STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018749	A. BUILDING: _____ B. WING _____	C 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - HAYWARD I	10260 WHITE BIRCH LN HAYWARD, WI 54843

(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 06/30/2026, Surveyors began a complaint investigation at Vitacare Living Hayward I. Data was collected through 07/07/2026. One of 2 complaints was substantiated. Six new violations were identified. Two of 5 violations were repeat deficiencies. See Statement of Deficiency (SOD) 40VK12, dated 06/18/2024 and SOD OX7211, dated 09/12/2022. Census: 16	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:	N 158		

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
	0018749	A. BUILDING: _____ B. WING _____	C 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - HAYWARD I	10260 WHITE BIRCH LN HAYWARD, WI 54843

(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 158	Continued From page 1	N 158		

Based on record review and interview, the provider did not take immediate steps to ensure the safety of all residents, investigate, and document any allegation of abuse or neglect of a resident.

Findings include:

On 06/08/2026, the Department received a complaint regarding administration and staff.

The provider is licensed to care for 16 residents in the client groups: terminally ill, irreversible dementia/Alzheimer's disease, physically disabled, and advanced aged.

On 06/30/2026 at approximately 12:10 PM, Surveyor interviewed Resident 2 who asked to speak with the Surveyor. Resident 2 discussed an incident that occurred on or around 06/20/2026 involving Caregiver E and Caregiver F. Resident 2 stated around 7:30 PM, s/he wanted to get up and s/he waited for about 30 minutes when s/he started hollering for staff. Resident 2 stated Caregiver E and Caregiver F both entered his/her room with "guns blazing" and that Caregiver E called Resident 2 a "misogynistic womanizing [expletives]" and that Resident 2 needed to learn patience. Resident 2 stated that Caregiver E went on to say, "I don't care if I get fired. I quit." Resident 2 stated that Caregiver E was yelling approximately 10 inches from his/her face. Resident 2 stated s/he told Team Lead (TL) A what occurred and that if something like this happened again, Resident 2 would call the police.

At approximately 12:16 PM, Surveyor interviewed TL A who stated s/he attempted to speak with Caregiver E about the incident, but s/he got upset and walked away. TL A indicated Resident 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018749	A. BUILDING: _____ B. WING _____	C 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - HAYWARD I	10260 WHITE BIRCH LN HAYWARD, WI 54843

(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 158	Continued From page 2 tended to have more adverse behaviors at night. TL A stated s/he did not complete an investigation or write-up but did report the incident to Administrator C and Regional Director (RD) G. On 07/01/2026 at 4:42 PM, Surveyor received an email communication from Administrator C that read, in part, " ...[RD G] or I were not made of any incidents involving [Caregiver E]. I did not find any notes or incident reports ..." The provider did not complete an investigation into the allegation of abuse. Cross Reference: N0214 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 158		
N 163	83.12(4)(a) Reporting when resident's whereabouts unknown A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time a resident ' s whereabouts are unknown, except those instances when a resident who is competent chooses not to disclose his or her whereabouts or location to the CBRF, the CBRF shall notify the local law enforcement authority immediately upon discovering that a resident is missing. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies or persons recovering from substance abuse. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written report was sent	N 163		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018749	A. BUILDING: _____ B. WING _____	C 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - HAYWARD I	10260 WHITE BIRCH LN HAYWARD, WI 54843

(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 163	Continued From page 3	N 163		

to the Department within 3 working days after a resident's whereabouts were unknown.

Findings include:

On 06/08/2026, the Department received a complaint regarding staffing.

The provider is licensed to care for 16 residents in the client groups: terminally ill, irreversible dementia/Alzheimer's disease, physically disabled, and advanced aged.

On 06/30/2026 at approximately 10:00 AM, Surveyor interviewed Caregiver B who stated Resident 3 had entered homes in the community and demanded coffee, tried to get into a transport vehicle that was on site for another resident, and that s/he had eloped on numerous occasions. Caregiver B stated s/he was unsure if all elopements were documented.

On 07/06/2026, Surveyor reviewed Resident 3's record. Resident 3 was admitted on 11/04/2024 and diagnosed with dementia (primary), brain aneurysm, and high risk for elopement. Resident 3 had a power of attorney (POA). Resident 3's record included the following:

-Missing Resident Reports dated 04/01/2026, 04/07/2026, and 04/12/2026.

-Missing Person Report dated 04/01/2026 read, in part, " ...resident had ran [sic] away to the neighbors [sic] house while staff were busy with other residents ...neighbors called the police to report [him/her] missing ...[s/he] was brought back by the neighbors. Prior to this incident resident had tried going over to the neighbors house several times ...

-Missing Person Report dated 04/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018749	A. BUILDING: _____ B. WING _____	C 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - HAYWARD I	10260 WHITE BIRCH LN HAYWARD, WI 54843

(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 163	Continued From page 4 read, in part, " ...[resident] took off from the property ...searched everywhere...contacted management, police ... -Missing Person Report dated 04/12/2026 read, in part, " ...phone started ringing ...was none of the neighbors calling saying that [resident] was there ..." -Resident Notes dated 04/1/2026 through 06/30/2026 indicated Resident 3 eloped on 04/01/2026, 04/02/2026, and 04/03/2026. On 07/07/2026, Surveyor reviewed Department self-report records and found that for 2026 no self-reports were submitted. The provider did not notify the Department after Resident 3 eloped on multiple occasions. Cross Reference: N0214 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 163		
N 200	83.14(2)(e) Notify within 7 days of administrator change The licensee shall notify the department within 7 days after there is a change in the administrator. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not notify the department within 7 days after there was a change in the administrator. Findings include: On 06/08/2026, the Department received a complaint regarding administration and staff.	N 200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018749	A. BUILDING: _____ B. WING _____	C 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - HAYWARD I	10260 WHITE BIRCH LN HAYWARD, WI 54843

(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 200	Continued From page 5 The provider is licensed to care for 16 residents in the client groups: terminally ill, irreversible dementia/Alzheimer's disease, physically disabled, and advanced aged. On 06/30/2026, Surveyor reviewed the Department's records and observed Administrator C was listed as the current administrator. At 3:37 PM, Surveyor received an email communication from Administrator C. The email contained a document titled Assisted Living Administrator Notification, dated 06/03/2026, that indicated Registered Nurse (RN) D was the new administrator. The email thread also indicated the notification was sent to the department on 06/13/2026. On 07/06/2026 at 9:23 AM, Surveyor received an email communication from Administrator C that confirmed RN D role changed to Administrator on 05/28/2026. The licensee did not notify the department within 7 days after there was a change in the administrator. Cross Reference: N0214 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 200		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel,	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018749	A. BUILDING: _____ B. WING _____	C 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - HAYWARD I	10260 WHITE BIRCH LN HAYWARD, WI 54843

(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 214	Continued From page 6 finances, and physical plant. The administrator shall 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. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure an administrator supervised the daily operation of the facility, programming, and personnel in a way that ensured residents received proper care and treatment. Findings include: On 06/08/2026, the Department received a complaint regarding administration and staff. The provider is licensed to care for 16 residents in the client groups: terminally ill, irreversible dementia/Alzheimer's disease, physically disabled, and advanced aged. The survey was prompted by 2 complaints. One of the complaints was substantiated, and the following issues were identified during the course of the survey: - It was unclear to residents and staff who was in charge. - The change in administrator was not reported to the Department within 7 days. - Residents did not receive adequate supervision to meet their needs. - Residents were not offered a daily activity	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018749	A. BUILDING: _____ B. WING _____	C 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - HAYWARD I	10260 WHITE BIRCH LN HAYWARD, WI 54843

(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 214	Continued From page 7	N 214		

program.
- An incident of abuse and neglect was not investigated.

On 06/30/2026 at approximately 8:10 AM, Surveyor interviewed Administrator C by phone. Administrator C stated Team Lead (TL) A was on site and had limited access to electronic records. Surveyor inquired who was the program administrator and Administrator C stated that Manager H and Registered Nurse (RN) I walked off the job on 04/27/2026. Administrator C stated Regional Director (RD) G and Administrator C were covering. Administrator C stated Director J was recently hired to oversee the program.

At approximately 8:40 AM, Surveyor interviewed Hospice Registered Nurse (HRN) K who stated s/he did not know who the administrator was but did hear that a new director had been hired.

At approximately 8:30 AM, Surveyor interviewed TL A who stated that it was challenging for Administrator C and RD G to manage the program remotely. TL A stated that s/he (TL A) was on call 24/7 and s/he was "going through the ringer" because there was no direct manager. TL A stated, "They (Administrator C and RD G) try to train me from a distance... I'm figuring things out as I go." TL A stated s/he heard RN D was supposed to be overseeing the program, but s/he also heard RN D had been pulled to another facility in the southern part of the state. TL A stated RN D "was here whenever [s/he] feels like it... believe [s/he] was here a day last week." TL A stated s/he would reach out to RN D if s/he had a medical question, but s/he was unsure if the nurse really was overseeing the program, so s/he typically contacted Administrator C or RD G instead.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018749	A. BUILDING: _____ B. WING _____	C 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - HAYWARD I	10260 WHITE BIRCH LN HAYWARD, WI 54843

(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 214	Continued From page 8 At approximately 9:45 AM, Surveyor interviewed Resident 2 who stated if s/he had concerns s/he would go to Manager L. At approximately 10:02 AM, Surveyor interviewed Resident 1 who stated who was not sure who was in charge and maybe TL A was the administrator. At approximately 11:09 AM, Surveyor interviewed Administrator C by phone. Administrator C stated RN D was the nurse contact for the program and the administrator. Administrator C stated s/he knew things became confusing after Manager H and RN I walked out. At approximately 11:55 AM, Surveyor interviewed TL A who stated it was unclear who was in charge. TL A said if s/he had questions or needed to report something s/he would call Administrator C, RD G, or Manager L until someone answered. TL A stated s/he had been in the TL role for about 2 weeks. On 07/06/2026 at 9:23 AM, Surveyor received email communication from Administrator C that confirmed RN D became administrator for the building on 05/28/2026. Administrator C confirmed Director J would start on 07/13/2026. On 07/06/2026 at approximately 2:05 PM, Surveyor interviewed Caregiver B. Surveyor inquired who was in charge of the program and Caregiver B responded, "I have no idea." Caregiver B stated it was confusing, but s/he believed Manager L, TL M, Administrator C, and RD G could be called with questions. Caregiver B stated s/he thought staff were to call a nurse on the weekends, but who staff were to call changed all the time.	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018749	A. BUILDING: _____ B. WING _____	C 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - HAYWARD I	10260 WHITE BIRCH LN HAYWARD, WI 54843

(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 214	Continued From page 9 The provider did not ensure an administrator supervised the daily operation of the facility, programming, and personnel in a way that ensured residents received proper care and treatment. Cross references: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse And Neglect N0163 DHS 83.12(4)(a) Reporting When Resident's Whereabouts Unknown N0200 DHS 83.14(2)(e) Notify Within 7 Days Administrator Change N0426 DHS 83.38(1)(b) Supervision N0427 DHS 83.38(1)(c) Leisure Time Activities	N 214		
N 426	83.38(1)(b) Supervision. 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: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, record review and interview, the CBRF (community based residential facility) did not provide supervision appropriate to meet the resident's needs.	N 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018749	A. BUILDING: _____ B. WING _____	C 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - HAYWARD I	10260 WHITE BIRCH LN HAYWARD, WI 54843

(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 426	Continued From page 10 This is a repeat deficiency. See Statement of Deficiency (SOD) OX7211, dated 09/12/2022. Findings include: On 06/08/2026, the Department received a complaint regarding staffing. The provider is licensed to care for 16 residents in the client groups: terminally ill, irreversible dementia/Alzheimer's disease, physically disabled, and advanced aged. On 07/06/2026, Surveyor reviewed Resident 3's record. Resident 3 was admitted on 11/04/2024 and diagnosed with dementia (primary), brain aneurysm, and high risk for elopement. Resident 3 had a power of attorney (POA). Resident 3's record included the following: -Master care plan dated 06/26/2026 which read, in part, " ...Elopement Risk history of elopement ...Resident had recent elopement on 08/19/2025. Since recent elopement resident has attempted to leave facility grounds multiple times while being supervised outside smoking. Staff supervise resident with all smoking ..." -Planned Services dated 07/01/2026 which read, in part, " ...Safety Check ...Perform a visual check of the resident, every 30 minutes during daytime hours minimum and every hour after 11pm during the night to ensure their safety and well-being. Staff are to sit with resident when [s/he] is outside smoking at all times." -Resident Notes from 04/01/2026 to 06/30/2026 included: " ...04/01/2026 ...elopement threat ...about nine times today resident running away to the	N 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018749	A. BUILDING: _____ B. WING _____	C 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - HAYWARD I	10260 WHITE BIRCH LN HAYWARD, WI 54843

(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 426	Continued From page 11	N 426		

neighbor's house, staff has to be by [his/her] side 24/7 in order to stop ...
Resident tried to elope once again this evening ...Staff members were with another resident ...
04/02/2026 ...ran away to neighbors ...went to the neighbors [sic] house again while staff where [sic] with a 2 assist ...Resident was seen walking back from the neighbors [sic] house with both staff members were with a 2 assist ...resident was going outside trying to get on the transit bus ...Resident seen going outside to smoke ...staff member was going to check on resident smoking, [s/he] was not here ...seen trying to get into neighbors [sic] house ...
04/03/2026 ...Resident was seen going outside to smoke, staff went to check up on [him/her] and [s/he] was seen wandering in the parking lot ...seen walking to neighbors ...Resident trying to go to the neighbors [sic] house ...punched staff member ...went to get help ...[s/he] was no longer there ...
04/04/2026 ...redirect resident became aggressive and attempted to hit staff in the face multiple times ....tried to go to neighbors [sic] ...became verbally and physically aggressive towards staff ...slapped staff ...[s/he] walked past and hit me ...
04/05/2026 ....multiple attempts to go to the neighbors [sic] house ...
04/19/2026 ...refusing to wait for staff to be available to go out to smoke ...
04/23/2026 ...ISP (individualized service plan) updated with to reflect further interventions staff can utilize ..."

On 06/30/2026 at approximately 8:30 AM, Surveyor interviewed Team Lead (TL) A who stated Resident 3 was an elopement risk and had a Wanderguard alarm. TL A stated s/he did not believe the alarm was working properly because

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018749	A. BUILDING: _____ B. WING _____	C 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - HAYWARD I	10260 WHITE BIRCH LN HAYWARD, WI 54843

(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 426	Continued From page 12	N 426		

s/he had not heard it go off all day and s/he knew Resident 3 had been outside multiple times.

At approximately 8:30 AM, Surveyor went out the back entrance to meet with Resident 2 and Resident 3. Surveyor observed that Resident 3 got up 2 times, went back into building and came back outside. Surveyor did not observe any staff with Resident 3.

At approximately 9:41 AM, Surveyor observed Caregiver E ask TL A if the Wanderguard alarm was removed because it was not going off.

At approximately 10:04 AM, Surveyor interviewed TL A. TL A stated Resident 3 had wandered to the provider's other location (approximately 0.5 miles away). TL A stated Resident 3's family wanted staff to sit with Resident 3 whenever s/he was outside, "but we can't... only 2 staff here. I fear for [his/her] safety and wish [s/he] could move back to a locked facility." TL A stated Resident 3 had wandered into homes within the community and demanded coffee and had been found attempting to get into a transport vehicle outside. TL A stated Resident 3 had multiple elopements in 2026 and his/her ISP directed staff to be with Resident 3 whenever s/he went outside.

At approximately 11:35 AM, Surveyor interviewed TL A who stated Resident 3's Wandergaurd alarm was supposed to go off when s/he exited either the front or back door. TL A stated staff were to be outside with him/her but Resident 3's Wanderguard alarm goes off every 2-3 minutes and it was not possible. TL A stated the back yard exit area was not enclosed.

The provider did not ensure adequate supervision when Resident 3 was able to leave the building

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018749	A. BUILDING: _____ B. WING _____	C 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - HAYWARD I	10260 WHITE BIRCH LN HAYWARD, WI 54843

(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 426	Continued From page 13 on multiple occasions. Cross Reference: N0214 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 426		
N 427	83.38(1)(c) Leisure time activities. 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 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, interview, and record review, the provider did not ensure there was a daily activity program to meet the interests and capabilities of the residents or develop and post an activity schedule in an area available to residents. This is a repeat deficiency. See Statement of Deficiency (SOD) 40VK12, 06/18/2024. Findings include: On 06/08/2026, the Department received a	N 427		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018749	A. BUILDING: _____ B. WING _____	C 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - HAYWARD I	10260 WHITE BIRCH LN HAYWARD, WI 54843

(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 427	Continued From page 14 complaint regarding administration and staff. The provider is licensed to care for 16 residents in the client groups: terminally ill, irreversible dementia/Alzheimer's disease, physically disabled, and advanced aged. On 06/30/2026, Surveyor observed that no activities occurred between 8:10 AM and 12:20 PM. At approximately 9:45 AM, Surveyor interviewed Resident 1 who stated there were very few activities occurring. At approximately 10:02 AM, Surveyor interviewed Resident 2 who stated there was not much to do. At approximately 12:03 PM, Surveyor interviewed Team Lead (TL) A who stated s/he tried to do activities at least 1 time a day but often there was no time. TL A stated there was supposed to be a posted calendar, but s/he was unsure if it was updated. TL A stated s/he would like to change the calendar to events that the residents were interested in participating. TL A stated Daily Chronicles was typically on the calendar Monday through Friday, but the residents were not interested as they preferred watching the news. TL A stated some of the residents would play weekly Bingo and 1 time s/he manicured a resident's nails. Surveyor reviewed the posted activity schedule dated April 2026. Activities listed for 06/30/2026 were: 10:00 Snack 11:00 Daily Chronicles 2:00 Bingo	N 427		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018749	A. BUILDING: _____ B. WING _____	C 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - HAYWARD I	10260 WHITE BIRCH LN HAYWARD, WI 54843

(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 427	Continued From page 15 On 07/06/2026 at approximately 2:05 PM, Surveyor interviewed Caregiver B who stated there was about 1 activity completed each week. Caregiver B was not sure if the posted activity schedule was current. The provider did not ensure there were activities the residents were interested in or that a current activity calendar was posted. Cross Reference: N0214 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 427		