STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018751	A. BUILDING: _____ B. WING _____	C 07/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - HAYWARD II	15497 PINEWOOD DRIVE 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 II. Data was collected through 07/08/2026. One of 2 complaints was substantiated. Four new violations were identified. Four of 4 violations were repeat deficiencies. See Statement of Deficiency (SOD) JYPQ12, dated 06/24/2025, and JYPQ11, dated 08/28/2024. Census: 12	N 000		
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. This is a repeat deficiency. See Statement of Deficiency (SOD) JYPQ11, dated 08/28/2024 Findings include: On 06/08/2026, the Department received a complaint regarding administration and staff. The provider is licensed to care for 13 residents in the client groups: irreversible dementia/Alzheimer's disease, physically disabled, developmentally disabled, and advanced aged.	N 200		

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

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N 200	Continued From page 1 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, 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.	N 214		

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N 214	Continued From page 2	N 214		

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.

This is a repeat deficiency. See Statement of Deficiency (SOD) JYPQ12, dated 06/25/2025 and SOD JYPQ11, dated 08/28/2024.

Findings include:

The provider is licensed to care for 13 residents in the client groups advanced aged, terminally ill, physically disabled, irreversible dementia/Alzheimer's disease, and developmentally disabled.

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.
- Resident 4 did not receive medication.
- Residents were not offered a daily activity program.

On 06/30/2026 at approximately 12:45 PM, Surveyor interviewed Caregiver B. Surveyor asked who was in charge and Caregiver B stated

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typically Team Lead (TL) J was in charge. Caregiver B stated TL J was on call 24/7, and TL J would soon be transferring to another program. Caregiver B stated information about who was in charge changed often and was very confusing. Caregiver B stated they could reach out to a nurse on the weekend, but it was unclear who to call for each situation. Caregiver B stated Administrator C and Regional Director (RD) E could also be called.

At approximately 2:20 PM, Surveyor interviewed Caregiver A who stated s/he was unsure who the administrator was.

At approximately 2:26 PM, Surveyor interviewed Resident 3 who stated s/he did not know who was in charge and had not been introduced to an administrator.

On 07/08/2026 at approximately 12:00 PM, Surveyor interviewed Administrator C and RD E. Administrator C confirmed Manager F and Registered Nurse (RN) G walked off the job on 04/27/2026. Administrator C stated RD E and Administrator C covered the program for a few days and then interim directors from other programs would rotate in to cover the program. Administrator C confirmed that RN D started in the administrator role on 05/28/2026. Administrator C stated things had been very confusing. Administrator C confirmed Manager H had been hired to oversee the program and was starting on 07/13/2026 and RN I had been hired to oversee the program and was starting on 07/27/2026.

The provider did not ensure an administrator supervised the daily operation of the facility, programming, and personnel in a way that

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N 214	Continued From page 4 ensured residents received proper care and treatment. Cross references: N0200 DHS 83.14(2)(e) Notify Within 7 Days Administrator Change N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medications N0427 DHS 83.38(1)(c) Leisure Time Activities	N 214		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the right for Resident 4 to receive prescribed medications. This is a repeat deficiency. See Statement of Deficiency (SOD) JYPQ12, dated 06/24/2025 and SOD JYPQ11, dated 08/28/2024. Findings include: The provider is licensed to care for 13 residents in the client groups: irreversible dementia/Alzheimer's disease, physically disabled, developmentally disabled, and advanced aged. On 07/08/2026, Surveyor reviewed Resident 4's	N 352		

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record. Resident 4 was admitted on 05/20/2026 and was diagnosed with unspecified dementia unspecified severity with other behavioral disturbances, unspecified mood disorder, anxiety, and chronic musculoskeletal pain. Resident 4 had a guardian. Resident 4's record included the following:

-A medication error report, dated 05/23/2026 at 2:20 AM included, in part, " ...Resident was admitted to facility on 05-20-26 without signed medication orders ...Resident enrolled with rounding service ...upon admission. Intake appt [appointment] was not set until Wednesday, May 27th, 2026 ...[Administrator C] spoke with [physician] on Saturday, May 23rd, 2026, to have medication orders sent to ...pharmacy on an emergency fill basis ...". The report indicated the following medications were not given: Acetaminophen 325mg, Artificial Dro Tears, Carbamide Peroxide 6.5% Otic Solution, Clotrimazole 1% Cre, Gold Bond Med Body 0.8% Powder, Hydrocortisone 1% Cream, Loperamide, Lorazepam 0.5, Minerin Lot, Mirtazapine 30 mg, Pantoprazole 40 mg, and Trolamine.

On 07/08/2026 from 11:37 AM to 12:26 PM, Surveyor interviewed Administrator C and Regional Director (RD) E who stated they were contacted by Team Lead (TL) J on 05/23/2026 at approximately 2:20 AM as Resident 4 was experiencing agitation and physical aggression towards staff, the police had been contacted, and Resident 4 had been transferred to the hospital. RD E stated s/he was checking the MAR (medication administration record) to see if there were medications to assist with behaviors when s/he observed all medications had been on hold since Resident 4 admitted on 05/20/2026. Administrator C stated Registered Nurse (RN) K

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N 352	Continued From page 6 did not reach out to anyone to procure orders or inform anyone of the issue. Administrator C stated s/he did not know why RN K made this decision and stated RN K had left their employment. Surveyor reviewed Resident 4's May 2026 MAR and observed that no medications had been administered from 05/20/2026 to 05/23/2026 when Resident 4 went to the emergency room (ER). The provider did not ensure Resident 4 had the right to receive medication as ordered resulting in Resident 4 not receiving medications for 3 days.	N 352		
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	N 427		

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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) JYPQ12, 06/24/2025 and JYPQ11, dated 08/28/2024.

Findings include:

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

The provider is licensed to care for 13 residents in the client groups: irreversible dementia/Alzheimer's disease, physically disabled, developmentally disabled, and advanced aged.

On 06/30/2026, Surveyor observed that no activities occurred between 12:40 PM and 3:15 PM.

At approximately 1:56 PM, Surveyor interviewed Resident 1 who stated there were no activities occurring, and that s/he would like to try new things.

At approximately 2:09 PM, Surveyor interviewed Resident 2 who stated activities maybe occurred 1 time a week. Resident 2 stated s/he would like to see activities that were occurring outside of the building.

At approximately 2:26 PM, Surveyor interviewed Resident 3 who stated s/he had not observed any activities and there was nothing to do.

At approximately 2:41 PM, Surveyor interviewed Caregiver A who stated, "I'm not going to lie,

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N 427	Continued From page 8 nothing is planned, and we get busy." Surveyor asked if an activity schedule was posted and Caregiver A responded, "I don't know." Caregiver A stated s/he thought the team lead was to post the activity schedule, but s/he did not think one was posted. At approximately 3:15, Surveyor interviewed Caregiver B who stated it was rare for activities to occur. At approximately 3:20 PM, Surveyor observed an activity schedule was posted and was dated April 2026. The provider did not ensure there were activities the residents were interested in or that a current posted activity calendar was posted. Cross Reference: N0214 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 427		