Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 0018749	(X2) MULTIPLE CONSTRUCTION A. BUILDING B.WING	(X3) DATE SURVEY COMPLETED 10/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING- HAYWARD I	**10260 WHITE BIRCH LN , HAYWARD, Wisconsin, 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)	(XS) COMPLETION DATE
N0000	Initial Comments On 09/24/2026, Surveyors conducted a complaint investigation and self-report review at Vitacare Living Hayward I. Data was collected through 10/05/2026. Five of 7 complaints were substantiated. Six violations were identified. One of 6 violations was a repeat deficiency. See Statement of Deficiency (SOD) OX7211, dated 09/12/2022. Census: 15.	N0000		
N0158	Caregiver: Investigating abuse & neglect 83.12(2)(a) 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview the provider did not investigate and document an allegation of abuse or neglect of a resident.	N0158		

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

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N0158	Continued from page 1 Findings include: On 07/14/2026 and 08/26/2026, the Department received complaints regarding neglect. 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 09/24/2026 at approximately 9:30 AM, Surveyor interviewed Regional Director (RD) C and RD D regarding an incident that occurred on 07/12/2026 with Resident 6. RD C and RD D stated Team Lead (TL) F had informed them that Residents 6's state was not as bad as hospice indicated. On 09/28/2026 from 2:40 PM to 3:20 PM, Surveyor interviewed Caregiver G who stated Hospice Nurse (HN) H told him/her how bad of condition Resident 6 was in when hospice visited on 07/12/2026. On 09/26/2026 from 10:21 AM to 10:50 AM, Surveyor interviewed Hospice Director (HD) I who stated on 07/13/2026, s/he spoke with RD C and RD D about the condition Resident 6 was found and was informed by RD C and RD D that they were going to figure this out. On 09/29/2026 at 2:36 PM, Surveyor received an email communication titled [Hospice] Complaints Form from HD I that included the following: -"... Date of Occurrence 2026-07-12 ... an RN visit on 7/12/26. It was noted that [Resident 6] was half on and half off the bed ... Nasal cannula for O2 [oxygen] was on the floor. Arms and legs were mottling and cold to the touch. Bed was in high position ..45 degrees ... [Resident 6] had slid down in the bed. Brief saturated and appeared unchecked. Powder/cream was caked onto peri area and had to be soaked off. Patient was repositioned and moved, [s/he] cried out in pain ... Staff did not know when morphine was given ... PC [phone call] with ... [RD D] and [RD C] ... Explained the situation and they said they would look into it on their end. They expressed understanding of my reporting to the state..." On 09/30/2026 from 11:05 AM to 12:20 PM,	N0158		

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N0158	Continued from page 2 Surveyor interviewed RD C and RD D. Surveyor asked if an investigation had been completed. RD C stated that TL F may have documented the event. On 10/01/2026 from 10:47 AM to 11:18 AM, Surveyor interviewed TL F who stated that on 07/12/2026, s/he was walking into Resident 6's room to change his/her brief when HN J arrived. TL F stated Resident 6's bed was horizontal and s/he asked HN J to assist with a bed bath.TL F stated Resident 6 was always cold to the touch, his/her nasal canula came off often, his/her feet were off the side of the bed, and safety checks had been completed every 2 hours. TL F stated HN J never said anything to him/her about Resident 6's condition. As of 10/05/2026, Surveyor had not received an investigation from the provider regarding the condition Resident 6 was found on 07/12/2026. The provider did not conduct an investigation into potential neglect of Resident 6. Cross reference: N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N0158		
N0164	Reporting when law enforcement is called. 83.12(4)(b) A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider did not send a written report to the Department within 3 working days after law enforcement personnel were called to the program following an	N0164		

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N0164	Continued from page 3 incident when Resident 3 became agitated and did not want to go to the hospital. Findings include: On 09/09/2026, the Department received a complaint regarding behavior. The provider is licensed to care for 16 residents in the client groups terminally ill, physically disabled, advanced aged and irreversible dementia/Alzheimer's disease. On 09/30/2026, Surveyor reviewed Resident 3's record. The record included a document titled Incident [Resident 3] dated 08/19/2026 read, " ... Suspected UTI [urinary tract infection] ... emergency services summoned ... yes ... [Resident 3's] [family] called and wanted [Resident 3] sent out immediately ... refused ... to go to the hospital for about an hour unless [s/he] spoke to an officer ... 911 was called ... officers talked him/her into going in ..." A review of the Department's files indicated there had not been any self-reports submitted by the provider related to Resident 3. On 09/30/2026 at approximately 11:52 AM, Surveyor interviewed Regional Director (RD) C and RD D who were asked if it was policy a self-report be submitted for Resident 3's incident. RD C and RD D stated the incident should have been reported to DQA (Department of Quality Assurance). RD C stated Former Director (FD) E was responsible for self-reports, and that RD C and RD D were not informed of the incident until 09/30/2026. The provider did not send a written report to the Department when law enforcement was called to the facility due to Resident 3's behavior. Cross reference: N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N0164		

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N0196	Licensee ensures facility complies with laws 83.14(2)(a) The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the licensee did not ensure compliance with all laws governing the operation of the program and facility. Findings include: 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. In the past 6 years, the provider displayed a pattern of noncompliance with regulations. Over the course of the following surveys, the provider received a total of 16 violations and 3 substantiated complaints: -SOD OX7211, dated 09/12/2022, which included the following deficiency: Supervision -SOD OX7212, dated 01/27/2023, which included the following deficiency: Nutrition: Menus -SOD 40VK11, dated 11/30/2023, which included the following deficiencies: Implement, Following The Individual Service Plan; Service Plans Updated Annually Or On Changes -SOD 40VK12, dated 06/18/2024, which included the following deficiencies: Maintain current written staffing schedule; Leisure Time Activities, Toilet And Bathing Area, Habitable Room Window Coverings -SOD 40VK13, dated 11/10/2025, which included the following deficiencies: Environment Safe, Clean, And Comfortable -SOD J81L11, dated 07/07/2026, which included the following deficiencies: Caregiver Investigating Abuse & Neglect; Reporting When Resident's Whereabouts Unknown; Notify within 7 days of Administrator Change; Administration Shall Supervise Daily Operation; Supervision; Leisure Time Activities	N0196		

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N0196	Continued from page 5 On 12/6/2022, the Department issued SOD OX7211, which resulted in enforcement action. The enforcement action included an order to comply with the requirements, that read, in part, "... licensee shall correct all violations identified in Statement of Deficiency (SOD) OX7211 and will achieve substantial compliance with all laws and administrative rules governing the facility and it's operation prior to expiration of facilities probationary license on 04/29/2023." On 08/14/2026, the Department issued SOD J81L11 which resulted in enforcement action. The enforcement action included a notice of special orders that read, in part, "... effective immediately, the licensee shall develop and implement corrective measures to ensure all residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected." The current survey was prompted by 7 complaints. Six of 7 complaints were substantiated. One of 6 citations was a repeat violation. The Statement of Deficiency (SOD) J81L11, dated 07/07/2026 was sent to the provider on 08/14/2026 and the provider was ordered to correct the deficiencies within 45 days. The deficiencies included the following: -Caregiver Investigating Abuse and Neglect, -Supervision. The current survey resulted in the following deficiencies: 83.12(2)(a) Caregiver: Investigating Abuse & Neglect 83.12(4)(b) Reporting When Law Enforcement Is Called 83.14(2)(a) Licensee Ensures Facility Complies With Laws 83.32(3)(h) Right Of Resident: Receive Medication 83.38(1)(b) Supervision 83.47(2)(d) Fire Drills	N0196		

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N0196	Continued from page 6 Cross References: N0158 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0164 83.12(4)(b) Reporting When Law Enforcement IS Called N0352 83.32(3)(h) Right Of Resident: Receive Medication N0426 83.38(1)(b) Supervision N0525 83.47(2)(d) Fire Drills	N0196		
N0352	Rights of Residents: Receive medication 83.32(3)(h) 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider did not ensure Resident 5 received all prescribed medications in the dosage and at intervals prescribed by a practitioner. Findings include: On 08/31/2026, the Department received a complaint regarding medications. 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 09/24/2026 at approximately 10:15 AM, Surveyor interviewed Regional Director (RD) C and RD D who stated Resident 5 had a urinary tract infection (UTI) in August 2026. RD C and RD D stated Resident 5 had prescription orders for 2 antibiotics. RD C and	N0352		

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N0352	Continued from page 7 RD D were not aware if there were errors with how the 2 antibiotics were administered. On 09/30/2026, Surveyor reviewed the following in Resident S's record: -A document titled E-Rx New Prescription dated 08/20/2026 read, in part, "... nitrofurantoin ... (Macrobid) 100 MG capsule ... Take 1 Capsule [sic] by mouth two times a day with meals for 7 days ... infection ... " and -A document titled E-Rx Prescription dated 08/23/2026 read, in part, "... ciprofloxacin (Cipro) 500 MG tablet ... Take 1 Tablet [sic] by mouth every 12 hours for 7 days ... infection ... " -A Medication Administration Record (MAR) for August 2026 included the following: "Ciprofloxacin Tab 500mg (Every 12 [sic] 500 mg days [sic] Take one tablet by mouth every 12 hours for 7 days ... " The MAR indicated staff were to administer only 1 dose in August on 08/25/2026 which occurred at 4:50 PM. "Ciprofloxacin (Cipro) (Daily) 500 mg Take twice daily ... " The MAR indicated staff were to administer the first dose on 08/29/2026 at 8:00 AM. The 08/29/2026 was not signed by staff. On 09/30/2026 from 11:05 AM to 12:20 **PM,** Surveyor interviewed RD C and RD D who stated that Former Director (FD) E had entered Resident S's Ciprofloxacin order to be administered 2 times a day every 12 days and that Team Lead (TL) F had discovered the error on 08/29/2026 and made the correction in the MAR. On 10/01/2026 from 10:47 AM to 11:18 AM, Surveyor interviewed Team Lead (TL) F who stated that since s/he was moved to cover the program s/he had found multiple medication errors. TL F stated FD D had been responsible for entering medication orders. In summary, Resident S's Ciprofloxacin was ordered on 08/23/2026, added to the MAR incorrectly on 08/25/2026, and corrected on the MAR on 08/29/2026. The transcription error resulted in 7	N0352		

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N0352	Continued from page 8 missed doses. Cross reference: N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N0352		
N0426	Supervision. 83.38(1)(b) 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the CBRF (community based residential facility) did not provide supervision appropriate to meet the resident's needs. Resident 4 eloped from the facility 3 times between 09/19/2026 to 09/21/2026. This is a repeat deficiency. See Statement of Deficiency (SOD) OX7211, 09/12/2022. Findings include: On 09/23/2026, the Department received 3 facility self-reports from the provider, all of which described elopement incidents for Resident 4. The first report indicated Resident 4 had left the facility on 09/19/2026 while outside smoking. Staff were unable to find Resident 4 on facility grounds, and law enforcement ultimately found him/her and escorted him/her back to the facility. The second report indicated Resident 4 had left the facility grounds after going outside to smoke on 09/20/2026. A neighbor brought Resident 4 back to the facility. The third report indicated Resident 4 had wandered from the facility while out smoking on 09/21/2026. Staff called law enforcement when they could not locate Resident 4. Resident 4 returned to the facility on his/her own before law enforcement arrived. The provider is licensed to care for 16 residents in the client groups: terminally ill, irreversible	N0426		

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N0426	Continued from page 9 dementia/Alzheimer's disease, physically disabled, and advanced aged. On 09/24/2026, at approximately 9:22 AM, Surveyor interviewed Caregiver A. Caregiver A stated it was hard to care for all residents at the facility because there were not enough staff to perform resident cares, and Resident 4 frequently attempted to elope. On 09/30/2026, Surveyor reviewed Resident 4's record. Resident 4 was admitted on 11/04/2024 and diagnosed with dementia (primary), brain aneurysm, and high risk for elopement. Resident 4 had a power of attorney (POA). Resident 4's record included shift notes from 08/01/2026 to 09/25/2026 and his/her planned services. The shift notes included the following information: - A note dated 08/20/2026, which read, 'Walked off to a the [sic] property." - A note dated 09/10/2026, which read, 'Wandering by road [sic] and [nearby neighborhood complex] office today" - A note dated 09/13/2026, which read, 'Wandering more often by road [sic]" - A noted dated 09/13/2026, which read, "Resident has tried eloping 3 times today. Also, shortly after [s/he] came back from lunch with [his/her] [sibling] [s/he] [sic] went into a staff members [sic] car and started smoking. PRN [as-needed] lorazepam was given earlier after [his/her] first attempt to leave, but has been ineffective and can only be given every 6 hours." - A note dated 09/15/2026, which read, "Resident has been having wandering tendencies and leaving the property for about a week now. Today when [Resident 4] went outside to smoke after lunch [sic] before we could even get to the door prompted by the alarm system [sic] another resident was walking in saying that [Resident 4] was "Taking off going to the big building by the road", when staff immediately went to get [him/her] [sic] another resident was walking back with [him/her] from the realty company. The resident who walked [him/her] back said, "I can't live like this with [his/her] alarm going off every 5 minutes and [him/her] leaving anyways, [s/he] can't be watched 24/7 and [s/he's] going to end up in the road. This is assisted living ... I feel like I'm in a nursing home it's making me lose my mind"	N0426		

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N0426	Continued from page 10 - A note dated 09/15/2026, which read, "Keep wandering off to the road" - A note dated 09/20/2026, which read, "Resident tried to elope to the neighbors [sic] next door to the facility. Neighbor brought resident back to the facility stating that [s/he] was looking for coffee." - A note dated 09/20/2026, which read, "Resident had a better day, still attempting elopement." - A note dated 09/22/2026, which read, "[Resident 4] takes off every time [s/he] go [sic] out to smoke, every 10 minutes" - A note dated 09/22/2026, which read, in part, "Resident has been leaving the property followed by staff all day about every 10-15 minutes since 8:00AM [sic]. Resident is walking to other buildings/properties and by the road. Staff has been redirecting [him/her] with snacks and coffee but 10-15 minutes later it happens again ..." - A note dated 09/23/2026, which read, in part, "Resident has been wandering and try [sic] to leave the property every smoke break [s/he] takes ..." Resident 4's planned services, dated 09/24/2026, included the following information: - Staff were to perform a visual check of Resident 4 every 30 minutes during daytime hours and hourly past 11:00 PM. The "Safety Check" portion of the planned services read, in part, "... Staff are to sit with resident when [s/he] is outside smoking at all times." - Staff were to monitor Resident 4 when s/he was outside smoking at all times due to his/her increased elopement rise. The "smoking" portion of the planned services read, in part, "... Staff are to sit with resident until [s/he] goes back inside." - The planned services read, in part, "Manage Behavior - Elopement Threat AM - Daily ... Target behavior-seeking [child], exit seeking to go hom Triggers- Dx [diagnosis] of Dementia, missing home Goals-decreased behaviors due to successful redirection and participation in activities of choice Interventions- allow resident to help with chores that are appropriate, call [children], offer activities of choice ... , offer snack, perform a visual check of the resident to ensure their safety and well-being, staff can also allow periods of time for [Resident 4] to ambulate about the yard and parking lot for some	N0426		

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N0426	Continued from page 11 physical activity during times staff is also outside with [him/her] ..." The provider did not ensure adequate supervision when Resident 4 was able to leave the building on multiple occasions. Cross reference: N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N0426		
N0525	Fire drills. 83.47(2)(d) Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider did not conduct fire evacuation drills at least quarterly with both employees and residents. Findings include: On 08/11/2026, the Department received a complaint regarding fire drills. The provider is licensed to care for 16 residents in the client groups terminally ill, physically disabled, advanced aged and irreversible dementia/Alzheimer's disease. On 09/30/2026 at approximately 11:52 AM, Surveyor	N0525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 0018749	(X2) MULTIPLE CONSTRUCTION A. BUILDING B.WING	(X3) DATE SURVEY COMPLETED 10/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING- HAYWARD I	**10260 WHITE BIRCH LN , HAYWARD, Wisconsin, 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) COMPLETION DATE
N0525	Continued from page 12 interviewed Regional Director (RD) C and RD D who stated they believed a fire drill was conducted in February 2026 and July 2026. Surveyor requested documentation of completed fire drills conducted in 2026. On 09/30/2026 2:31 PM, Surveyor received an email communication from RD C that included documentation of fire drill completed on 07/22/2026. RD C stated, 'We were unable to locate the 2/26 fire drill ..." The provider did not conduct quarterly fire drills. Cross reference: N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N0525		