| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019178 | A. BUILDING: _____ B. WING _____ | R-C 12/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VITACARE LIVING MOUNT HOREB | 104 LINCOLN CT MOUNT HOREB, WI 53572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| {N 000} | Initial Comments<br><br>On 11/25/2025, with information gathered through 12/08/2025, Surveyor conducted a standard licensure survey, a complaint investigation and a verification visit. Eighteen deficiencies were identified.<br><br>Complaint was substantiated.<br><br>Five of 18 deficiencies, were repeat violations (See Statement of Deficiency (SOD) NYMZ11).<br><br>Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed.<br><br>Census: 12 | {N 000} | | |
| N 196 | 83.14(2)(a) Licensee ensures facility complies with laws<br><br>The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the licensee did not ensure the facility, and its operation complied with all laws governing a Community-Based Residential Facility (CBRF).<br><br>Findings include:<br><br>The facility was licensed as a Class CNA (non-ambulatory) assisted living facility on 04/15/2024 and the licensee can provide care and services to 23 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, and physically disabled. | N 196 | | |

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 |
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| N 196 | Continued From page 1<br>On 11/25/2025, with information gathered through 12/08/2025, Surveyor conducted a standard licensure survey, a complaint investigation and a verification visit. Eighteen deficiencies were identified:<br>N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws<br>N0352 83.32(3)(h) Rights of Residents: Receive Medication. This is a repeat deficiency. See Statement of Deficiency (SOD) VTVD11, dated 07/16/2025.<br>N0357 83.32(3)(m) Rights of Residents: Recording and Filming<br>N0381 83.35(1)(a) Pre-Admission and Ongoing Assessment<br>N0385 83.35(2) Temporary Service Plan<br>N0388 83.35(3)(c) Implement, Follow The Individual Service Plan<br>N0389 83.35(3)(d) Service Plans Updated Annually or On Changes. This is a repeat deficiency. See SOD VTVD11, dated 07/16/2025.<br>N0400 83.37(1)(a) Written Order for Medications, Supplements<br>N0412 83.37(2)(a) Self-Administered by Resident<br>N0415 83.37(2)(d) Documentation of Medication Administration. This is a repeat deficiency. See SOD VTVD11, dated 07/16/2025.<br>N0427 83.38(1)(c) Leisure Time Activities<br>N0431 83.38(1)(g) Health Monitoring<br>N0446 83.41(1)(b) Equipment<br>N0447 83.41(1)(c) Dishwashing<br>N0450 83.41(2)(c) Nutrition: Menus. This is a repeat deficiency. See SOD VTVD11, dated 07/16/2025.<br>N0454 83.42(1) Resident Record Maintained<br>N0481 83.43(1) Environment Safe, Clean, and Comfortable. This is a repeat deficiency. See SOD VTVD11, dated 07/16/2025.<br>N0488 83.44(1)(c) Clothes Dryer Enclosed and Vented | N 196 | | |

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| N 196 | Continued From page 2<br><br>Review of facility records documented previous survey event identifying noncompliance, as follows:<br><br>SOD VTVD11 - On 07/11/2025, with information gathered through 07/16/2025, Surveyor conducted 2 complaint investigations at VitaCare Living Mount Horeb. Two of 2 complaints were substantiated. Ten deficiencies were identified:<br>N0352 83.32(3)(h) Rights of Residents: Receive Medication<br>N0389 83.35(3)(d) Service Plans Updated Annually or On Changes<br>N0408 83.37(1)(i) PRN Psychotropic Medications<br>N0415 83.37(2)(d) Documentation of Medication Administration<br>N0420 83.37(3)(d) Medication Storage: Refrigeration<br>N0425 83.38(1)(a) Personal Cares<br>N0426 83.38(1)(b) Supervision<br>N0450 83.41(2)(c) Nutrition: Menus<br>N0481 83.43(1) Environment Safe, Clean, and Comfortable<br>N0499 83.45(3) Toxic Substances<br><br>SPECIAL ORDERS: 1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., the licensee shall develop and implement corrective measures to ensure all resident care staff provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected.<br><br>WITHIN 45 DAYS of receipt of this notice, the licensee will provide training to all resident care staff on the corrective actions taken to resolve each deficient practice identified in Statement of Deficiency (SOD) VTVD11. Training will be | N 196 | | |

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| N 196 | Continued From page 3<br>documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and evidence of successful completion of the training.<br><br>SOD NYMZ12 - On 04/29/2025, with information gathered through 05/02/2025, Surveyor conducted a complaint investigation at VitaCare Living Mount Horeb. Complaint was substantiated. Six deficiencies were identified:<br>N0163 83.12(4)(a) Reporting When Resident's Whereabouts Unknown<br>N0215 83.15(3)(b) Administrator Responsible For Staff Training<br>N0355 83.32(3)(k) Rights of Residents: Self-Determination<br>N0358 83.32(3)(n) Rights of Residents: Safe Environment<br>N0432 83.38(1)(h) Medication Administration<br>N0454 83.42(1) Resident Record Maintained. This is a repeat deficiency. See Statement of Deficiency (SOD) NYMZ11, dated 12/09/2024.<br><br>SOD NYMZ11 - On 11/12/2024, with information obtained through 12/09/2024, Surveyor conducted a complaint investigation at VitaCare Living Mount Horeb. Complaint was substantiated. Two deficiencies were identified:<br>N0353 83.32(3)(i) Rights of Residents: Adequate Treatment<br>N0454 83.42(1) Resident Record Maintained<br><br>On 12/08/2025 at 10:00 AM, Surveyor interviewed Regional Director O. Surveyor discussed ongoing concerns with the provider. Regional Director O stated s/he was aware there were concerns and that appropriate actions were being taken to ensure future compliance. | N 196 | | |

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| {N 352} | Continued From page 4 | {N 352} | | |
| {N 352} | 83.32(3)(h) Rights of Residents: Receive medication<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not administer medications in the intervals prescribed by a practitioner for 1 of 1 resident.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) VTVD11, dated 07/16/2025.<br><br>Resident 9's 'as-needed (PRN)' Hydromorphone (narcotic pain medication) was not available for administration and was not administered as prescribed.<br>Resident 9's Lantus Solostar and Insulin Lispro were not available for administration.<br><br>Findings Include:<br><br>On 10/28/2025, the department received a concern alleging medication administration was not properly completed.<br><br>On 12/04/2025, Surveyor reviewed Resident 9's record.<br><br>Resident 9 moved into the facility 08/01/2025 with diagnosis including severe low back pain and diabetes. | {N 352} | | |

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| {N 352} | Continued From page 5 | {N 352} | | |

Resident 9's Medication Administration Record, dated 10/01/2025 to 10/31/2025, documented: "Lantus Solostar 100 Unit/ML (milliliter) - Inject 6 units subcutaneously once daily for diabetes. Scheduled at 8:00 AM."
The MAR documented "None" on 10/04 and 10/05.
"Insulin Lispro 100 U/ML (units/milliliter) Kwikpen - Inject 0-5 Units subcutaneously 3 times daily after meals per sliding scale: 70-139: 0 Units; 140-189: 1 Unit; 190-239: 2 Units; 240-289: 3 Units; 290-339: 4 Units; 340-389: 5 Units. Scheduled at 8:00 AM, 12:00 PM and 5:00 PM."
The MAR documented "None" 10/04 and 10/05 at 8:00 AM and no record for 10/04 and 10/05 at Noon.

Resident 9's progress notes documented: 11/10/2025 9:30 PM - Resident been wanting a pain pill, but pharmacy hasn't come yet. S/he's out of his/her PRN pain pills.

Resident 9's Medication Administration Record, dated 11/03/2025 to 11/25/2025, documented: Hydromorphone tablet 4 MG (milligram) - take ½ tablet (2 MG) by mouth twice daily as needed for pain.
The MAR documented on 11/22/2025 the Hydromorphone had been administered at 4:04 AM, 11:49 AM, and 7:20 PM. The order stated twice daily, not thrice.
The MAR documented that Resident 9 received a dose of Hydromorphone on 11/10/2025 at 7:18 AM and did not receive another dose until 11/11/2025 at 9:23 PM and 10:27 PM.
The MAR documented that Resident 9 on average took his/her PRN twice a day.

On 12/05/2025 at 6:27 AM, Surveyor emailed Executive Director A and requested Resident 9's

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| {N 352} | Continued From page 6<br>pharmacy delivery report for his/her Hydromorphone.<br><br>On 12/05/2025 at 12:54 PM, Regional Director O emailed Surveyor and stated Executive Director A was no longer with the provider and they were working on getting all the information that had been requested.<br><br>As of 6:00 PM on 12/05/2025, Surveyor received various requested documentation but did not receive Resident 9's pharmacy delivery report for his/her Hydromorphone.<br><br>On 12/08/2025 at 10:00 AM, Surveyor interviewed Regional Director O. Surveyor asked for clarification on how the provider ensured resident medications were available for administration. Regional Director O stated that staff are to notify management at least 5 to 7 days prior to medications running out. Then a fax is sent to the pharmacy and if a new script is required, the pharmacy or the provider will work with the prescribing physician. If there is a delay due to communication with the prescribing physician, staff should document that in the resident's chart. Surveyor explained during further review of Resident 9's MARs, it was determined there were concerns about the availability of his/her insulin. Surveyor reviewed the MARs with Regional Director O. Regional Director O stated Resident 9's hydromorphone and insulin should have always been available. | {N 352} | | |
| N 357 | 83.32(3)(m) Rights of Residents: Recording and filming<br><br>In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: | N 357 | | |

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| N 357 | Continued From page 7<br>Recording, filming, photographing. Not be recorded, filmed or photographed without informed, written consent by the resident or resident ' s legal representative. The CBRF may take a photograph for identification purposes. The department may photograph, record or film a resident pursuant to an inspection or investigation under s. 50.03(2), Stats., without his or her written informed consent.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure residents had the right not to be recorded and filmed without consent.<br><br>Findings include:<br><br>The facility was licensed as a Class CNA (non-ambulatory) assisted living facility on 04/15/2024 and the licensee can provide care and services to 23 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, and physically disabled.<br><br>On 10/28/2025, the department received a concern alleging that residents were being recorded without their consent.<br><br>On 11/25/2025, at approximately 11:15 AM, Surveyor observed a camera in the kitchen, in the med room and the downstairs stairwell which were accessible to residents. Surveyor noted the scale for weighing residents and the med cart where residents could receive their medication were in line with the camera. Surveyor noted the kitchen was an open concept and residents could easily ambulate in and out of the kitchen. The kitchen camera was angled to view the | N 357 | | |

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| N 357 | Continued From page 8 | N 357 | | |

refrigerator and the door that lead to the downstairs stairwell. Surveyor observed resident rooms on the lower level of the facility which can be accessed by walking down the stairwell where the camera was posted. When residents who resided on the lower level utilized the stairwell, they would be on camera while they ascended the stairs and would be on camera when they utilized the door at the top of the stairwell to enter the first level, which led into the kitchen.

On 11/25/2025, at approximately 11:45 AM, Surveyor interviewed Resident Care Specialist M. Surveyor asked for clarification on why there were cameras in the kitchen. Resident Care Specialist M stated, "I think it is to ensure staff aren't stealing the food."

On 11/25/2025, at approximately 1:00 PM, Surveyor interviewed Executive Director (ED) A, Assistant Executive Director (AED) B and Licensed Practical Nurse (LPN) L. LPN L stated s/he thought cameras were okay if they weren't directly recording residents. LPN L stated residents were not allowed in the kitchen, so they would not be recorded. Surveyor asked for clarification as to why residents were not allowed into their kitchen. ED A, AED B, LPN L and Surveyor discussed what constituted resident communal areas and resident rights. LPN L stated the corporate office would be contacted to discuss the removal of the cameras.

On 12/08/2025 at 10:00 AM, Surveyor interviewed Regional Director O. Regional Director O stated s/he would discuss the concern with the corporate office.

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| N 381 | Continued From page 9 | N 381 | | |
| N 381 | 83.35(1)(a) Pre-admission and ongoing assessments.<br><br>Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure an assessment of 1 of 1 resident's physical and mental condition was completed when Resident 3 utilized bedrails.<br><br>Findings include:<br><br>The facility was licensed as a Class CNA (non-ambulatory) assisted living facility on 04/15/2024 and the licensee can provide care and services to 23 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, and physically disabled.<br><br>On 12/04/2025, Surveyor reviewed Resident 3's record.<br><br>Resident 3 moved into the facility 10/12/2019.<br><br>Resident 3's progress notes documented:<br>10/19/2025 - Resident had an unwitnessed fall. | N 381 | | |

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| N 381 | Continued From page 10<br>Staff went to get resident up and dressed for the day at 6 AM and when s/he entered resident's room observed the resident on the floor wrapped up in his/her bedding and his/her upper body under table that is next to the bed.<br>11/03/2025 - Writer received a call reporting resident was found on the floor in his/her room. Was on the floor between his/her bed and wall holding onto the cords that were on the floor.<br>11/05/2025 - Email received from case manager asking bed to be placed against the wall to prevent him/her from rolling out and getting stuck between the bed and the wall<br><br>Resident "Assessment," dated 10/16/2025, documented:<br>Bed Safety - Bed rail in use. Order received from hospice that resident may use side rails for positioning.<br>Mobility - Bed - Staff will assist resident with getting in and out of bed.<br>Mobility - Ambulation - Unable to ambulate<br>Fall Risk Summary - 24 hour supervision with 24 hour awake staff.<br>General Safety - Unable to activate the call pendant appropriately<br><br>On 12/08/2025 at 10:00 AM, Surveyor interviewed Regional Director O. Surveyor asked if Resident 3 had been reassessed for him/her to safely utilize bedrails. Regional Director O stated that hospice often orders bedrails for residents but we still require our own bedrail assessments to ensure their safety. Regional Director O stated Resident 3 should have been reassessed for bedrails after his/her 10/19/2025 fall to ensure the provider agreed with hospice on the safety use of bedrails. | N 381 | | |

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| N 385 | Continued From page 11 | N 385 | | |
| N 385 | 83.35(2) Temporary Service Plan.<br><br>Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not prepare and implement a temporary service plan for 3 of 3 resident's (Resident 8, Resident 9 and Resident 10) upon admittance.<br><br>Findings include:<br><br>The facility was licensed as a Class CNA (non-ambulatory) assisted living facility on 04/15/2024 and the licensee can provide care and services to 23 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, and physically disabled.<br><br>On 10/28/2025, the department received a concern alleging residents did not receive adequate cares.<br><br>On 11/25/2025, Surveyor reviewed Resident 8's, Resident 9's and Resident 10's records.<br><br>Example 1: Resident 8<br><br>Resident 8 moved into the facility, 08/19/2025, with a diagnosis including multiple sclerosis. Surveyor was unable to locate a temporary individual service plan available to staff when Resident 8 moved into the facility. | N 385 | | |

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| VITACARE LIVING MOUNT HOREB | 104 LINCOLN CT MOUNT HOREB, WI 53572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| N 385 | Continued From page 12<br><br>Surveyor was not provided Resident 8's file prior to leaving the facility at approximately 4:30 PM. Surveyor informed Executive Director A and Assistant Executive Director B to forward all requested documentation by the end of business on 11/26/2025.<br><br>On 11/26/2025 at 9:20 AM, Surveyor emailed Executive Director A and requested Resident 8's individual service plans.<br><br>On 12/02/2025 at 8:40 AM, Surveyor emailed Surveyor emailed Executive Director A and requested Resident 8's individual service plans.<br><br>On 12/02/2025 at 8:42 AM, Executive Director A emailed Surveyor and stated s/he had just returned to the office from vacation and would forward requested documentation.<br><br>Executive Director A proceeded to forward documentation, but the documentation did not include Resident 8's individual service plans.<br><br>On 12/05/2025 at 12:54 PM, Regional Director O emailed Surveyor and stated Executive Director A was no longer with the provider and they were working on getting all the information that had been requested.<br><br>As of 6:00 PM on 12/05/2025, Surveyor received various requested documentation but did not receive Resident 8's individual service plans.<br><br>On 12/08/2025 at 10:00 AM, Surveyor interviewed Regional Director O. Surveyor asked for clarification on when the temporary assessments/individual service plans should be made available to staff. Regional Director O stated that when a resident moves into the facility, | N 385 | | |

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| N 385 | Continued From page 13 | N 385 | | |

staff should already be aware of what cares that resident will require; Resident 8's record should have contained a temporary service plan.

Example 2: Resident 9

Resident 9 moved into the facility 08/01/2025 with diagnoses including, but not limited to, diabetes, incontinence, generalized anxiety disorder with panic attacks, generalized weakness, hyperkalemia (higher than normal level of potassium in the bloodstream) and spinal osteomyelitis (infection of the vertebrae).

Resident 9's "Admission Assessment," was dated 08/15/2025, which is fifteen days after admittance.

On 11/25/2025, at approximately 2:30 PM, Surveyor asked for clarification if the assessments were considered resident individual service plans. Executive Director A stated the software utilized by the provider labeled them as assessments, as the 08/15/2025 document is all that is on file for Resident 9.

On 12/08/2025 at 10:00 AM, Surveyor interviewed Regional Director O. Surveyor asked for clarification on when the temporary assessments/individual service plans should be made available to staff. Regional Director O stated that when a resident moves into the facility, staff should already be aware of what cares that resident will require.

Example 3: Resident 10

On 10/28/2025, the department received a concern that resident families were not updated timely upon their passing.

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| N 385 | Continued From page 14<br><br>On 11/25/2025, at approximately 11:00 AM, Surveyor asked Assistant Executive Director B if the provider had any residents who had passed away after a short stay in the last 6 months. Assistant Executive Director B stated Resident 10. Assistant Executive Director B stated Resident 10 had been admitted on hospice and staff was 'shocked' that s/he passed within days. Surveyor requested Resident 10's record.<br><br>Resident 10 moved into the facility, 08/18/2025, with diagnosis including non-small cell lung cancer (NSCLC).<br><br>On 11/25/2025, Surveyor was provided Resident 10's progress notes and incident report regarding his/her death.<br><br>On 11/26/2025, at approximately 8:45 AM, Surveyor interviewed Resident Care Specialist P. Surveyor asked how s/he knew what cares to provide Resident 10. Resident Care Specialist P stated s/he was not given any guidelines regarding Resident 10, "I never felt like we were properly trained. I wasn't told that [Resident 10] came to the facility to die. We weren't told that [Resident 10] should be on checks throughout the evening. When I started my shift on 08/19/2025, I always do a walk about to check on the residents. I saw [Resident 10] sitting in [his/her] chair which I thought was unusual, but [s/he] stated [s/he] was fine. When I was doing my final rounds around 6:00 AM, so I could report to first shift, I checked on [Resident 10] who was still in [his/her] chair, but [s/he] was deceased. I can't say when [s/he] officially passed away. I called management."<br><br>On 11/26/2025 at 9:20 AM, Surveyor emailed | N 385 | | |

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| N 385 | Continued From page 15 | N 385 | | |

Executive Director A and requested Resident 10's individual service plans.

On 12/02/2025 at 8:40 AM, Surveyor emailed Surveyor emailed Executive Director A and requested Resident 10's individual service plans.

On 12/02/2025 at 8:42 AM, Executive Director A emailed Surveyor and stated s/he had just returned to the office from vacation and would forward requested documentation.

Executive Director A proceeded to forward documentation, but the documentation did not include Resident 10's individual service plans.

On 12/05/2025 at 12:54 PM, Regional Director O emailed Surveyor and stated Executive Director A was no longer with the provider and they were working on getting all the information that had been requested.

As of 6:00 PM on 12/05/2025, Surveyor received various requested documentation but did not receive Resident 10's individual service plans.

On 12/08/2025 at 10:00 AM, Surveyor interviewed Regional Director O. Surveyor asked for clarification on when the temporary assessments/individual service plans should be made available to staff. Regional Director O stated that when a resident moves into the facility, staff should already be aware of what cares that resident will require. Regional Director O stated that when a resident first moved into a facility that resident should always be on two-hour checks until we have established their baseline.

On 12/08/2025, Surveyor reviewed Resident 10's managed care organization documentation

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| N 385 | Continued From page 16<br>provided by his/her MCO provider which documented:<br>08/20/2025 - Team was notified by [hospice] of members death. Member was found deceased in his/her chair in his/her room this morning at 7:51 AM. | N 385 | | |
| N 388 | 83.35(3)(c) Implement, follow the individual service plan<br><br>Implementation. The CBRF shall implement and follow the individual service plan as written.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review, and interview, the provider did not follow 1 of 1 resident's Individual Service Plan (ISP) as written.<br><br>Resident 9's ISP documented that s/he required dietary assistance by having his/her food cut up. Resident 9 was observed trying to eat his/her fish patty with his/her fingers due to it not being cut up.<br>Resident 9's ISP documented that s/he required standby assist with showering which was not provided.<br><br>Findings include:<br><br>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.<br><br>On 10/28/2025, the department received a concern that the provider did not offer nutritious meals. | N 388 | | |

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| N 388 | Continued From page 17<br><br>On 11/25/2025, at approximately 12:00 PM, Surveyor observed the residents eating lunch. The lunch consisted of a breaded fish patty and was served to resident's whole, not cut into bite size pieces. Surveyor observed Resident 9 pick his/her fish patty up with his/her hands and try to bite off it. Surveyor commented to Licensed Practical Nurse L that it appeared residents were struggling to cut the fish patty. Licensed Practical Nurse L then went and started to assist residents.<br><br>On 12/01/2025, Surveyor reviewed Resident 9's record.<br><br>Resident 9 moved into the facility 08/01/2025.<br><br>Resident 9's "Clinical Update Assessment (ISP)," dated 09/22/2025, documented:<br>"Eating Needs - Feeding: Needs assistance with meal set up. Staff set up for all meals; cut foods, pour liquids."<br>"Bathing Needs: Standby assist of 1 staff for safety. Resident uses shower chair and grab bars. Resident is able to wash independently. Staff to assist with bathing and nailcare as needed. Staff to report any skin concerns to AED (assistant executive director) / ED (executive director)."<br><br>Resident 9's progress notes documented:<br>09/27/2025 - Resident is independent with showers<br>11/07/2025 - Resident is independent with showers<br>Staff documented that Resident 9 was independent with showers and his/her ISP documented that s/he was a standby assist.<br><br>On 12/08/2025, Surveyor reviewed Resident 9's | N 388 | | |

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| N 388 | Continued From page 18<br>member centered organization (MCO) record provided by his/her MCO provider which documented:<br>08/22/2025: Bathing: Due to physical impairments, member requires assistance with bathing. S/he needs assistance to safely transfer in/out of the shower due to pain/weakness in legs. Members sit on shower chair and uses grab bar while showering. Member is able to wash his/her upper body but experiences debilitating pain/weakness when bending to wash lower body and needs assistance.<br><br>On 12/08/2025 at 10:00 AM, Surveyor interviewed Regional Director O. Surveyor discussed his/her observations of Resident 9 and compared that to what his/her individual service plan documented. Regional Director O stated staff would be redirected on how to ensure proper dietary requirements were met for each resident. Surveyor asked for clarification on whether Resident 9 required standby assist when showering and how staff monitored his/her skin. Regional Director O stated that Resident 9 should be provided standby assist when showering. If staff do not provide this, then they cannot adequately monitor his/her skin.<br><br>Cross Reference: N0425 DHS 83.38(1)(a) Personal Cares | N 388 | | |
| {N 389} | 83.35(3)(d) Service plans updated annually or on changes<br><br>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 | {N 389} | | |

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| {N 389} | Continued From page 19<br>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.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview, the provider did not ensure 2 of 2 Individual Service Plans (ISP) were reviewed when the resident experienced a change of condition.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) VTVD11, dated 07/16/2025.<br><br>Resident 9's ISP did not provide guidelines for staff on how to redirect Resident 9 would refuse his/her showers.<br>Resident 13's ISP did not document s/he utilized a urinal.<br><br>Findings include:<br><br>On 10/28/2025, the department received a concern that alleged residents did not receive adequate cares.<br><br>Example 1: Resident 9<br><br>On 11/25/2025, Surveyor reviewed Resident 9's record.<br><br>Resident 9 moved into the facility 08/01/2025. | {N 389} | | |

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| {N 389} | Continued From page 20<br><br>Resident 9's "Clinical Update Assessment (ISP)," dated 09/22/2025, documented:<br>Bathing Needs: Standby assist of 1 staff for safety. Resident uses shower chair and grab bars. Resident is able to wash independently. Staff to assist with bathing and nailcare as needed. Staff to report any skin concerns to AED (assistant executive director) / ED (executive director).<br><br>Resident 9's progress notes documented:<br>09/08/2025 - Resident declined shower today due to not feeling too good physically today.<br>09/27/2025 - Resident did not shower today, s/he is independent. (Nineteen days since last documented shower).<br>10/11/2025 - Bathing Assistance - Shower - Not feeling well.<br>10/15/2025 - Resident called me into his/her room around 11 AM to inform me s/he was going to be taking a shower and to save his/her lunch. I asked resident if s/he needed any assistance, and s/he told me no.<br>11/04/2025 - Bathing Assistance - Shower - No shower. Resident not feeling well today.<br>11/14/2025 - No shower today.<br>11/18/2025 - Resident did not shower today.<br>11/22/2025 - No shower, resident is in pain.<br>11/24/2025 - No shower today.<br><br>Resident 9's ISP did not identify that s/he refused his/her showers and did not provide guidelines for staff on how to possibly redirect Resident 9.<br><br>On 12/08/2025 at 10:00 AM, Surveyor interviewed Regional Director O. Surveyor reviewed Resident 9's documentation with Regional Director O who stated based on the documentation, one would not be able to determine if Resident 9 was receiving his/her | {N 389} | | |

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| {N 389} | Continued From page 21 | {N 389} | | |

scheduled showers or if staff were able to redirect Resident 9 when s/he refused his/her scheduled shower. Regional Director O stated Resident 9 was scheduled for one shower a week, unless s/he requested additional showers, which would be honored. Regional Director O stated s/he would be reviewing the concern with staff to ensure residents are receiving proper cares and to determine if Resident 9 preferred his/her showers during a specific time of day or other suggestions Resident 9 would have. Regional Director O stated that staff needed to communicate with each other to ensure resident cares were not overlooked. Regional Director O stated s/he would review all resident ISPs to ensure they were individualized.

Example 2: Resident 13

On 11/25/2025, at approximately 11:00 AM, Surveyor observed a urinal sitting on the bathroom vanity in Resident 13's room.

On 11/25/2025, at approximately 12:15 PM, Surveyor observed Resident 13 agitated at the dining room table. Assistant Executive Director B walked over to assist him/her. Resident 13 wanted Assistant Executive Director B to retrieve his/her urinal so s/he could use it. Assistant Executive Director B tried to redirect him/her stating s/he would assist him/her with his/her urinal in his/her bedroom. Resident 13 did not want to return to his/her bedroom.

On 11/25/2025, Surveyor reviewed Resident 13's record.

Resident 13 moved into the facility 07/08/2020.

Resident 13's "Master Care Plan," dated

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| {N 389} | Continued From page 22<br><br>11/13/2025, documented:<br>"Toileting Needs: Independent. No assistance needed with toileting. Wears depends. [S/he] will page for staff assistance if [s/he] has a bowel movement as [s/he] will need assistance from the staff."<br><br>On 12/08/2025 at 10:00 AM, Surveyor interviewed Regional Director O. Surveyor discussed his/her observations of Resident 13. Regional Director O stated Resident 13's individual service plan should have been updated to identify that s/he utilized a urinal and could display behaviors about where s/he could utilize a urinal.<br><br>Cross Reference: N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan | {N 389} | | |
| N 400 | 83.37(1)(a) Written order for medications, supplements.<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview, the provider did not obtain a written practitioner's order for 1 of 1 resident (Resident 8) for his/her over-the-counter (OTC) medication acetaminophen and niacin (vitamin B3). | N 400 | | |

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| N 400 | Continued From page 23<br>Findings include:<br><br>On 11/25/2025, at approximately 1:40 PM, Surveyor interviewed Resident 8 in his/her bedroom. Surveyor observed opened bottles of Niacin 500 MG (milligram) and an opened bottle of Acetaminophen 500 MG sitting on his/her dresser. Surveyor asked Resident 8 if s/he self-administered his/her medications. Resident 8 stated s/he did but was not taking some of the medications.<br><br>On 12/01/2025, Surveyor reviewed Resident 8's record.<br><br>Resident 8 moved into the facility 08/19/2025.<br><br>Resident 8's Medication Administration Records (MARs), dated 10/01/2025 to 11/29/2025, did not document that s/he was prescribed Niacin and Acetaminophen.<br><br>On 12/08/2025 at 10:00 AM, Surveyor interviewed Regional Director O. Surveyor discussed his/her observation of Resident 8's medications and Resident 8's MARs. Regional Director O stated that Resident 8 was not self-administering medications and all medications, including OTC medications, require a physician order.<br><br>Cross Reference: N0412 DHS 83.37(2)(a) Self-Administered by Resident<br>Cross Reference: N0385 83.35(2) Temporary Service Plan | N 400 | | |
| N 412 | 83.37(2)(a) Self-administered by resident.<br><br>Self-administered by resident. 1. The resident | N 412 | | |

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| N 412 | Continued From page 24<br>shall self-administer prescribed and over-the-counter medications and dietary supplements, unless the resident has been found incompetent under ch. 54, Stats., or does not have the physical or mental capacity to self-administer as determined by the resident ' s physician, or the resident requests in writing that CBRF employees manage and administer medication. 2. Except as specified under sub. (4), when a resident self-administers medications, prescribed and over-the-counter medications and dietary supplements shall remain under the control of the resident. The CBRF shall provide a secure place for the storage of medications in the resident ' s room. 3. A resident with the mental and physical capacity to develop increased independence in medication administration shall receive self-administration instruction.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview, the provider did not ensure 1 of 1 resident (Resident 8) reviewed had physician orders that identified their physical or mental capacity to self-administer their medications and did not provide a secure place for the storage of medications in resident's room.<br><br>Findings include:<br><br>On 11/25/2025, at approximately 1:40 PM, Surveyor interviewed Resident 8 in his/her bedroom. Surveyor observed the following medications sitting on his/her dresser: two bottles of Niacin 500 MG (milligram), a bottle of Acetaminophen 500 MG, a bottle of Active B Complex, a bottle of Vitamin D3 125 MCG (microgram), two bottles of Lion's Mane (dietary supplement made with mushrooms), and a bottle | N 412 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| VITACARE LIVING MOUNT HOREB | 104 LINCOLN CT MOUNT HOREB, WI 53572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| N 412 | Continued From page 25<br>of Tamsulosin 0.4 MG. Surveyor asked Resident 8 if s/he self-administered his/her medications which s/he stated s/he did. Surveyor asked if Resident 8 locked his/her room when s/he was not in it, which s/he answered s/he did not. Surveyor observed a pill cup next to his/her bottles of medications that contained two white tablets. Resident 8 stated those were supplements s/he had not taken yet.<br><br>On 12/01/2025, Surveyor reviewed Resident 8's record.<br><br>Resident 8 moved into the facility 08/19/2025.<br><br>Resident 8's Medication Administration Record (MAR), dated 11/01/2025 to 11/29/2025, documented:<br>-Lions Mane Mushroom Gummies - Swallow 1 gummie once daily. Ends 11/18/2025. Reason for Hold: Resident does not want tot take these. Waiting for a d/c (discontinue) order.<br>-Vitamin B-12 1000 MCG Tablet - Take 1 tablet by mouth once daily. (The bottle in Resident 8's room did not identify how many MCGs each capsule was.)<br>-Vitamin D3-400 iu (international unit) 10 MCG Tablet - Take 1 tablet by mouth once daily. (The bottle in Resident 8's room was 125 MG (5000 IU) per softgel.)<br>-Tamsulosin 0.4 MG Capsule - Take 1 capsule by mouth once daily after a meal.<br>-Gabapentin Capsule 300 MG - Take 1 capsule by mouth at bedtime.<br>The MAR did not document Acetaminophen nor the Niacin.<br>The MAR documented staff had administered the medications and stated Resident 8 had self-administered his/her Lions Mane on 11/03, 11/12 and 11/13. | N 412 | | |

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| N 412 | Continued From page 26<br><br>On 11/25/2025, at approximately 2:30 PM, Surveyor observed Resident 8 exit his/her room and walk across the common area to access the patio area. Surveyor walked to Resident 8's room and determined his/her room was not locked and his/her medications were still sitting on top of his/her dresser.<br><br>On 12/08/2025 at 10:00 AM, Surveyor interviewed Regional Director O. Surveyor asked for clarification if Resident 8 self-administered his/her medication. Regional Director O stated that the MAR would document if a resident self-administered a medication and Resident 8's did not. Regional Director O stated staff would be re-educated on how to properly document medication administration.<br><br>Cross Reference: N0415 DHS 83.37(2)(d) Documentation of Medication Administration<br>Cross Reference: N0400 DHS 83.37(1)(a) Written Order for Medications, Supplements | N 412 | | |
| {N 415} | 83.37(2)(d) Documentation of medication administration.<br><br>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 27 | {N 415} | | |

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not ensure proper documentation on the Medication Administration Record (MAR) for 2 of 4 residents reviewed.

This is a repeat deficiency. See Statement of Deficiency (SOD) VTVD11, dated 07/16/2025.

Resident 8's MAR documented medication was not available when s/he stored medication in his/her room.
Resident 9's MAR did not document his/her pain levels when administered 'as-needed' (PRN) Hydromorphone (narcotic pain medication).
Resident 9's MAR did not document blood sugar (BS) levels to correspond with amount of sliding scale insulin administered.

Findings include:

On 10/28/2025, the department received a concern alleging residents did not receive correct medication administration.

Example 1: Resident 8

On 11/25/2025, at approximately 1:40 PM, Surveyor interviewed Resident 8 in his/her bedroom. Surveyor observed two bottles of Lion's Mane (dietary supplement made with mushrooms) sitting on his/her dresser. Surveyor asked Resident 8 if s/he self-administered his/her medications which s/he stated s/he did.

On 12/01/2025, Surveyor reviewed Resident 8's record.

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| {N 415} | Continued From page 28<br><br>Resident 8 moved into the facility 08/19/2025.<br><br>Resident 8's Medication Administration Record (MAR), dated 11/01/2025 to 11/29/2025, documented:<br>-Lions Mane Mushroom Gummies - Swallow 1 gummie once daily. Ends 11/18/2025. Reason for Hold: Resident does not want to take these. Waiting for a d/c (discontinue) order.<br>The MAR documented medication had been administered except on:<br>11/01/2025 8:00 AM - Not available<br>11/03/2025 8:00 AM - Resident self-administers<br>11/06/2025 8:00 AM - Medication unavailable<br>11/07/2025 8:00 AM - Medication unavailable<br>11/10/2025 8:00 AM - Medication unavailable<br>11/12/2025 8:00 AM - Resident self-administers<br>11/13/2025 8:00 AM - Resident self-administers<br><br>On 12/08/2025 at 10:00 AM, Surveyor interviewed Regional Director O. Surveyor asked for clarification on the status of Resident 8's Lions Mane medication due to observation of the medication in his/her room. Surveyor and Regional Director O reviewed Resident 8's MARs and determined that some staff documented that the medication was administered by staff, some documented that Resident 8 self-administered the medication and some documented that the medication was not available. Regional Director O stated staff would be re-educated on how to properly document medication administration.<br><br>Example 2: Resident 9<br><br>On 11/25/2025, Surveyor reviewed Resident 9's record.<br><br>Resident 9 moved into the facility 08/01/2025. | {N 415} | | |

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| {N 415} | Continued From page 29<br><br>Resident 9's MARs, dated 10/01/2025 to 11/25/2025, documented:<br>"Insulin Lispro 100 U/ML (units/milliliter) Kwikpen - Inject 0-5 Units subcutaneously 3 times daily after meals per sliding scale: 70-139: 0 Units; 140-189: 1 Unit; 190-239: 2 Units; 240-289: 3 Units; 290-339: 4 Units; 340-389: 5 Units. Scheduled at 8:00 AM, 12:00 PM and 5:00 PM."<br>The MARs documented administration as:<br>10/01/2025 8:00 AM - No documentation regarding BS levels or Units given<br>10/01/2025 12:00 PM - Administered<br>10/01/2025 5:00 PM - BP [sic: BS] 143 - one unit given<br>10/02/2025 8:00 AM - Not administered per instructions (No BS level listed)<br>10/02/2025 12:00 PM - 1 Unit administered (No BS level listed)<br>10/06/2025 8:00 AM - 1 Unit administered (No BS level listed)<br>10/06/2025 12:00 PM - No documentation regarding BS levels or Units given<br>10/07/2025 8:00 AM - Administered (No BS level or Units given)<br>10/07/2025 12:00 PM - 1 Unit (No BS Level)<br>10/08/2025 8:00 AM - Administered (No BS level or Units given)<br>10/08/2025 12:00 PM - No documentation regarding BS levels or Units given<br>10/08/2025 5:00 PM - No documentation regarding BS levels or Units given<br>The MARs documentation continued in the same manner.<br>"Hydromorphone Tablet 4 MG (milligram) - Take ½ tablet (2 MG) by mouth every 4 hours as needed for pain. Discontinued date 11/02/2025)."<br>"Hydromorphone Tablet 4 MG - Take ½ tablet by mouth twice daily as needed for pain."<br>The MARs documented administration on | {N 415} | | |

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| {N 415} | Continued From page 30<br>average twice a day and the MAR did not document pain levels.<br>The MAR documented effectiveness of the Hydromorphone 85 out of 100 opportunities.<br><br>Surveyor noted that Resident 9's MARs did not document that his/her 8:00 AM medications had been administered on 11/25/2025 when Surveyor had requested the MAR at approximately 11:00 AM. Surveyor had observed Resident 9's medications in the med cart at approximately 10:50 AM and the blister cards showed that the 11/25/2025 dose had been dispensed.<br><br>On 12/08/2025 at 10:00 AM, Surveyor interviewed Regional Director O. Surveyor reviewed the MAR documentation with Regional Director O. Regional Director O stated staff are trained to always document the blood sugar levels that correspond with the sliding scale insulin. Regional Director O stated staff are responsible to document pain levels when administering PRN pain narcotics. Regional Director O stated staff would be re-educated on the proper way to document medication administration. | {N 415} | | |
| N 427 | 83.38(1)(c) Leisure time activities.<br><br>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: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall | N 427 | | |

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| N 427 | Continued From page 31 | N 427 | | |

encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not arrange for services adequate to meet the needs of the residents in leisure time activities.

Findings include:

The facility was licensed as a Class CNA (non-ambulatory) assisted living facility on 04/15/2024 and the licensee can provide care and services to 23 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, and physically disabled.

On 10/28/2025, the Department received a concern alleging provider does not provide activities to the residents.

On 11/25/2025, from approximately 10:15 AM to 4:30 PM, Surveyor was onsite. During this timeframe, activities were not conducted with the residents. Several residents sat in the dining room, but staff did not conduct an activity.

On 11/25/2025, at approximately 1:20 PM, Surveyor interviewed Resident 12. Surveyor asked if s/he participated in any of the activities scheduled by the provider. Resident 12 stated, "Activities would be nice. I am just watching my tv."

On 11/25/2025, at approximately 1:40 PM, Surveyor interviewed Resident 8. Surveyor

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| N 427 | Continued From page 32<br>asked if s/he participated in any of the activities scheduled by the provider. Resident 8 explained that activities did not occur very often and when they did, it would be like coloring a picture.<br><br>On 11/25/2025, at approximately 2:00 PM, Surveyor interviewed Resident Care Specialist N. Surveyor asked for clarification on how activities were planned for the residents. Resident Care Specialist N stated when staff have time, residents will be asked what they want to do.<br><br>On 11/25/2025, at approximately 3:00 PM, Surveyor interviewed Executive Director A. Surveyor asked for clarification on how activities were planned for the residents. Executive Director A stated, "In all honesty, activities occur when certain staff members are working, you can just see that they enjoy it and are able to manage their time to ensure resident's received some kind of activity." Executive Director A stated s/he could not confirm if the activity calendar that was posted was followed.<br><br>On 12/08/2025 at 10:00 AM, Surveyor interviewed Regional Director O. Surveyor discussed that this concern had also been discussed during the last survey on 07/16/2025 as complaints kept getting called in regarding it. The activity calendar that had been hung up referenced Daily Chronicles (Linked Senior) and staff did not know what that was. Regional Director O stated that activities was an area that could be improved on and would be discussed with staff. | N 427 | | |
| N 431 | 83.38(1)(g) Health monitoring.<br><br>As appropriate, the CBRF shall teach residents | N 431 | | |

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| N 431 | Continued From page 33<br>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 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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 2 of 2 residents received appropriate health monitoring to meet his/her needs.<br><br>Staff were unable to provide Resident 3's vitals to hospice when s/he experienced a change of condition due to equipment not working. Resident 9, who had a diagnosis of Type 2 diabetes, was not monitored for his/her high blood glucose levels. | N 431 | | |

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| N 431 | Continued From page 34<br><br>Findings include:<br><br>The facility was licensed as a Class CNA (non-ambulatory) assisted living facility on 04/15/2024 and the licensee can provide care and services to 23 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, and physically disabled.<br><br>Example 1: Resident 3<br><br>On 12/04/2025, Surveyor reviewed Resident 3's record.<br><br>Resident 3 moved into the facility 10/12/2019.<br><br>Resident 3's hospice documentation provided by his/her attending hospice organization reported: "11/09/2025 11:50 AM - Facility reporting [s/he] 'isn't right' requesting a visit to make sure [his/her] 'vitals didn't go down.' Facility unable to elaborate on patient's condition. Facility unable to obtain vitals, their machine is not working. [Hospice] nurse will see patient to ensure safety this date d/t (due to) lack of information provided by facility staff."<br>"11/09/2025 1:30 PM - PRN (as needed) visit temp 97.5, Pulse 62, B/P (blood pressure) 118/50, Resp (respiratory) 16. Patient resting comfortably upon arrival, stated "I don't know why you're here, I'm fine. Lungs CTA bilaterally (CT [computed tomography] angiography of both lungs), patient denied pain."<br><br>On 12/08/2025 at 10:00 AM, Surveyor interviewed Regional Director O. Surveyor reviewed the hospice documentation with Regional Director O and asked for clarification on the requirement for staff to perform vitals. | N 431 | | |

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| N 431 | Continued From page 35 | N 431 | | |

Regional Director O stated that all staff were required to complete vitals at least monthly and 'as-needed,' and if there was faulty equipment, management should have been informed immediately, but this was the first s/he had heard of the concern. Regional Director O stated staff should have also known Resident 3's baseline and been able to give a more concise description of their concern. Regional Director O stated this concern would be discussed with management and staff.

Example 2: Resident 9

On 11/25/2025, Surveyor reviewed Resident 9's record.

Resident 9 moved into the facility, 08/01/2025, with diagnosis including diabetes.

Resident 9's progress notes documented: "08/30/2025 (Saturday) 3:14 AM, updated 09/03/2025, written by Assistant Executive Director B - [Assistant Executive Director B] received call from staff that [Resident 9's] blood sugar being at 32. Staff said upon going in residence [sic: resident's] room [s/he] seem sweaty and that's when [s/he] checked [his/her] sugar and it was 32. [S/he] gave [him/her] snacks to eat peanut butter and jelly sandwiches, fruit & water and staff insured resident. [S/he] will be back in 15 minutes to check [his/her] blood sugar in 15 minutes went past [s/he] went to check it again. It went up to 67. Asked [him/her] if [s/he] want to go out to the ER (emergency room). [Resident 9] stated no around 3 or 4 am that morning I received another call with another blood sugar at 236. I told staff I would consult his/her doctor on the next business day." "08/30/2025 7:19 AM written by Resident Care

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Specialist C - At 5 AM [Resident 9] called stating [s/he] thinks [his/her] sugar was dropping once it was taken it read 53. [S/he] was given two root beer floats a twinkie and two half's of peanut butter on bread it went up to 93 after rechecking it 40 minutes later."
08/30/2025 2:56 PM - Resident wasn't feeling too good this morning and declined breakfast.
08/30/2025 11:16 PM written by Resident Care Specialist Q- Blood Pressure [sic: blood sugar] 32 - 32. Pt (patient) stated that [s/he] wanted [his/her] sugar checked and that [s/he] felt sweaty. Staff checked pts sugar, and it was 32. Pt was given fruit, water and a peanut butter and jelly sandwich. Management was notified. Staff will go back in 15 minutes to check [his/her] sugar again.
08/30/2025 11:19 PM written by Resident Care Specialist Q - Blood Glucose 67 - Staff checked pts sugar again and it was 67. Pt was asked if [s/he] wanted to go to the hospital and [s/he] said no. Pt was given ice cream and cranberry juice.
08/31/2025 3:01 AM written by Resident Care Specialist Q - Blood Glucose: 236. Pts sugar was check and [s/he] is doing better.

Surveyor noted Assistant Executive Director B's notation occurred prior to the incident. Assistant Executive Director B started his/her notation at 3:14 AM, but the staff documented that Resident 9 voiced concerns around 5:00 AM.

Resident 9's "Admission Assessment," dated 08/15/2025, documented:
"Staff to administer all medications per MD (medical doctor) orders. Diabetic. Blood sugar checks before every meal and before bedtime. Insulin dependent. Staff are to notify PCP office or on call provider for BG (blood glucose) < (less than) 70 or > (greater than) 400."

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| N 431 | Continued From page 37<br><br>On 12/08/2025 at 10:00 AM, Surveyor interviewed Regional Director O. Surveyor reviewed the documentation regarding Resident 9's blood sugar concerns on 08/30/2025. Regional Director O stated Resident 9 should have been prescribed a PRN (as-needed) glucose tab or glucose gel so that was always available in a situation like this. Regional Director stated protocol would be for staff to administer small amounts of carbs/sugar like 4 to 6 ounces of fruit juice or regular soda, some hard candy, in small increments or else the resident could experience 'a rebound affect,' which sounds like occurred as s/he went from a BS level of 32 to a BS level of 236. Regional Director O stated that a blood sugar level of 32 should have been a 'red flag' and 911 should have been contacted. Regional Director O explained if the blood sugar levels did not elevate above 70 after 15 minutes, then one would repeat the steps; offer small food option, wait 15 minutes, retest blood sugar level. If resident did not obtain a blood sugar level above 70 then 911 would be contacted to transport resident for emergency evaluation. Regional Director O stated there was always a nurse available to the staff who could have been contacted to assist in providing proper guidance. Regional Director O stated when resident blood sugars leveled out and it was hours before a scheduled meal, then staff should offer healthier carb alternatives like milk or a nutritious sandwich. Regional Director O stated that staff will be re-educated on how to address high blood sugar levels.<br><br>"Hypoglycemia is a condition in which your blood sugar (glucose) level is lower than the standard range. Glucose is your body's main energy source. Hypoglycemia needs immediate | N 431 | | |

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treatment. For many people, a fasting blood sugar of 70 milligrams per deciliter (mg/dL), or 3.9 millimoles per liter (mmol/L), or below should serve as an alert for hypoglycemia." (Source: Mayo Clinic website, Hypoglycemia, November 18, 2023, https://www.mayoclinic.org/diseases-conditions/hypoglycemia/symptoms-causes/syc-20373685 (retrieval date - December 07, 2025).)

"Check your blood sugar whenever you have symptoms of low blood sugar. If your blood sugar is below 70 mg/dL, treat yourself right away.
1. Eat something that has about 15 grams (g) of carbohydrates. Examples are:
" 4 glucose tablets
" One half cup (4 ounces or 120 mL) of fruit juice or regular, non-diet soda
" 5 or 6 hard candies
" 1 tablespoon (tbsp) or 15 mL of sugar, plain or dissolved in water
" 1 tbsp (15 mL) of honey or syrup
2. Wait about 15 minutes before eating any more. Be careful not to eat too much. This can cause high blood sugar and weight gain.
3. Check your blood sugar again.
4. If you do not feel better in 15 minutes and your blood sugar is still lower than 70 mg/dL (3.9 mmol/L), eat another snack with 15 g of carbohydrates.
You may need to eat a snack with carbohydrates and protein if your blood sugar is in a safer range -- over 70 mg/dL (3.9 mmol/L) -- and your next meal is more than an hour away." (Source: Medline Plus website, Low blood sugar - self-care, February 28, 2024, https://medlineplus.gov/ency/patientinstructions/000085.htm (retrieval date - December 7, 2025).)

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| N 446 | Continued From page 39 | N 446 | | |
| N 446 | 83.41(1)(b) Equipment.<br><br>Equipment. The CBRF shall store equipment and utensils in a clean manner and shall maintain all utensils and equipment in good repair.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure that equipment was maintained in good repair. The oven was not fully functionable, and the stove hood fan was covered in what appeared to be a heavy layer of grease.<br><br>Findings include:<br><br>On 10/28/2025, the department received a concern alleging equipment in the kitchen were not operable.<br><br>On 11/25/2025, at approximately 11:35 AM, Surveyor toured the kitchen and observed the following:<br><br>Stove:<br>- One of the knobs for the gas burner was missing and the space where the knob would have been had a significant amount of what appeared to be food debris.<br>Surveyor asked Caregiver M, who was working in the kitchen, if the burner associated with the missing knob was workable. Caregiver M stated, "Yes, you just have to use a match to light the pilot light of the gas burner." Surveyor looked above the burners and observed the stove fan that did not have a cover and was covered in a | N 446 | | |

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| N 446 | Continued From page 40<br>heavy layer of what appeared to be grease. The entire underside of the stove hood was covered in what appeared to be a heavy layer of grease. The stove light in the stove hood was not covered.<br><br>On 12/08/2025 at 10:00 AM, Surveyor interviewed Regional Director O. Surveyor described his/her observation with Regional Director O. Regional Director O stated s/he would have the concern addressed immediately as it was a safety concern with staff using matches to light a burner and the stove should be in operable condition. | N 446 | | |
| N 447 | 83.41(1)(c) Dishwashing<br><br>Dishwashing. 1. Whether washed by hand or mechanical means, all equipment and utensils shall be cleaned using separate steps for pre-washing, washing, rinsing and sanitizing. Residential dishwashers may be used in kitchens serving 20 or fewer residents. Kitchens serving 21 or more residents shall have a commercial type dishwasher for washing and sanitizing equipment and utensils in accordance with standard practices described in the Wisconsin food code. 2. A 3-compartment sink for washing, rinsing and sanitizing utensils, with drain boards at each end is required for all large facilities with a central kitchen. Washing, rinsing and sanitizing procedures shall be in accordance with standard practices described in the Wisconsin food code. In addition, a single compartment sink or overhead spray wash located adjacent to the soiled drain board is required for pre-washing. | N 447 | | |

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| N 447 | Continued From page 41<br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure dishes, equipment and utensils washed by hand were cleaned using separate steps for pre-washing, washing, rinsing, and sanitizing. This had the potential to affect 5 of 5 residents residing in the home.<br><br>Findings include:<br><br>The facility was licensed as a Class CNA (non-ambulatory) assisted living facility on 04/15/2024 and the licensee can provide care and services to 23 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, and physically disabled.<br><br>On 10/28/2025, the department received a concern alleging equipment in the kitchen were not operable.<br><br>On 11/25/2025, at approximately 1:00 PM, Surveyor observed Resident Care Specialist M washing dishes by hand in the kitchen sink. Surveyor asked why s/he wasn't utilizing the dishwashers. Resident Care Specialist M stated the dishwashers did not work. Resident Care Specialist M utilized 2 separate sink compartments, one was used for washing with soapy water and one was for rinsing. The washed dishes were stacked on the counter.<br><br>On 11/25/2025, at approximately 1:30 PM, Surveyor asked Executive Director A and Assistant Executive Director B why staff did not utilize the dishwashers in the kitchen. Assistant Executive Director B stated, "The one dishwasher works, I don't know why they aren't utilizing it."<br><br>On 12/08/2025 at 10:00 AM, Surveyor | N 447 | | |

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| N 447 | Continued From page 42<br>interviewed Regional Director O. Surveyor described his/her observation with Regional Director O. Regional Director O stated s/he would have the concern addressed immediately. Regional Director O stated that all equipment should be in working condition and the provider needs to ensure the dishes have been washed sanitarily. | N 447 | | |
| {N 450} | 83.41(2)(c) Nutrition: menus.<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview, the provider did not document on the menu deviations from the planned menu.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) VTVD11, dated 07/16/2025.<br><br>Findings include:<br><br>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.<br><br>On 10/28/2025, the department received a | {N 450} | | |

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concern that the provider did not offer nutritious meals.

On 11/25/2025, at approximately 11:55 AM, Surveyor observed the menu which documented: "Week Three Fall Menu - Tuesday 11/25/2025 handwritten on it - Breakfast: Continental (light, simple morning meal focused on cold items), Lunch: Ham, Scalloped Potatoes, Carrots and Jello."

On 11/25/2025, at approximately 12:00 PM, Surveyor observed the residents eating lunch. The lunch consisted of processed breaded fish patties, potatoes and carrots. Surveyor commented to Assistant Executive Director B that the lunch meal did not match the menu. Assistant Executive Director B commented that they had updated the whiteboard where they write what is being served for a meal. Surveyor asked if the paper menus were updated which Assistant Executive Director B stated they were not.

On 12/01/2025, Surveyor reviewed the menu again. The menu documented that on Sunday, 11/23/2025 the residents were served a turkey roast with stuffing for lunch. Assistant Executive Director B had taken a turkey out of the freezer to be thawed for a turkey meal on thanksgiving, 11/27/2025. The menu stated that on 11/27/2025 for lunch the meal was to be smoked sausage, german potato salad and cauliflower but Assistant Executive Director B stated that was when the thanksgiving meal was to be served.

On 12/08/2025 at 10:00 AM, Surveyor interviewed Regional Director O. Surveyor asked for clarification on how often the menu was followed and if the provider could provide the previous weekly menus to show all meals that

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| {N 450} | Continued From page 44<br>had been altered. Regional Director O stated the menus could not be provided as staff had not updated the current one, let alone previous ones. Surveyor commented that mensu are required to be maintained for 60 days. Regional Director O stated s/he would address that concern with staff. Regional Director O stated that based on Surveyors observation, the menus are not being followed and some of that is due to staff not being able to cook and/or organizing/prepping the food to ensure it is ready for the next meal. Surveyor commented that the food concerns had been an ongoing concern with the provider. Regional Director O stated there was going to be some additional changes with staffing to ensure compliance. | {N 450} | | |
| N 454 | 83.42(1) Resident record maintained.<br><br>The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following:<br>(a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in | N 454 | | |

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condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x)

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| N 454 | Continued From page 46<br>Date, time and circumstances of the resident's death, including the name of the person to whom the body is released.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not maintain 1 of 2 residents (Resident 8) pre-admission assessment.<br><br>Findings include:<br><br>The facility was licensed as a Class CNA (non-ambulatory) assisted living facility on 04/15/2024 and the licensee can provide care and services to 23 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, and physically disabled.<br><br>On 11/25/2025, at approximately 1:40 PM, Surveyor interviewed Resident 8. Surveyor commented that s/he did not see him/her participate in the noon meal. Resident 8 explained that s/he would rather eat in his/her room because s/he did not like sitting with his/her tablemates who had some memory impairments. Resident 8 commented, "I have MS (multiple sclerosis) but my mind is fine." Resident 8 stated that his/her managed care organization determined his/her placement.<br><br>On 11/25/2025, Surveyor reviewed Resident 8's record.<br><br>Resident 8 moved into the facility, 08/19/2025, with a diagnosis including multiple sclerosis. Surveyor determined there was no pre-admission paperwork in Resident 8's file.<br><br>On 11/25/2025, at approximately 2:15 PM, | N 454 | | |

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| N 454 | Continued From page 47<br><br>Surveyor interviewed Executive Director A, Assistant Executive Director B and Licensed Practical Nurse L. Executive Director A stated the corporate office completed the resident pre-assessments and determined which provider home was the best fit for the potential resident. Surveyor requested Resident 8's pre-admission paperwork. Surveyor did not receive documentation prior to his/her departure at approximately 4:30 PM.<br><br>On 11/26/2025 at 9:20 AM, Surveyor emailed Executive Director A and requested Resident 8's pre-admission assessment.<br><br>On 12/02/2025 at 8:40 AM, Surveyor emailed Surveyor emailed Executive Director A and requested Resident 8's pre-admission assessment.<br><br>On 12/02/2025 at 8:42 AM, Executive Director A emailed Surveyor and stated s/he had just returned to the office from vacation and would forward requested documentation.<br><br>Executive Director A proceeded to forward documentation, but the documentation did not include Resident 8's pre-admission assessment.<br><br>On 12/08/2025 at 10:00 AM, Surveyor interviewed Regional Director O. Regional Director O stated the assessment had been completed but obviously did not get filed with Resident 8's record. Regional Director O stated the provider was aware of the documentation concerns and was working diligently to ensure compliance. | N 454 | | |

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| {N 481} | Continued From page 48 | {N 481} | | |
| {N 481} | 83.43(1) Environment safe, clean, and comfortable<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure a living environment that is clean, comfortable, and homelike.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) VTVD11, dated 07/16/2025.<br><br>Findings include:<br><br>The facility was licensed as a Class CNA (non-ambulatory) assisted living facility on 04/15/2024 and the licensee can provide care and services to 23 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, and physically disabilities.<br><br>On 10/28/2025, the department received a concern alleging the facility had environmental concerns.<br><br>On 11/25/2025, at approximately 10:30 AM, Surveyor toured the facility and observed:<br><br>Laundry Room:<br>Extra freezer placed next to communications equipment box that had numerous wires hanging from it that a staff member could accidentally bump/pull when removing food items from the | {N 481} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019178 | A. BUILDING: _____ B. WING _____ | R-C 12/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VITACARE LIVING MOUNT HOREB | 104 LINCOLN CT MOUNT HOREB, WI 53572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {N 481} | Continued From page 49 | {N 481} | | |

freezer. The freezer shelves were covered in a thick layer of ice and what appeared to be food debris.

Kitchen:
Stove hood top was covered in what felt like a grease-like substance.
Outlets were covered in what appeared to be food-like splatter.
Automatic coffee machine was covered in what appeared to be a food-like splatter and felt greasy to the touch.
Cabinets felt greasy to the touch.

Stairwell to Downstairs:
Carpeting displayed what appeared to be a dirt-like buildup giving the appearance it was not regularly vacuumed.

Sunroom:
The paint on the white wicker patio furniture set chips when the furniture is moved leaving a white powdering substance on the floor.

Storage Room:
The ceiling had a section approximately 4 feet by 3 ft that was brown which appeared to be water damage. The drywall appeared to be pealing. Under this section, on the carpet, was a white substance.

Resident 11's Bathroom:
The linoleum around the shower base was lifting and the flooring under the linoleum was damp. There was a puddle of water near the shower causing the flooring to be slippery. The toilet bowl had a brown ring at the water line.

Vacant Resident Bedroom:
Wallpaper was lifting from the wall and could

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| VITACARE LIVING MOUNT HOREB | 104 LINCOLN CT MOUNT HOREB, WI 53572 |

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| {N 481} | Continued From page 50 | {N 481} | | |

easily be peeled away. The bathroom appeared to be touched up with paint that was not the same color as the original color. A light switch which went to the closet was not operable.

Throughout facility where cabinetry was placed on walls, there appeared to be a dust-like appearance on the walls and hanging from the ceiling/walls above the cabinetry.

On 11/25/2025, at approximately 11:10 AM, Surveyor interviewed Assistant Executive Director B and Licensed Practical Nurse L. Surveyor asked for clarification on the condition of the ceiling in the storage room. Assistant Executive Director B stated it was a storage room and not of significance. Surveyor asked if there had been reported concerns of the extra freezer being placed to close to the communication box with the hanging wires. Assistant Executive Director B stated s/he had not experienced any problems. Surveyor asked if the vacant room observations were going to be addressed prior to a new resident moving in. Licensed Practical Nurse L stated maintenance can be contacted regarding the flooring but did not consider the wallpaper a concern. Licensed Practical Nurse L stated the lightbulbs would be replaced prior to a new resident moving in to ensure the light switch worked. Licensed Practical Nurse L stated a new resident was moving into the room with the wallpaper concern and was not concerned with it.

On 12/08/2025 at 10:00 AM, Surveyor interviewed Regional Director O. Surveyor discussed all observations. Regional Director O stated the concerns would be discussed with staff and the corporate office to determine a plan of correction.

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|---|---|---|---|
| | 0019178 | A. BUILDING: _____ B. WING _____ | R-C 12/08/2025 |

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| VITACARE LIVING MOUNT HOREB | 104 LINCOLN CT MOUNT HOREB, WI 53572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 488 | Continued From page 51 | N 488 | | |
| N 488 | 83.44(1)(c) Clothes dryers enclosed and vented<br><br>Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure that the clothes dryer in the residential laundry room had vent tubing of rigid material, with a fire rating that exceeds the temperature rating of the dryer. The clothes dryer was observed to have the flexible foil type vent tubing and a lent trap that was packed with lint.<br><br>Findings include:<br><br>On 10/28/2025, the department received a concern alleging safety concerns in the laundry room.<br><br>On 11/25/2025, at approximately 11:10 AM, Surveyor and Assistant Executive Director B toured the laundry room. Surveyor stated there had been reported concerns that the lint trap was not emptied on a consistent basis creating a fire hazard. Assistant Executive Director B checked the lint trap which was observed to be packed with lint. Assistant Executive Director B scoffed and emptied the lint trap. Surveyor then observed the dryer vent which was a flexible style. Surveyor asked if the dryer vent exceeded the temperature rating of the dryer. Assistant Executive Director B stated s/he was unsure and | N 488 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| VITACARE LIVING MOUNT HOREB | 104 LINCOLN CT MOUNT HOREB, WI 53572 |

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| N 488 | Continued From page 52<br>would discuss the concern with maintenance.<br><br>On 12/08/2025 at 10:00 AM, Surveyor interviewed Regional Director O. Surveyor discussed all observations. Regional Director O stated the concerns would be discussed with staff and the corporate office to determine a plan of correction. | N 488 | | |