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	0018786	A. BUILDING: _____ B. WING _____	05/28/2026

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SILVER LAKE HAVEN	N2641 17TH LANE WAUTOMA, WI 54982

(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 05/28/2026, Surveyor reviewed one self-report at Silver Lake Haven. Two deficiencies were identified. Census: 7	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did conduct or document investigations into allegations of neglect to determine if the incidents required reporting to the Department. On 11/28/2025, Licensee A received an allegation	N 158		

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

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that Caregiver E did not provide Resident 2 necessary incontinence care during the overnight hours of 11/27 - 11/28/2025. Licensee A did not conduct or document an investigation into the incident to determine if neglect occurred requiring reporting to the Office of Caregiver Quality.

Resident 1 was protectively placed, had diagnoses of Alzheimer's dementia and was a known elopement risk. On 01/11/2026 during 3rd shift, Caregiver E heard the delayed egress doors alarm. S/he disabled the alarms and then did not check Resident 1's whereabouts to ensure s/he was still in the facility. At 3:30 AM, Resident 1 was found 1/2 mile from the facility. Licensee A did not conduct or document a thorough investigation into the incident. Licensee A concluded Caregiver E was negligent in his/her actions but did not report the incident to the Office of Caregiver Quality.

Findings include:

The Department received a self-report from the provider on 01/19/2026 which read, "On 1/11/26 at approximately 3:30 AM, staff member...received a phone call from law enforcement that [Resident 1] was found approximately 1/2 a mile from the facility, at the [Gas Station F] parking lot...resident resides in a delayed egress facility. Staff are to continue with current protocols of keeping door alarms armed and responding to any alarms with a count of all residents."

RESIDENT 1

On 05/28/2026 at 11:09 AM, Surveyor observed the facility doors are delayed egress. When pressure is applied to a door, it alarms for 15

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seconds before opening and it continues to alarm until it is manually cleared.

Surveyor reviewed Resident 1's record on 05/28/2026 at 1:14 PM. Resident 1 was admitted on 12/03/2025. S/he was elderly, had a legal guardian and had diagnoses to include "severe Alzheimer's dementia..." The individual service plan (ISP) dated 12/17/2025 indicted s/he required "total supervision" and could not make needs known. The ISP read, "History of wandering. Resident is protectively placed after wandering from [his/her] home on multiple occasions." Observation notes in the week preceding the elopement documented persistent exit seeking.

Surveyor interviewed Caregiver C on 05/28/2026 at 11:21 AM. S/he said Resident 1 was a known elopement risk and persistently tried to leave the facility. Caregiver C said s/he could not understand how Resident 1 was able to leave the facility without Caregiver E hearing the alarms and/or immediately looking for Resident 1 to ensure s/he was still in the building. Caregiver E said, "[S/he] was found at [Gas Station F]. It's far for [him/her] to walk in the middle of winter. That resident could have frozen to death."

Surveyor interviewed Licensee A and Manager B at 12:34 PM. Licensee A confirmed police returned Resident 1 to the facility during the overnight hours on 01/11/2026, after s/he was found at a local gas station. Licensee A said s/he met with Caregiver E who admitted hearing the door alarm, but turning it off and then "did not follow protocols" to check the whereabouts of all residents. Licensee A said s/he determined the incident was "pure negligence on the part of the employee and [s/he] was fired before [s/he] could

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work in the building again." Licensee A said the extent of the investigation was his/her discussion with Caregiver E. Surveyor asked if s/he knew when Resident 1 left the building and Licensee A said, "If I recall, around 1 or 2:00 AM." Licensee A said s/he did not know what Resident 1 was wearing when s/he left the building or his/her physical condition when s/he was returned. S/he did not describe steps to ensure Resident 1's safety for the remainder of 3rd shift on 01/11/2026. Licensee A acknowledged s/he did not document any of the steps s/he took and did not submit a Misconduct Incident Report to the Office of Caregiver Quality. Licensee A said s/he felt the caregiver's admission and decision to terminate was "straightforward."

Surveyor reviewed Caregiver E's record on 05/28/2026 at 1:29 AM. S/he was hired on 07/23/2021 and employment ended 01/13/2026. A "Disciplinary Action Record" documented the 01/11/26 elopement incident and decision to terminate employment. The document did not include information about interviews, record reviews or other investigative steps.

Surveyor reviewed the provider's procedure on "Caregiver Misconduct Reporting" on 05/28/2026 at approximately 1:45 PM. It read, "Each staff member of Silver Lake Manor is required to immediately disclose all allegations of misconduct, including abuse or neglect of a client or misappropriation of a client's property. Suspected incidents of resident abuse must be communicated to a manager immediately upon suspicion of such an event occurring...Immediately upon learning of a suspected incident steps must be taken to protect the resident from subsequent incidents of misconduct or injury. Any staff member who is

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aware of an alleged incident is responsible to take these steps...Upon receiving an allegation of caregiver misconduct a facility will commence an internal investigation. This must be done within one working day of receiving the report. The internal investigation will be conducted utilizing the facility Complaint Investigation form. The Caregiver Misconduct Reporting Requirements Worksheet and the Caregiver Misconduct and Injuries of Unknown Source Entity Investigation and Reporting Requirements flow sheet will be used to determine if the incident must be reported to DHS Office of Caregiver Quality."

RESIDENT 2

During the aforementioned interview with Caregiver C, s/he described concerns with Caregiver E that preceded the elopement incident. Caregiver C said when s/he would report for 1st shift after Caregiver E worked 3rd shift, s/he would find residents heavily incontinent. Caregiver C said residents would complain that Caregiver E would be "outside smoking constantly overnight" and Resident 2 "would tell us [Caregiver E] would not come in and change [him/her]." Caregiver C said s/he frequently reported the concerns to Lead Staff D and Manager B, but the situation did not improve.

Surveyor interviewed Lead Staff D at 11:45 AM. S/he also expressed concerns about Caregiver E not providing adequate care to residents. Lead Staff D said 1st shift that relieved Caregiver E could tell residents had not been rotated or changed during 3rd shift, charting was not consistently completed and medications remained in the card in spite of Caregiver E charting they had been administered. Lead Staff D recalled during November 2025, Resident 2

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had been complaining that Caregiver E was not providing him/her incontinence care overnight, so Lead Staff D initialed and dated Resident 2's brief at bedtime on 11/27/2025. Lead Staff D said Resident 2 was bed bound and needed incontinence checks/care every 2 hours (until 4:00 AM when s/he preferred to sleep until 9 or 10:00 AM.) Lead Staff D said when s/he checked Resident 2 at 9:30 AM on 11/28/2025, s/he was wearing the same brief from 11/27/2025, which was heavily soaked with urine. Lead Staff D said s/he took and showed photos to Manager B and Licensee A. Lead Staff D said, "I told [Licensee A] I can put up with a lot of stuff, but I can't put up with neglect...It almost made me cry when came in. [Resident 2] was also crying and telling me [s/he] has not been changed." Lead Staff D showed Surveyor the photos of the brief, time stamped 11/28/2025 at 9:45 AM. The absorbent core appeared visibly thick and weighted from fluid retention and was discolored yellow. The yellow discoloration extended beyond the absorbent core to the elastic leg cuffs. The brief was dated 11/27 with Lead Staff D's initials. Lead Staff D stated, "I told [Manager B and Licensee A]... I was worried every night [s/he] worked." Lead Staff D said s/he began keeping his/her own documentation of concerns about Caregiver E in a personal notebook. Lead Staff D said after the elopement, s/he told Licensee A about the concerns s/he had been documenting but Licensee A did not review or copy anything from the notebook. Lead Staff D said since it had been several months since Caregiver E was terminated so s/he recently threw out the notebook.

Surveyor reviewed Resident 2's record. Resident 2 was admitted on 10/17/2024. S/he was elderly, had an activated power of attorney for health care and had diagnoses to include overactive bladder,

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chronic pain, insomnia and generalized anxiety. The ISP indicated s/he needed incontinence checks/care every 2 hours. An ISP update on 01/08/2026 indicated s/he was reliant on staff assistance with transfers using a Hoyer lift.

During the aforementioned review of Caregiver E's record, Surveyor noted it did not contain evidence of disciplinary actions or investigations related to the 11/28/2025 incident or similar care concerns.

During the aforementioned interview with management, Licensee A said s/he had not received "formal complaints" about Caregiver E prior to the elopement and added, "There was a little bickering between coworkers. I considered [him/her] a good employee." Surveyor explained interviews with staff identified care concerns that had been reported, including times when residents were found heavily incontinent by 1st shift staff after Caregiver E worked. Licensee A said, "I did not have any concerns about that." Surveyor inquired about a photo of Resident 2's saturated incontinence brief that was reportedly shared with him/her during November 2025. Licensee A said, "Oh, that would have been from [Lead Staff D], I do remember that. I did talk to [Caregiver E] about that." Licensee A said s/he did not document the incident or the discussion, but s/he believes Caregiver E denied the situation and Licensee A reminded him/her of the expectations for care. Licensee A said s/he did not conduct interviews with other staff or Resident 2 as part of his/her response.

Manager B said s/he recalled the November incident and photo and said, "I don't remember the dates. I remember the concern was brought to me." Manager B said s/he could not recall any

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N 158	Continued From page 7 other details of the incident or Caregiver E's response. Manager B said s/he talked with Resident 2 who s/he described as "very oriented" and then followed up with Resident 2 and other staff "after a couple of days" to see if things had improved. Manager B said s/he did not have documentation about the situation or his/her response. Cross Reference N0348 DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment	N 158		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was free from neglect. Resident 1 was diagnosed with Alzheimer's dementia, was protectively placed at the facility due to past incidents of elopement and continued to display exit seeking behavior after admission. On 01/11/2026 between 12:30 AM and 2:30 AM, Resident 1 exited the building which activated the door alarms. Caregiver E cleared the alarms but	N 348		

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did not verify Resident 1's whereabouts or subsequently provide supervision. At approximately 3:30 AM, Resident 1 was observed by a citizen at approximately ½ mile away from the facility wearing only socks and lightweight short sleeved pajamas.

"Neglect" means the failure of a caregiver, as evidenced by an act, omission, or course of conduct, to endeavor to secure or maintain adequate care, services, or supervision for an individual ...creating significant risk or danger to the individual ' s physical or mental health ..."

Findings include:

The Department received a self-report from the provider on 01/19/2026 which read, "On 1/11/26 at approximately 3:30 AM, staff member...received a phone call from law enforcement that [Resident 1] was found approximately 1/2 a mile from the facility, at the [Gas Station F] parking lot...resident resides in a delayed egress facility. Staff are to continue with current protocols of keeping door alarms armed and responding to any alarms with a count of all residents."

Surveyor reviewed historical weather data and on 01/11/2026 at 3:15 AM, the temperature was 24°F with 9 mph winds. Source: https://www.wunderground.com/history/daily/KPCZ/date/2026-1-11, retrieval date 06/01/2026.

Surveyor reviewed Caregiver E's record on 05/28/2026 at 1:29 PM. S/he was hired on 07/23/2021 and employment ended 01/13/2026. The record contained a "Disciplinary Action Record" read, "Personnel Policy/Resident Right Violated: Residents have the right to be free from

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neglect and to be in safe [sic] monitored environment...Details of Violation: On 1/11/2026 [Caregiver E] responded to an alarm sounding on an exterior door at Silver Lake Haven. [S/he] turned off the alarm and proceeded to not check the wherabouts [sic] of any residents in the facility. Two (crossed off and handwritten "one") hours later local law enforcement found [Resident 1] in the [Gas Station F] parking lot. Employee was still not aware of [Resident 1's] absence until contacted by local authorities. This scenario is only accentuated that the exterior door that was alarming was directly ajacent [sic] to [Resident 1]'s room. It would have taken less than 30 seconds to perform a check in [his/her] room to ensure [his/her] safety. Expectations: Silver Lake Haven is a delayed egress facility specifically intended to meet the needs of advanced dementia individuals. Any time an alarm sounds, a count of all residents should be performed. Actions Being Taken...The decision to not check on residents [sic] welfare after an alarm sounded is inexcusable. Termination as of 1/13/20026 [sic]"

Surveyor reviewed Resident 1's record on 05/28/2026 at 1:14 PM. Resident 1 was admitted on 12/03/2026. S/he was elderly, had a legal guardian and had diagnoses to include "severe Alzheimer's dementia..." The record contained a Green Lake County Circuit Court protective placement order dated 12/03/2026 for Resident 1 to reside at the facility. The document indicated protective placement was necessary due to supervision concerns in his/her prior living arrangement to include "Multiple APS (adult protective services) and law enforcement contacts with the ward engaging in dangerous behavior ...Ward continues to wander in a high traffic area in inclement weather, demonstrating

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confusion and putting self at risk." The individual service plan (ISP) dated 12/17/2025 indicted s/he required "total supervision" and 2 hour checks and could not make his/her needs known. Observation notes documented exit seeking persisted after s/he was admitted to the facility.

Observation notes preceding and on the day of the elopement:

--01/07: "[S/he] was exit seeking for about 5 hours today."
--01/08: "Resident was same as yesterday but lastest [sic] from 9am - 4:30 PM."
--01/11: "[S/he] kept exit seeking all morning ...Resident was given a PRN (as needed) melatonin at 7:20 PM. [S/he] slept until around 12:30 AM ...Caregiver last toileting was around --2:30 AM...After that caregiver was folding laundry an [sic] got another resident [his/her] soda ...while caregiver was getting ice the door alarm went off. Caregiver went an [sic] turned the alarm off. Noticed resident's bedroom light was on." The caregiver was later notified by the caregiver at the sister facility the police had called because Resident 1 was found at the gas station. "Resident was dropped off around am. Resident is okay no injury's [sic]." Author: Caregiver E
--01/11: "Resident did not get up all morning ...S/he was barely opening [his/her] eyes. [Family] came in clapping trying to get [him/her] up. [S/he] got up after a while looked very tired."

Surveyor interviewed Caregiver C on 05/28/2026 at 11:21 AM. S/he described Resident 1 as a "big time wanderer. It was hard to get [him/her] to sleep ...[s/he] would go door to door to door to door [sic] and set the alarms off." Caregiver C recalled the 01/11/2026 elopement incident and was told Caregiver E did not look for Resident 1

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after [s/he] exited the building and set off the door alarms. Caregiver E said it would have been common to sense to immediately look for Resident 1 upon hearing the alarm, and s/he also indicated the door alarms for a full 15 seconds before opening which should have given Caregiver E enough time to prevent the elopement in the first place.

Surveyor interviewed Lead Staff D on 05/28/2026 at 11:45 AM. Lead Staff D recalled 1's elopement. Lead Staff D said s/he talked with a different resident, Resident 2, who said s/he heard the door alarm around 12:30 AM. Lead Staff D said not only was it concerning that Caregiver E did not check on Resident 1's well-being immediately upon hearing the alarms, but based on Resident 2's report of when the doors alarmed, it would also indicate s/he did not complete 2 hour checks between 12:30 AM and 3:30 AM.

Surveyor obtained and reviewed Waushara County Sheriff's Office police report 26WS00251 on 05/28/2026 at 3:00 PM.

Deputy H's report read, "On 01/11/2026 at approximately 0328 hours...Dispatch advised there was an elderly [person] found on State Road 21 and 73, by [Gas Station F]. The [person] was not dressed for the weather, did not know where [s/he] came from, and appeared confused. I met the complainant, [Citizen G], at the Waushara County Sheriff's Office. [Citizen G] reported finding the [person] on the roadway and advised that [s/he] learned the [person]'s name was [Resident 1]. [Citizen G] had turned up the heat in [his/her] vehicle to assist in regulating [Resident 1]'s body temperature. I obtained a blanket from my squad and wrapped [Resident 1] up in the blanket...I observed [Resident 1]

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wearing a short-sleeved pajama set that was made from very thin fabric. [Resident 1] had a pair of socks on [his/her] feet, but no shoes. [Citizen G] advised that [Resident 1]'s socks were covered in snow when [s/he] found [him/her]. The socks were wet and very cold to the touch. I requested EMS staff respond to check out [Resident 1]. [Resident 1] had a difficult time answering any questions...Dispatch had contacted...Silver Lake Manor (sister facility), to inquire if they were missing a resident...I brought [Resident 1] inside the Sheriff's Office Lobby...We removed [Resident 1]'s wet socks. EMS arrived and checked [Resident 1] over. Deputies put new dry socks on [Resident 1] that we had available to hand out to the public in need. EMS staff found nothing medically wrong with [Resident 1] and provided us with a heated pad blanket to aid in getting [Resident 1] warm again. Ultimately, I transported [Resident 1] back to Silver Lake Manor without incident. [Resident 1] was returned to the staff inside the secure facility." The report referred to Deputy I's report for more information.

Deputy I's report read, "On 01-11-2026...I was informed that a resident from Silver Lake Manor had left the secure portion of the facility and was located walking in below freezing temperatures without adequate clothing on...I traveled to (Silver Lake Haven). The employee, [Caregiver E], advised that [s/he] didn't know the resident had left until Waushara County Dispatch had called...asking if they were missing someone. [Caregiver E] stated that [s/he] did not know how [Resident 1] had left the facility as they have alarms on the doors. The front door alarm was in working condition and went off when [Deputy H & Resident 1] entered the building. [Caregiver E] informed me that [Resident 1] had been displaying 'exit seeking' behavior and believed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018786	A. BUILDING: _____ B. WING _____	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER LAKE HAVEN	N2641 17TH LANE WAUTOMA, WI 54982

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N 348	Continued From page 13 that [s/he] snuck though one of the exit doors when [s/he] was helping another patient...I suggested that Caregiver E be more vigilant as this could have been a lot worse of a situation." On 05/28/2026 at 12:34 PM, Surveyor interviewed Licensee A and Manager B. They both confirmed the elopement incident on 01/11/2026. Licensee A agreed Resident 1 was at high risk for elopement and said Caregiver E acted negligently when s/he did not ensure Resident 1 was in the facility after hearing the door alarm. Cross Reference N0158 DHS 83.12(2)(a) Caregiver Investigating Abuse & Neglect	N 348		