [s/he] was ok and [s/he] has not had any brain seizures. [POA K] discussed with me that [s/he] will call and talk to [Resident 5] to let [him/her] know that when [s/he] get back off of vacation, [s/he] will be in to take [him/her] out. 06/30/2025 - Writer receive a call from [Med Passer H] stating that [Resident 5] had a seizure at around 11 o'clock. Staff stated [s/he] put the magnet on [his/her] chest as other family members were surrounding [Resident 5] for comfort staff stated that [s/he] completed vitals bp 109/70 oxygen was 94 heart rate 58 temperature 97.5 [Med Passer H] also stated after 15 minutes [s/he] wanted to go relax in [him/her] room. Staff also walked back to [him/her] room to ensure [s/he] was safe. writer a contacted PCP. Also, [his/her] [POA K] and [managed care	N 389		

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organization] about the incident.
07/02/2025 - Resident refused [his/her] scheduled 8 pm vitamin B-6 on 7 /1 /25 and [his/her] 8 am Diclofenac Gel on this date.
07/03/2025 - Writer received a call from [agency worker name] complaining about [Resident 5] was refusing [him/her] 8 o'clock meds. I asked to speak with [Resident 5] on how important it is taking your medication and how important is for your seizures. [Resident 5] said that [s/he] is not taking any meds writer called [POA K] to ask if [s/he] can talk to [Resident 5] about taking [his/her] meds [POA K] said yes, [POA K] call [Resident 5] to discuss how important is on taking [him/her] medication. [Resident 5] also commented with I don't wanna take pill at night anymore, [POA K] express how important it was for [him/her] to take [him/her] pills and [s/he] finally said OK [s/he] will take them.
07/11/2025 - Care staff, [Caregiver I] reported that as they were getting ready for dinner, [s/he] could hear this resident yelling at another resident who was trying to speak. Resident's [sister/brother] came out of [him/her] room to see what the yelling was about, resident [sister/resident] told [him/her] that [s/he] is not allowed to talk or treat others that way when it did not concern [him/her]. Staff reported that resident was upset that everyone was looking at [him/her] acting like that. Staff reported that again sister told resident that nobody said anything to you. Resident ended up yelling at [him/her] [sister/brother] and then hit [him/her], and staff reported [sister/brother] hit [him/her] back. they ended up apologizing to each other and [sister/brother] went to [his/her] room to talk with resident. [Assistant Executive Director B] spoke to resident [sister/brother].
07/08/2025 - It was reported by [Caregiver I] that at 9:15 am another resident had bent over to pick

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something off dining room and accidently touched this resident's shoe, this resident Yelled " Don't touch me" then at about 10:45 a.m. the other resident was rocking [his/her] leg and this resident went to put [his/her] walker in the walkway so the other resident could not move to aggravate [him/her]. This resident got really upset and made a remark that [s/he] did not like the other resident and does not want [him/her] to color or touch [his/her] crayons. Agency worker, [name] told resident that the other resident can sit there and [s/he] can't talk or treat [him/her] that way, this resident then went and sat in [his/her] room and waited for [his/her] sister. [Caregiver I] told resident [sister/brother], [POA K] that [s/he] went in [him/her] room because [s/he] was not getting [him/her] way .. [s/he] did come out to the dining room, but staff reported that [s/he] did not eat.
07/11/2025 - Manage Behavior - Anxiety/agitation/aggression - yelled at resident [Resident 4] saying shut your mouth and was told to put away puzzles to eat lunch. was rude to staff when it was medication time

Resident 5's "Master Care Plan," dated 07/02/2025, documented:
"Medications - Needs reminders to take medications. Behaviors in place with a schedule for every shift to monitor. Behavior and Mood tracking in place."
"Behavior - Prescribed Clonazepam for agitation."
"Manage Behavior - Anxiety/agitation/aggression - 5:00 AM, 8:00 AM, 8:00 PM."
"Physical - Neurological - History of TIA (transient ischemic attack), seizures."

On 07/11/2025, at approximately 4:00 PM, Surveyor interviewed Assistant Executive Director B. Surveyor commented that Resident 5 was

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yelling at Resident 1 for being in the kitchen. Assistant Executive Director B stated s/he had to redirect residents from yelling at Resident 1 because s/he does not understand why they are upset with him/her; s/he doesn't understand the rule of staying out of the kitchen.

Example 2: Resident 7

On 07/11/2025, at approximately 12:48 PM, Surveyor observed Resident 7's room. Surveyor observed a hospital bed that contained half side bedrails and a scooped mattress.

On 07/11/2025, Surveyor reviewed Resident 7's record.

Resident 7 admitted into the facility 02/26/2025 with diagnosis including muscle weakness.

Resident 7's "Assessment," dated 04/08/2025, documented:
"Bed Safety: Electric Bed - Mattress original to bed. No assistive devices needed for bed. Does not use bed rails."
"Mobility - Bed: Needs assistance with turning and repositioning. Staff assist to reposition every two hours."

According to the U.S. Food & Drug Administration's Hospital Bed Safety Workgroup, "...Strangling, suffocating, bodily injury, or death can occur when patients or parts of their bodies are caught between rails or between the bed rails and mattresses...Regardless of the purpose for which bed rails are being used or considered, a decision to utilize or remove those in current use should occur within the framework of an individual patient assessment...3. Use of bed rails should be based on patient's assessed medical needs

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N 389	Continued From page 11 and should be documented clearly...Bed rail effectiveness should be reviewed on a regular basis...The patient's chart should include a risk-benefit assessment that identifies why other care interventions are not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the patient. 4. Bed rail use for treatment of a medical symptom or condition should be accompanied by a care plan (treatment program) designed for that symptom or condition. The plan should present clear directions for further investigation of less restrictive care interventions. The documentation should describe the attempts to use less restrictive care interventions and, if indicated, their failure to meet patients' assessed needs...The care plan should: include educating the patient about possible bed rail danger to enable the patient to make an informed decision; and address options for reducing the risks of the rail use..." (Source: "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings" https://www.fda.gov/media/88765/download (retrieval date 08/13/2024)). On 07/16/2025 at 5:32 PM, Surveyor emailed Executive Director A a summary of the findings regarding the complaint investigation. Surveyor commented that the resident's individual service plan was not updated to reflect the use of the scoop mattress or bedrails.	N 389		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF	N 408		

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N 408	Continued From page 12 shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 2 of 2 resident records included the rationale for use and description of behaviors requiring the as-needed (PRN) psychotropic medications. Resident 2's ISP did not document a rationale for med administration of his/her PRN Hydroxyzine Pamoate. Resident 5's ISP did not document a rationale for med administration of his/her PRN Clonazepam. Findings include: On 06/13/2025, a concern was filed with the department alleging residents did not receive proper medication administration.	N 408		

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Example 1: Resident 2

On 07/16/2025, Surveyor reviewed Resident 2's record.

Resident 2 admitted into the facility, 06/18/2025, with diagnoses including schizophrenia, mood disorder, and anxiety.

Resident 2's MARS, dated 06/18/2025 to 07/14/2025, documented:
"Hydroxyz Pam (hydroxyzine pamoate) 25 MG - Take 1 capsule by mouth 3 times daily as needed for anxiety."

Resident 2's "Assessment," dated 06/18/2025, documented:
"Psychotropic Medication - Hydroxyz Pam Cap 25 MG that [s/he] is to take 1 capsule by mouth 3 times daily as needed for anxiety."
"Behavior: Verbal aggression. [Resident 2] can become verbally aggressive when [s/he] refuses to take [his/her] medications."

The ISP did not document a rationale for the administration of the PRN Hydroxyzine Pamoate.

Example 2: Resident 5

On 07/11/2025, Surveyor reviewed Resident 5's record.

Resident 5 admitted into the facility, 12/03/2024, with diagnoses including obsessive compulsive disorder (OCD), seizure disorder and agitation.

Resident 5's June and July 2025 Medication Administration Records (MARs) documented:
"Clonazepam Odt (orally disintegrating tablet) - Dissolve 1 tablet orally once daily as needed for

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N 408	Continued From page 14 agitation" Resident 5's "Master Care Plan," dated 07/02/2025, documented: "Needs reminders to take medications." "Psychotropic Medication Review: Clonazepam Odt 0.5 MG (milligram) Tab (tablet) by mouth as needed agitation." The ISP did not document a rationale for the administration of the PRN Clonazepam. On 07/11/2025, at approximately 5:00 PM, Surveyor interviewed Executive Director A and Assistant Executive Director B. Surveyor discussed the concern that behaviors and/or rationale was not identified in the resident's individual service plan (Assessment) regarding the administration of their PRN psychotropic medications. Executive Director A and Assistant Executive Director B did not have a response as to why it was not included.	N 408		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented.	N 415		

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N 415	Continued From page 15 This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure proper documentation of the Medication Administration Record (MAR) for 2 of 4 resident reviewed. Resident 2's and Resident 6's MARs contained blanks where staff should have documented that they had completed medication administration. Findings include: Example 2: Resident 2 On 07/16/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted into the facility 06/18/2025. Resident 2's MAR, dated 06/18/2025 to 07/14/2025, documented: "Levothyroxin Tab (tablet) 50 MCG (microgram) - Take 1 tablet by mouth daily before breakfast for hypothyroidism. Start Date: 06/18/2025." Not documented as administered on 06/20, 06/23, 07/04, 07/05, 07/06, 07/08, 07/10, 07/11, 07/13 and 07/14. Example 2: Resident 6 On 07/11/2025, Surveyor reviewed Resident 6's record. Resident 6 was admitted into the facility 04/22/2024. Resident 6's June 2025 MAR documented: "Acetaminophen 500 MG (milligram) - Take 2	N 415		

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N 415	Continued From page 16 tablets by mouth 3 times daily." Not documented as administered on 06/08 and 06/24 at 2:00 PM. "Multivitamin Tab (tablet) - Take 1 tablet by mouth once daily for supplement." Not documented as administered on 06/02, 06/03, 06/07, 06/10, 06/11, 06/12, 06/17, 06/21, 06/22, and 06/26 at 5:00 PM. "Vitamin C Tab 500 MG - Take 1 tablet by mouth once daily." Not documented as administered on 06/02, 06/03, 06/07, 06/10, 06/11, 06/12, 06/17, 06/21, 06/22, and 06/26 at 5:00 PM. "Vitamin E 180 MG - Take 1 capsule by mouth once daily." Not documented as administered on 06/02, 06/03, 06/07, 06/10, 06/11, 06/12, 06/17, 06/21, 06/22, and 06/26 at 5:00 PM. On 07/11/2025, at approximately 4:00 PM, Surveyor observed Resident 6's current blister cards, which were put into cycle on 06/16/2025, and determined all medications had been given in June. On 07/11/2025, at approximately 5:00 PM, Surveyor interviewed Executive Director A and Assistant Executive Director B. Surveyor discussed that MARs reviewed had blank spaces where staff should have recorded their initial showing that the medications had been administered. Executive Director A and Assistant Executive Director B did not have a response.	N 415		
N 420	83.37(3)(d) Medication storage: refrigeration Refrigeration. Medications stored in a common refrigerator shall be properly labeled and stored in a locked box.	N 420		

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N 420	Continued From page 17 This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure medications stored in the medication refrigerator were securely stored. Resident 2's Lantus Solostar insulin pens were not securely stored. Findings include: On 07/11/2025, at approximately 1:25 PM, Surveyor toured the unlocked med room and observed the medication refrigerator that was not locked. Inside the refrigerator, Surveyor found 6 Lantus Solostar insulin pens that were prescribed for Resident 2. On 07/11/2025, at approximately 5:00 PM, Surveyor interviewed Executive Director A and Assistant Executive Director B. Surveyor discussed the concern that Resident 2's Lantus Solostar pens were not securely stored. Surveyor did not receive a response. On 07/14/2025, Surveyor reviewed Resident 2's record. Resident 2 moved into the facility 06/18/2025. Resident 2's Medication Administration Record, dated 07/01/2025 to 07/14/2025, documented: "Lantus Solostar 100 Unit/ML (milliliter) - Inject 76 Units subcutaneously every morning for Type 2 Diabetes Mellitus. Start Date: 06/18/2025."	N 420		
N 425	83.38(1)(a) Personal care.	N 425		

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N 425	Continued From page 18 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: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure residents received appropriate care. Resident 2, Resident 4, and Resident 5 did not receive his/her shower as outlined in his/her ISP. Resident 6 did not receive timely assistance when his/her colostomy bag had become detached. Findings include: The facility is licensed as a Class CNA (non-ambulatory) assisted living facility that can provide care and services to 23 residents within the client groups: irreversible dementia/Alzheimer's, advanced aged, and physically disabled. Example 1: Resident 2	N 425		

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N 425	Continued From page 19 On 07/11/2025, at approximately 1:00 PM, Surveyor observed Resident 2 sitting in the common area with other residents. Resident 2's hair appeared to have a greasy like appearance. On 07/11/2025, Surveyor reviewed Resident 2's record. Resident 2 admitted into the facility 06/18/2025. Resident 2's "Assessment," dated 06/18/2025, documented: "Bathing Needs: Needs moderate assistance with bathing/showering. [Resident 2] needs staff assistance of one with bathing needs. Staff will assist [Resident 2] with getting in the shower. Staff will wash [his/her] hair and [his/her] back. [Resident 2] is able to wash [his/her] face as well as [his/her] upper and lower extremities and peri area with cues from staff. Staff will assist [him/her] with drying off and getting out of the shower. [Resident 2] will use the grab bars and shower bench for extra safety in the shower. Resident 2's "Service Detail," dated Wednesday, 06/18/2025, documented: "Will remain clean, free from body odor and skin breakdown. Schedule Friday AM." Documented shower on: 07/04/2025. Resident 2 was not documented as receiving a shower since admittance until 07/04/2025. On 07/11/2025, at approximately 5:00 PM, Surveyor interviewed Executive Director A and Assistant Executive Director B. Executive Director A and Assistant Executive Director B did not have a reason they could give as to why residents did not receive scheduled showers. Example 2: Resident 4	N 425		

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N 425	Continued From page 20 On 07/11/2025, at approximately 12:10 PM, Surveyor interviewed Resident 4's Family Member (FM) F. FM F stated Resident 4 often confided in him/her that s/he does not receive his/her scheduled shower, so Resident 4 will wipe him/herself down with a washcloth. On 07/11/2025, Surveyor reviewed Resident 4's record. Resident 4 admitted into the facility 10/23/2024. Resident 4's task [s/he]et, dated 06/11/2025 to 07/11/2025, documented: "Tuesday AM: Staff assistance of one needed to assist [Resident 4] with showers. Staff will assist with getting [him/her] in the shower. They will wash [his/her] hair, face, upper and lower extremity, [his/her] back and peri area. Staff will assist with drying [him/her] off and getting [him/her] out of the shower. [Resident 4] will use the shower chair and grab bar for extra safety in the shower. Staff to complete skin/nail care if needed." Start Date: 05/13/2025. Documented showers on: 06/17/2025, 07/01/2025 and 07/08/2025. Resident 4 was not documented as receiving a shower the week of 06/22/2025. On 07/11/2025, at approximately 5:00 PM, Surveyor interviewed Executive Director A and Assistant Executive Director B. Executive Director A and Assistant Executive Director B did not have a reason as to why residents did not receive scheduled showers. Example 3: Resident 5 On 07/11/2025, at approximately 1:00 PM,	N 425		

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Surveyor observed Resident 5 sitting in the common area. Resident 5's hair had a greasy like appearance.

On 07/11/2025, Surveyor reviewed Resident 5's record.

Resident 5 admitted into the facility 12/03/2024.

Resident 5's "Master Care Plan," dated 07/02/2025, documented:
"Needs minimal assistance with bathing/showering - Staff assist of one needed for Bathing. Care staff will assist [Resident 5] with getting in the shower. Staff will wash [Resident 5's] hair and face. Assist with washing [his/her] upper and lower extremities. Staff will wash [his/her] back and peri area. Staff will assist with drying [him/her] off and getting [him/her] out of the shower."

Resident 5's "Service Detail," dated 06/11/2025 to 07/11/2025, documented:
"Wednesday AM - will remain clean, free from body odor and skin breakdown."
Documented shower on: 07/02/2025.

Resident 5's progress notes documented:
06/22/2025 - Completed shower at 7:45 PM

Resident 5 was not documented as receiving a shower the week of 06/08/2025, 06/15/2025, or 07/06/2025.

On 07/11/2025, at approximately 5:00 PM, Surveyor interviewed Executive Director A and Assistant Executive Director B. Executive Director A and Assistant Executive Director B confirmed that the showers were not given and did not have a reason as to why they were not

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being done.

Example 4: Resident 6

On 07/11/2025, at approximately 12:45 PM, Surveyor toured Resident 6's room and detected feces like scent emanating throughout the room while Resident 6 was lying in his/her bed.

On 07/11/2025, at approximately 1:40 PM, Surveyor observed Resident 6 sitting in the common area with other residents. Surveyor detected feces like scent emanating from Resident 6.

On 07/11/2025, at approximately 1:45 PM, Caregiver D started doing a puzzle with Resident 6 and the other residents sitting at the table I the common area.

On 07/11/2025, at approximately 3:30 PM, Caregiver D stated out loud to him/herself, "What is that smell," as s/he stood next to the residents in the common area. Caregiver D proceeded to check the garbage cans in the kitchen.

On 07/11/2025, at approximately 4:15 PM, Med Passer E informed Assistant Executive Director B that Resident 6's colostomy bag had burst and was no longer attached.

On 07/11/2025, at approximately 4:25 PM, Surveyor interviewed Med Passer E. Surveyor asked Med Passer E how s/he determined that Resident 6 required assistance with his/her colostomy bag. Med Passer E stated, "I noticed [s/he] smelled and observed [feces] on [his/her] clothing. I walked [him/her] to [his/her] room to clean [him/her] up and noticed [his/her] colostomy bag was in the [urine] basin, in the toilet."

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N 425	Continued From page 23 On 07/11/2025, Surveyor reviewed Resident 6's record. Resident 6 was admitted into the facility 04/22/2024. Resident 6's "Master Care Plan," dated 07/02/2025, documented: Outcome - Colostomy - Daily 10:00 AM. Active Date: 01/21/2025. Toileting - 12:00 AM, 8:00 AM, 4:00 PM. Active Date: 01/21/2025. Resident 6's individual service plan, dated 04/22/2024, documented: Colostomy Assist - Check the colostomy bag and empty if needed OR apply new colostomy appliance: 4 times per day, Daily Toileting - Will remain independent with [his/her] toileting. Does have a colostomy bag that [s/he] is able to take care of independently as well. [S/he] will ring for staff assistance if [s/he] needs help. On 07/11/2025, at approximately 5:00 PM, Surveyor interviewed Executive Director A and Assistant Executive Director B. Executive Director A and Assistant Executive Director B stated there had been recent staffing concerns. Executive Director A stated Med Passer E is a regular staff member and the two staff that worked first shift, Med Passer C and Caregiver D, were agency staff.	N 425		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents	N 426		

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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:
Supervision. The CBRF shall provide supervision 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 adequate supervision.

Resident 1 exited from the facility and his/her whereabouts were unknown until a community bystander contacted the provider and stated there was a resident outside.

Findings include:

On 07/07/2025, the Department received a concern that a resident had eloped from the facility and staff were unaware.

On 07/11/2025, Surveyor reviewed a written report, dated 07/01/2025, submitted by the provider regarding Resident 1's unwitnessed fall that resulted in a fractured nose which documented:
"06/30/2025 1630 (4:30 PM) - Resident went through door in the kitchen which leads to the laundry room and a set of starts [sic: stairs] to the downstairs apartments. Resident fell, was found in the backyard of the community and was brought to the front door by a bystander."

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N 426	Continued From page 25 On 07/11/2025, at approximately 11:15 AM, Surveyor interviewed Resident 1's Power of Attorney (POA) G. Surveyor asked POA G to explain the series of events that occurred on 06/30/2025. POA G stated s/he had been contacted by the provider and stated Resident 1 had fallen outside and sustained an injury. POA G stated, "I do not understand why [s/he] is outside unattended. [S/he] has lived in the facility since March and s/he has already eloped, and staff didn't know s/he had until law enforcement returned [Resident 1] and now [s/he] has eloped again, fallen and broken [his/her] nose. And the way it sounds, they didn't know [s/he] had left the building until someone came to the building and told them." On 07/11/2025, at approximately 4:25 PM, Surveyor interviewed Med Passer E, who worked 06/30/2025 when Resident 1 sustained his/her unwitnessed fall. Med Passer E confirmed that Resident 1 had exited through the stairwell that is off the kitchen. The stairwell leads to the apartments on the lower level. Med Passer E stated a neighbor had come to the door of the facility, rang the doorbell, and stated a resident was out by the dumpsters. Med Passer E found him/her along the cement retaining wall. Med Passer E stated s/he had a facial injury and was bleeding. Med Passer E stated s/he escorted Resident 1 back into the building and contacted Assistant Director B. Surveyor asked if Med Passer E knew how long Resident 1 had been outside. Med Passer E stated based on the cameras, it was determined it had been 30 or 40 minutes when the neighbor had contacted us. On 07/11/2025, Surveyor reviewed Resident 1's record.	N 426		

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Resident 1 moved in 03/18/2025. Resident 1 was identified as a high risk for falls and had previously eloped.

Resident 1's incident report, dated 06/30/2025, documented by Med Passer H:
Location of Fall: outside on the hill
Detailed Description of fall: [S/he] left out the kitchen door and had a fall outside and a [lady/man] came to the front door and told us [s/he] was down on the floor and me and [Med Passer E] went to go get [him/her] up and help [him/her] back in the building and called [Assistant Executive Director B] to tell [him/her] what's going on and [s/he] called the son [family members] and messaged them when they did not answer
Did the fall result in a serious injury: Yes, resident broke their nose

Resident 1's assessment, dated 06/11/2025, documented:
"Mobility - Transfer: Independent - no assistance needed with transferring."
"Mobility - Ambulation: Independent - no assistance needed with ambulation."
"Elopement Risk: Resident has a cognitive diagnosis. Routine rounding is done by staff to ensure resident locality. Perform visual check of resident to ensure their safety and well-being. All exit/entry doors have delayed egress door locks that shall open when latch is held down for 15 seconds, which will activate an audible signal in the vicinity of the door and can only be re-locked by manual means only."
Surveyor observed the egress doors which were located on the first floor.
"Behavior - Elopement threat - [Resident 1] does wander and tries to exit seek."

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N 426	Continued From page 27 On 07/14/2025, Surveyor reviewed a previous police report, regarding Resident 1, which documented: "03/28/2025 at 7:20 PM officers were dispatched to a location where an elderly person had been found, confused and wandering the streets. Officers were able to determine the individual resided at VitaCare Living Mount Horeb and returned him/her to this location." On 07/11/2025, at approximately 5:00 PM, Surveyor interviewed Executive Director A and Assistant Executive Director B. Executive Director A stated staff were to ensure the kitchen door was locked. Since, this incident, an additional locking device may be added to the door so that it automatically locks and/or the provider is looking to enclose the kitchen with doors, so it is not an open concept, and residents would not be able to access the door that leads to the laundry room and the downstairs apartments. Cross Reference: N0353 DHS 83.32(3)(i) Rights of Residents: Adequate Treatment	N 426		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation, record review and	N 450		

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interview, the provider did not make weekly menus available to residents and deviations from the planned menu were not documented on the menu.

Findings include:

The facility is licensed as a Class CNA (non-ambulatory) assisted living facility that can provide care and services to 23 residents within the client groups: irreversible dementia/Alzheimer's, advanced aged, and physically disabled.

On 07/11/2025, at approximately 12:00 PM, Surveyor observed the residents eating lunch. The lunch consisted of popcorn shrimp and broccoli with potatoes. The menu board did not display a menu. There was a whiteboard that stated, "July 2, 2025 - Lunch: Swedish Meatballs, Egg Noodles, Pea, Yellow cake with choco (chocolate). Dinner: Chicken Strips, Waffle Fries, Broccoli salad, oreo cookie."

On 07/11/2025 at 12:15 PM, Surveyor observed the menu hanging on the bulletin board in the kitchen which documented:
"Friday: Lunch - Beer battered fish, waffle fry, broccoli, fruit cocktail. Dinner - Popcorn shrimp, roasted sweet potato, coleslaw, Rosy applesauce."

On 07/11/2025, at approximately 1:40 PM, Surveyor observed the whiteboard that now stated, "July 2, 2025 - Lunch: Popcorn Shrimp, Broc (broccoli) & potato, apple pie. Dinner: Chicken Strips, Waffle Fries, Broccoli salad, oreo cookie."

On 07/11/2025 at 2:00 PM, the leftover popcorn

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N 450	Continued From page 29 shrimp and broccoli with potatoes had finally been covered with saran wrap and were sitting on the kitchen island. On 07/11/2025 at 3:30 PM, the leftover popcorn shrimp and broccoli with potatoes were sitting on the kitchen island. On 07/11/2025 at 3:50 PM, Surveyor observed an 18 pack of thawed brats, 2 gallons of orange juice and a package of thawed smoked pre-sliced boneless uncured ham sitting on the kitchen island. On 07/11/2025 at 4:38 PM, Surveyor observed the leftover popcorn shrimp had been reheated and a thin crust pepperoni pizza had been prepared for dinner. On 07/11/2025 at 4:55 PM, Surveyor interviewed Assistant Executive Director B. Assistant Executive Director B stated s/he had to throw out the food that the previous staff had not put away. Surveyor walked back into the kitchen to determine what residents were being served for dinner. Med Passer E stated s/he was warming up canned carrots to go with the pizza. On 07/11/2025, at approximately 5:00 PM, Surveyor interviewed Executive Director A and Assistant Executive Director B. Surveyor discussed his/her concerns regarding the menu. Executive Director A stated staff would be re-educated on how to follow the designated menu.	N 450		
N 481	83.43(1) Environment safe, clean, and comfortable	N 481		

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N 481	Continued From page 30 Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a living environment that was comfortable, and homelike. 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. On 07/11/2025, at approximately 12:00 PM, Surveyor toured the home and determined the facility felt cool temperature wise. On 07/11/2025, at approximately 12:10 PM, Surveyor interviewed Resident 4's Family Member (FM) F. Surveyor asked if there were any concerns with Resident 4's cares. FM F stated that Resident 4 would inform him/her that his/her room is cold. Surveyor temped the room and it temped at 70.5 degrees Fahrenheit. On 07/11/2025, at approximately 12:35 PM, Surveyor observed the facility thermostat that had a holding temprature of 70 degrees Fahrenheit. The thermostat had a sign that stated, "Please don't change the thermostat."	N 481		

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N 481	Continued From page 31 On 07/11/2025, at approximately 1:25 PM, Resident 6 came out of his/her room wearing a long fur coat. Med Passer C asked him/her if s/he was cold and Resident 6 stated s/he was. On 07/11/2025, at approximately 3:30 PM, Surveyor observed residents sitting at a table in the common area. Surveyor noted that Resident 1 was wrapping his/her hands inside of his/her shirt. Surveyor asked if s/he was cold. Resident 1 stated s/he was. Surveyor observed Resident 4 wearing a sweater and was wrapping his/her arms around him/herself. Resident 4 stated it was cold. Surveyor asked Resident 2 if s/he was cold. Resident 2 stated his/her hands were cold. On 07/11/2025, at approximately 4:15 PM, Surveyor interviewed Resident 5 and his/her Power of Attorney (POA) K. Surveyor asked if the temperature in his/her room was comfortable for him/her. Resident 5 stated, "It can get cold." On 07/11/2025, at approximately 5:00 PM, Surveyor interviewed Executive Director A and Assistant Executive Director B. Executive Director A stated s/he would have staff turn the temperature up a couple of degrees and see if residents preferred the new temp. Executive Director A stated s/he understood that the facility needed to be able to maintain a temperature of 74 degrees Fahrenheit.	N 481		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area.	N 499		

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N 499	Continued From page 32 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds and toxic substances were stored in a secured area. 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. On 07/11/2025, Surveyor toured the facility and observed the following unsecured cleaning compounds: Kitchen Cabinet: -32 fluid ounce bottle of multipurpose cleaner -20 ounce spray can of disinfectant spray -Gallon jug of pet carpet shampoo -19 ounce spray can of disinfectant spray - crisp linin scent The kitchen cabinet appeared to have pest like droppings on the base of the cabinet. Kitchen Counter: -19 ounce spray can of disinfectant spray - crisp linin scent Laundry Room: -(2) gallon jugs of bleach -Gallon jug of window cleaner -(3) Gallon jugs of all purpose cleaner & degreaser - lavender scent -18 fluid ounce bottle of multi-purpose cleaner - Gain scent -(2) Gallon jugs of neutral ph floor cleaner	N 499		

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N 499	Continued From page 33 -(4) Gallon jugs of hand sanitizer gel - 70% ethyl alcohol -32 fluid ounce bottle of disinfecting - sanitizing bathroom cleaner These areas were accessible to all residents. Residents were observed moving freely throughout the facility.	N 499		