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 08/28/2024

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 06/03/2024, Surveyor began a self-report investigation and complaint investigation at Vitacare Living - Hayward II. Data was collected through 08/28/2024. Two of 2 complaints were substantiated. Twelve violations were identified. Census: 7 on 06/03/2024 and 5 on 08/26/2024	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 interview and record review, the licensee did not notify the Department within 7 days of a change in administrator. Findings include: On 06/02/2024, Surveyor reviewed the provider's correspondence with the Department. On 11/20/2023, the provider notified the Department of an administrator change, naming Clinical Nurse Director (CND) M as the person responsible for the daily operation. The Department did not receive notice of a change in administration after 11/20/2023. On 06/03/2024 at approximately 9:45 AM, Surveyor conducted an entrance meeting with Executive Director (ED) A and Clinical Nurse Director (CND) B. CND B explained the provider's management structure, stating s/he took over CND M's role as the administrator around March	N 200		

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
	0018751	A. BUILDING: _____ B. WING _____	C 08/28/2024

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 200	Continued From page 1 2024. At 3:20 PM, CND B confirmed s/he was hired on 02/06/2024, and s/he assumed administrator responsibilities around the end of February/early March.	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. 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: 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. On 06/03/2024 at approximately 9:45 AM,	N 214		

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 08/28/2024

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 214	Continued From page 2 Surveyor conducted an entrance meeting with Executive Director (ED) A and Clinical Nurse Director (CND) C. ED A and CND C discussed the provider's management structure, which included an assistant executive director (AED) and ED at each location. CND C stated each facility owned by the licensee had a CND who was responsible for the daily operation of multiple locations. CND C stated the CND was the named administrator for each location but was not typically onsite daily. At approximately 3:20 PM, CND C indicated s/he was hired on 02/06/2024, and s/he assumed administrator responsibilities around the end of February/early March. Prior to this time, CND M was the administrator at the location. CND C shared that the provider experienced a turnover in management (AED and ED) and lost many staff with the change between April and May 2024. CND C explained that AED B, hired 05/08/2024, and ED A, an ED from a neighboring facility, were the managers at the facility. On 06/18/2024 at 2:00 PM, Surveyor interviewed CND C. CND C stated ED A was no longer acting as the ED at the location; AED B had been promoted to the ED position. On 08/27/2024 at 11:30 AM, Surveyor interviewed CND C. CND C stated AED B stepped down from leadership and chose to work at the facility as a caregiver. CND C stated ED A was relocated to the facility in the interim, along with his/her AED at the Spooner location, AED L. CND C stated this transition occurred mid-August. CND C stated, "It has been very trying... [AED B] had no experience as an ED... [s/he] did not get proper training and unfortunately, [s/he] became burned out."	N 214		

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 08/28/2024

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 214	Continued From page 3 The survey was prompted by 2 complaints and a self-report. The complaints were substantiated, and the following issues were identified during the course of the survey: - Residents did not receive medications as ordered. - Residents were not thoroughly assessed prior to admission, resulting in an emergency discharge. - Temporary service plans were not in place upon admission. - Service plans were not updated when residents experienced a change in condition. - Adequate staff numbers were not provided to meet resident needs. - Accurate staff schedules were not maintained. - Medications were not destroyed according to the provider's written policy. - Medications were not securely stored. - Residents did not receive adequate supervision to meet their needs. - Residents were not offered a daily activity program. Cross references: N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0385 DHS 83.35(2) Temporary Service Plan N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0396 DHS 83.36(1)(a) Adequate Staff To Meet Resident Needs N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule N0406 DHS 83.37(1)(g) Disposition Of Medications N0419 DHS 83.37(3)(c) Medication Storage: Locked Cabinet	N 214		

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 08/28/2024

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 214	Continued From page 4 N0426 DHS 83.38(1)(b) Supervision 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 Resident 3 received his/her medications as prescribed when the provider failed to timely refill his/her medication in June and July 2024. Findings include: On 06/26/2024, the Department received a complaint related to medication services. On 08/26/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the facility on 03/27/2024. Resident 3's medication administration record (MAR) indicated Resident 3's mag (magnesium) oxide tablet 400 mg, take daily at 8:00 AM, was not administered from 06/08/2024 through 07/30/2024. The notes on the MAR during this timeframe indicated the medication was not available or out of stock. On 08/26/2024 at 11:55 AM, Surveyor interviewed	N 352		

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 08/28/2024

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 352	Continued From page 5 Assistant Executive Director (AED) L. AED L stated s/he started working at the facility in August 2024 to provide interim coverage until the provider could hire management for the location. AED L stated s/he contacted the pharmacy and learned that Resident 3's mag oxide was delivered to the facility on 05/24/2024. AED L stated 14 tablets of the medication were delivered on 05/24/2024 and the pharmacy did not receive a refill request until 07/25/2024. AED L stated Resident 3 would have run out of the medication on 06/07/2024. On 08/27/2024 at 11:30 AM, Surveyor interviewed Clinical Nurse Director (CND) C. CND C stated there was a 12-week period when AED B took on the role of the executive director (ED) and things were missed. CND C stated s/he could not say for certain why Resident 3's medication was not refilled in June and July but s/he stated it was not good for a resident to miss their medication for that length of time. CND C said it was possible staff did not notify AED B that the medication was out. CND C stated, "We never got to a place where we could audit the med (medication) cart." CND C also stated management did not routinely review resident MARs during that timeframe. CND C stated things were unorganized and AED B was not thoroughly trained on the ED role.	N 352		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. 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	N 381		

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 08/28/2024

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 381	Continued From page 6 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 2 was assessed prior to admission. Resident 2 was discharged within 6 days of admission because the provider could not meet his/her needs. 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. On 06/26/2024, the Department received a complaint related to admission procedures. On 08/26/2024 at approximately 9:30 AM, Surveyor interviewed Caregiver K. Caregiver K discussed Resident 2's placement. Caregiver K stated s/he worked with Resident 2 the day s/he was admitted to the facility. Caregiver K said staff were given very little information about Resident 2, but they quickly found out they could not meet Resident 2's needs. Caregiver K stated Resident 2 came to the facility with a tracking device that allowed family to locate him/her when s/he ran away at home. Caregiver K stated Resident 2 required one-on-one supervision because "we couldn't keep [him/her] in the building." Caregiver	N 381		

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 08/28/2024

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 381	Continued From page 7 K said Resident 2 was discharged to another facility that could meet his/her needs within 1 week. At approximately noon, Executive Director (ED) A provided Surveyor with Resident 2's complete record. ED A stated Resident 2 was not a respite or emergency placement, and s/he could not locate an assessment. Resident 2 was admitted to the facility on 06/19/2024. Resident 2's record included 2 medical appointment summaries. Both summaries were printed on 06/18/2024. The first summary, dated 05/03/2024, indicated Resident 2 was seen by his/her primary as a follow up to an emergency department visit. The document read, "History of Present Illness...F/U (follow up) to [his/her] cognitive and behavioral changes with the biggest behavior being the wandering off at night. [S/he] had to be picked up 1.5 hours away from [his/her] home as [s/he] walked all night. [S/he] was recently evaluated in our ED (emergency department). Psych was consulted but did not feel [his/her] behaviors reflected psychosis/mental health issues." The second summary, dated 06/18/2024, indicated Resident 2 was seen to complete paperwork for his/her admission to the facility. The summary read," [Resident 2's] cognitive status has steadily declined. [S/he] continues to wander if [s/he] is not being closely watched." According to information obtained during an interview on 06/03/2024 at 9:45 AM with Clinical Nurse Director (CND) C and ED A, CND C was responsible for multiple programs within the provider's network and each program had an executive director and assistant executive director to oversee the daily operations of the	N 381		

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 08/28/2024

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 381	Continued From page 8 individual programs. On 08/27/2024 at 11:30 AM, Surveyor interviewed CND C, who stated Assistant Executive Director (AED) B took the executive director position for a short time and had since decided to leave management to work as a caregiver. CND C said AED B was new to the executive director position when Resident 2's referral came in. CND C said AED B completed Resident 2's preadmission assessment and found no indication Resident 2 was an elopement risk or needed constant supervision. CND C said Resident 2's managed care organization (MCO) made the placement referral but they were new to Resident 2 so they did not have an assessment completed on Resident 2 at the time of admission. CND C stated s/he met with Resident 2's family the day after admission to discuss concerns and behaviors they observed within the first 24 hours of placement. CND C said the family disclosed Resident 2's elopement history at this time, stating they had to place furniture in front of doors to keep Resident 2 from wandering off. Surveyor referenced the medical summaries in Resident 2's record that indicated Resident 2 had a history of elopements that required emergency services. CND C stated s/he was not aware of this record, and s/he believed AED B's assessment was based solely on the information provided by Resident 2's family. CND C stated s/he could not locate an assessment summary; s/he believed the assessment occurred on 06/13/2024. CND C stated that had s/he been more involved with the assessment, s/he could have prevented the placement from happening. CND C said AED B was not fully trained in the executive director role and CND C was aware procedures were not followed.	N 381		

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 08/28/2024

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 381	Continued From page 9 On 08/27/2024 at 2:49 PM, Surveyor received an email from CND C that included Resident 2's initial referral information. The email thread (dated 06/12/2024 through 06/17/2024) identified Resident 2 as someone who needed supervision and redirection due to wandering behaviors.	N 381		
N 385	83.35(2) Temporary Service Plan. 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 2 had a temporary service plan (TSP) upon admission. 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. On 06/26/2024, the Department received a complaint related to resident care. On 08/26/2024 at approximately 9:30 AM, Surveyor interviewed Caregiver K. Caregiver K discussed Resident 2's placement. Caregiver K stated s/he worked with Resident 2 the day s/he was admitted to the facility. Caregiver K said staff were given very little information about Resident 2	N 385		

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 08/28/2024

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 385	Continued From page 10	N 385		

but they quickly found out they could not meet Resident 2's needs. Caregiver K stated Resident 2 came to the facility with a tracking device that allowed family to locate him/her when s/he ran away at home. Caregiver K stated Resident 2 required one-on-one supervision because "we couldn't keep [him/her] in the building." Caregiver K said Resident 2 was discharged to another facility that could meet his/her needs within 1 week.

At approximately noon, Executive Director (ED) A provided Surveyor with Resident 2's complete record. ED A stated Resident 2 was not a respite or emergency placement, and s/he could not locate a TSP or evidence of a care plan for Resident 2. ED A stated Assistant Executive Director (AED) B was the ED when Resident 2 resided at the facility. ED A stated Resident 2's electronic record did not include scheduled services or tasks for staff to follow.

Surveyor reviewed Resident 2's observations notes which indicated Resident 2 required emergency services on 06/19/2024 (date of admission) for panic attacks. Notes also indicated Resident 2's family brought Resident 2 to the emergency department a second time on 06/19/2024 to get medication to calm Resident 2. Notes from 06/20/2024 through 06/21/2024, referenced behaviors that included elopements, paranoia, and delusions. Notes indicated the provider requested Resident 2's family to assist with supervision during nighttime hours on 06/20/2024. There were no notes after 06/21/2024 but based on Resident 2's medication administration record, Resident 2 resided at the facility until 06/25/2024.

According to information obtained during an

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 08/28/2024

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 385	Continued From page 11 interview on 06/03/2024 at 9:45 AM with Clinical Nurse Director (CND) C and ED A, CND C was responsible for multiple programs within the provider's network and each program had an executive director and assistant executive director to oversee the daily operations of the individual programs. On 08/27/2024 at 11:30 AM, Surveyor interviewed Clinical Nurse Director (CND) C. CND C said AED B was new to the ED position when Resident 2's referral came in. CND C said AED B did not receive proper training and s/he did not complete Resident 2's record. CND C said Resident 2's service plan was not complete. CND C said AED B and CND C provided verbal direction to staff on how to care for Resident 2 during his/her placement. CND C stated, "It was unorganized. I take full ownership of that... I know certain things were not done."	N 385		
N 389	83.35(3)(d) Service plans updated annually or on changes 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 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.	N 389		

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 08/28/2024

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 389	Continued From page 12 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure individual service plans (ISP) for Resident 1, Resident 3, and Resident 4, were revised when their needs changed. The provider did not obtain a signature from Resident 1's legal representative indicating his/her agreement with the ISP. 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. On 04/30/2024 and 06/26/2024, the Department received complaints related to resident care. RESIDENT 1 On 06/03/2024 and 06/07/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 02/26/2024 and s/he began hospice services on 04/01/2024. His/her diagnoses included intracerebral hemorrhage, traumatic brain injury, hard of hearing, aphasia, impaired communication with impaired cognition, and chronic pain. Resident 1's record indicated s/he eloped from the facility 6 times between 03/07/2024 and 04/01/2024. Incident reports indicated the following interventions should have been added to prevent further incidents: - 03/10/2024 - eloped at 10:40 AM and at 7:30 PM; interventions included 1-hour safety checks. - 04/01/2024 - eloped at 6:24 PM; intervention did not change. Resident 1 remained on 1-hour	N 389		

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 08/28/2024

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 389	Continued From page 13	N 389		

safety checks.
- 04/13/2024 - eloped at 2:30 PM and 6:00 PM; interventions read, "2 staff at all times. One staff member out in the common areas where they can intervene and redirect [him/her]."
- 04/17/2024 - eloped at 3:10 PM; interventions read, "Staff have been instructed by ED (executive director) that a staff member needs to be near [him/her]. Also will be getting an alarm for [his/her] door."

Resident 1's last assessment, dated 04/03/2024, read: "Resident is at risk of elopement/wandering... Resident has an impaired cognitive diagnosis. Routine rounding is done by staff to ensure resident locality. Perform a visual check of the resident to ensure their safety and well-being. All exit/entry doors have delayed egress door locks that shall open when latch is held down for 15 seconds which will activate an audible signal in the vicinity of the door." Resident 1's assessment also indicated s/he was independently ambulatory without assistive device.

Resident 1's progress notes indicated s/he displayed the following behaviors:
- Taking resident and staff items and hoarding/hiding them in his/her room.
- Hiding food in [his/her] room
- Finding cigarette butts outside and "smoking" them
- Wandering into other residents' rooms
- Eating denture cleaning tablets
- Cutting/tampering with his/her oxygen tubing
- Spitting out his/her medication

Progress notes also indicated Resident 1 was incontinent and used briefs. Between 04/12/2024 and 05/02/2024, Resident 1 experienced a

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 08/28/2024

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 389	Continued From page 14	N 389		

change in condition that included edema (noted on 04/12/2024), shortness of breath (04/22/2024), and unsteadiness while walking (05/02/2024). On 05/02/2024, Resident 1 received a fall alarm, walker, and wheelchair; however, staff noted Resident 1 often refused to utilize the mobility devices. An incident report, dated 05/13/2024, indicated Resident 1 fell in the common area, injuring his/her knee.

An incident report, dated 04/13/2024, indicated Resident 1 was touching him/herself in the common area in front of staff. Resident 1 refused to go to a private area when redirected by staff.

Resident 1's ISP, updated 05/20/2024, included elopement/wandering interventions as follows: redirection, 1-hour safety checks, supervision when Resident 1 was outside smoking, and delayed egress doors. The ISP was not updated to reflect the interventions included in Resident 1's incident reports.

Resident 1's ISP indicated Resident 1 was independent with mobility and transfers. The ISP was not updated to reflect his/her need for mobility devices or unsteadiness.

Resident 1's ISP did not reference his/her behaviors or interventions related to hoarding/hiding items and food, smoking used cigarette butts, eating nonedible items like denture cleaning tablets, masturbating in public areas, spitting out his/her medications, or tendency to destroy/tamper with his/her oxygen tubing.

Resident 1's ISP did not reference Resident 1's incontinence, edema, or fall risk status.

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 08/28/2024

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 389	Continued From page 15 On 06/03/2024 at 3:20 PM, Surveyor interviewed ED A and Clinical Nurse Director (CND) B. Surveyor asked how Resident 1's elopement interventions listed on the incident reports were communicated to staff. ED A stated they should have been added to Resident 1's ISP, but because management failed to print or save a copy of Resident 1's ISP after each revision, there was no way to see if the interventions were added to the ISP. ED A stated the edits made to Resident 1's ISP on 05/20/2024 overrode past edits, and there was no way to see when each intervention on the current ISP was added. Surveyor reviewed Resident 1's 05/13/2024 fall report with ED A. The intervention on the report read, "Staff to redirect staff when walking." ED A stated s/he wrote the intervention, and it should have said staff should redirect Resident 1 to walk around the scale (the item s/he tripped on). ED A stated the intervention should have been added to the ISP under the mobility section but was not. On 06/18/2024 at 2:00 PM, Surveyor interviewed ED A and CND B. Surveyor asked about Resident 1's behaviors. ED A stated, "It should state on the ISP what behaviors [s/he] exhibits... triggers, goals, and interventions... it should have been on there." CND B stated, "[Assistant Executive Director (AED) E] did not report the behavior report to me... it was another example of lack of communication... had I reviewed it, I would have updated the ISP." CND B informed Surveyor that Resident 1 passed away on 06/16/2024. RESIDENT 3 On 08/26/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the facility on	N 389		

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 08/28/2024

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 389	Continued From page 16 03/27/2024. Resident 3's observation notes indicated s/he had falls with injury on 07/31/2024 and 08/10/2024. His/her incident reports indicated s/he also had a fall with injury on 08/18/2024. The interventions to prevent further falls (listed on his/her incident report, dated 08/18/2024), included a pressure alarm. Resident 3's ISP was updated on 08/25/2024 by CND C. The ISP did not reference Resident 3's need for a pressure alarm. On 08/26/2024 at 12:20 PM, Surveyor interviewed ED A. ED A reviewed Resident 3's ISP and confirmed Resident 3's pressure alarm was not added to the ISP. ED A stated the intervention should be added to the mobility or safety section of the ISP. RESIDENT 4 On 08/26/2024, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the facility on 10/26/2023, with diagnoses that included diabetes and diabetic foot ulcers. Resident 4's record indicated s/he had a history of toe amputation due to diabetic wounds. Resident 4's observation notes, dated 06/01/2024 through 08/26/2024, indicated s/he had a wound on his/her toe that caused pain and required wound care. Resident 4's ISP, updated 07/17/2024, read, "Skin ... denies skin problems ... No wound present." On 08/26/2024 at 10:58 AM, Surveyor interviewed Caregiver K. Caregiver K stated staff	N 389		

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 08/28/2024

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 389	Continued From page 17 provided wound services to Resident 4 that included cleaning the wound, applying ointment, and dressing the wound. On 08/27/2024 at 11:30 AM, Surveyor interviewed CND C. CND C stated Resident 4's ISP should have been updated since 07/17/2024 to reflect his/her need for wound care services. CND C stated Resident 4 received updated wound orders on 07/25/2024, and these orders were discontinued on 08/15/2024 because his/her wound healed.	N 389		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure employees were provided in sufficient numbers on a 24-hour basis to meet resident needs. On 04/13/2024, the provider did not have a staff member at the facility to pass medications. 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 facility is located approximately 1/2 mile from another facility owned by the licensee. On 04/30/2024, the Department received a	N 396		

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 08/28/2024

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 396	Continued From page 18 complaint related to adequate staffing. On 06/03/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 02/26/2024. An incident report dated 04/13/2024 indicated Resident 1 did not receive his/her scheduled Omeprazole 20mg capsule because Assistant Executive Director (AED) E (the prior AED) did not schedule a medication passer for the 2nd shift (2:00 PM to 10:00 PM). AED E's statement on the incident report read, "I did not follow up on Saturday like I should have to make sure that a medication passer from building 1 to go pass medications at building 2." According to this incident report, Caregiver H was the caregiver working who was not able to pass medications, and s/he did not notify AED E until 8:00 PM on 04/13/2024. The medication was scheduled for 4:00 PM. Between 06/03/2024 and 06/17/2024, Surveyor reviewed staff schedules and could not determine if there was a medication passer at the facility on 04/13/2024 or any date after. On 06/18/2024 at 2:00 PM, Surveyor interviewed Executive Director (ED) A and Clinical Nurse Director (CND) B. CND B stated AED E called him/her around 8:00 PM on 04/13/2024 because AED E was notified that 5:00 PM medications were not administered to residents. CND B stated s/he reviewed all charts and directed staff to administer some of the medications that could be given outside the scheduled administration window. CND B stated, "There were 3 or 4 residents that missed meds... going forward, we discussed needing to identify on the schedule who was a medication passer." CND B confirmed someone from building 1 came to the facility to administer the medications late on 04/13/2024.	N 396		

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 08/28/2024

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 396	Continued From page 19 Cross reference: N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule	N 396		
N 399	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain a staffing schedule. 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 facility is located approximately 1/2 mile from another facility owned by the licensee. On 04/30/2024, the Department received a complaint related to adequate staffing. On 06/03/2024 at approximately 9:45 AM, Surveyor requested staff schedules from Executive Director (ED) A and Clinical Nurse Director (CND) C. CND C explained there was a turnover in leadership at the facility, and the past assistant executive director (AED) did not utilize the provider's scheduling system to its full capability. ED A stated s/he took over scheduling	N 399		

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 08/28/2024

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 399	Continued From page 20	N 399		

responsibilities around 04/24/2024. ED A stated s/he would try to locate schedules prior to this date on the provider's scheduling system, but s/he did not know how accurate they would be. ED A stated that when s/he took over scheduling, s/he utilized a hard copy schedule and the provider's electronic scheduling system.

Surveyor reviewed the schedules provided for April through June. The schedules provided for dates prior to 04/24/2024 did not include employee names.

On 06/06/2024, Surveyor requested employee timecards for dates 03/10/2024, 04/13/2024, and 04/17/2024.

On 06/07/2024, Surveyor received an email that included a list of staff who worked at both locations on the dates requested. According to this list, there were times when no staff were scheduled at the facility. Surveyor requested timecards to verify.

On 06/18/2024, Surveyor reviewed the timecards provided for the 3 sampled dates and was unable to determine which staff worked at each facility.

On 06/18/2024 at 2:00 PM, Surveyor interviewed ED A and CND C. Surveyor asked if there was a way to determine who worked at each facility on 03/10/2024, 04/13/2024, and 04/17/2024. ED A stated the prior AED did not edit the electronic scheduling system to include building assignments. ED A stated they could guess which staff were at each facility and try to verify the staff's location with charting documentation. ED A stated there was no way to confirm who worked at each facility.

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 08/28/2024

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 399	Continued From page 21 On 06/26/2024, the Department received another complaint related to adequate staffing. On 08/26/2024 at 11:30 AM, Surveyor requested staff schedules for 06/22/2024 through 08/26/2024. CND C explained that AED B had been the ED in June and July. AED B stepped down from leadership and the Spooner location's management team, ED A and AED L, assumed oversight of the facility in the interim. This transition started mid-August 2024. CND C stated AED B had the staff schedules was on vacation. CND C stated they did not have access to staff schedules to provide Surveyor. On 08/27/2024 at 7:04 AM, Surveyor received the staff schedules for June and July via email. The schedules did not correlate with staff charting. For instance, there were staff who charted in medication administration records or progress notes that, according to the schedule, should not have been on duty at the time. On 08/28/2024, Surveyor reviewed employee timecards for the week of 06/22/2024 through 06/29/2024. Surveyor compared the staff timecards with the staff schedule and found discrepancies; staff who were not on the schedule were punched-in and vice versa.	N 399		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written	N 406		

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 08/28/2024

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 406	Continued From page 22 every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount. This Rule is not met as evidenced by: Based on record review and interview, the provider did not implement a policy for disposing unused, discontinued, outdated, or recalled medications. Resident 1 passed away on 06/16/2024 and medications belonging to Resident 1 remained in the provider's medication cart through 08/08/2024. Findings include: On 06/18/2024 at 2:00 PM, Surveyor interviewed Clinical Nurse Director (CND) C. CND C stated Resident 1 passed away on 06/16/2024. On 06/26/2024, the Department received a complaint related to medication destruction. On 08/26/2024 at approximately 9:30 AM, Surveyor interviewed Caregiver K. Caregiver K discussed the provider's medication destruction	N 406		

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 08/28/2024

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 406	Continued From page 23	N 406		

policies. Caregiver K stated that when a medication needed to be destroyed, caregivers placed the medication in one of the empty drawers in the medication cart and notified management that a medication was awaiting destruction. Caregiver K confirmed all staff with a medication cart key had access to medications awaiting destruction.

On 08/26/2024, Surveyor reviewed the provider's medication destruction policy and medication destruction logs for 06/01/2024 through 08/26/2024. The logs indicated Resident 1's medication was destroyed as follows:
- On 6/28/2024, CND C destroyed 68 tablets of omeprazole 20mg belonging to Resident 1. The reason listed for this medication destruction was "provider order to discontinue."
- On 07/03/2024, Assistant Executive Director (AED) B destroyed 11 prescriptions belonging to Resident 1. The reason listed for this medication destruction was "resident expired."
- On 07/22/2024, CND C and AED L destroyed 122 tablets of lorazepam 0.5mg and 15 20mg/ml syringes belonging to Resident 1.
- On 08/08/2024, CND C destroyed 44 nicotine patches prescribed to Resident 1.

The provider's medication policy, "Disposition or Disposal of Medications" (effective April 2023), indicated the ED or designee were to put medications awaiting disposal in a separate locked area. The ED or designee would then return the medication to the pharmacy or destroy them within 72 hours using a Med (medication) Buster or RX (prescription) Destroyer.

On 08/27/2024 at 11:30 AM, Surveyor interviewed CND C. CND C stated there was a 12-week period when AED B took on the role of ED and

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 08/28/2024

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 406	Continued From page 24 things were missed. CND C stated, "We never got to a place where we could audit the med cart." CND C stated s/he oversaw other facilities owned by the provider, and s/he suggested to these EDs and AEDs to audit their medication carts weekly to ensure medications in circulation matched current orders. CND C stated s/he expected staff would remove any expired, unused, or discontinued medication from the cart as they noticed it and notify management so they could dispose of the medication as soon as possible. CND C stated the provider had a locked area in the manager's office to store medications awaiting destruction. Surveyor asked if there was a reason Resident 1's medications were not timely destroyed. CND C stated s/he recently destroyed the last of his/her medications (nicotine patches), but there was no other reason these medications were not destroyed per the policy. CND C stated, "It just got missed."	N 406		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medication keys were available only to authorized staff. Medication keys were left unattended on the medication cart on 06/03/2024. 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	N 419		

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 08/28/2024

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 419	Continued From page 25 developmentally disabled. On 04/30/2024, the Department received a complaint related to secure medication storage. On 06/03/2024 at 1:20 PM, Surveyor entered the facility and interviewed Caregiver F. Caregiver F stated s/he was the only care staff at the facility at the time. Surveyor observed the medication cart behind the kitchen counter. A set of keys were on top. At 2:00 PM, Surveyor observed the same set of keys on top the medication cart. Surveyor found Caregiver F in the provider's storage room attached to the kitchen and asked if s/he could open the medication cart. Caregiver F removed the keys from the top of the medication cart and used them to open the medication drawer. Surveyor asked if Caregiver F usually kept the keys on top of the medication cart. Caregiver F stated s/he did not, and that the keys should be kept with the medication passer at all times. Caregiver F stated s/he was normally the one reminding others about this. Caregiver F stated the last time s/he was in the cart was prior to 1:20 PM, when Surveyor entered the facility.	N 419		
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	N 426		

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 08/28/2024

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 426	Continued From page 26 appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were adequately supervised. Resident 1 eloped 7 times between 03/07/2024 and 04/17/2024. 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. On 04/30/2024, the Department received a complaint related to staffing and supervision. On 06/03/2024 and 06/07/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 02/26/2024 and s/he began hospice services on 04/01/2024. His/her diagnoses included intracerebral hemorrhage, traumatic brain injury, hard of hearing, aphasia, impaired communication with impaired cognition, and chronic pain. Resident 1's record indicated s/he was ambulatory without assistive device. Resident 1's record included the following incident reports: - 03/07/2024 at 4:00 PM: Resident 1 left the facility and approached construction workers across the street to ask for a cigarette. The report read, "Additional actions recommended: 1 hour safety checks to be implemented."	N 426		

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 08/28/2024

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 426	Continued From page 27 - 03/10/2024 at 10:40 AM: A visitor found Resident 1 in the parking lot. Staff were unaware s/he was outside. "Additional actions recommended: 1 hour safety checks and door alarms installed on all exit/entry doors." - 03/10/2024 at 7:30 PM: A community member knocked on the facility door and notified staff that Resident 1 was inside their house. When staff went to retrieve Resident 1, they found Resident 1 trying to get into someone else's house. "Additional actions recommended: 1 hour safety checks and door alarms installed on all exit/entry doors." - 04/01/2024 at 6:24 PM: Resident 1 exited out the back door. Staff heard the alarm and left out the front door, meeting Resident 1 in the parking lot. "Additional actions recommended: 1 hour safety checks still in place. Staff education on how to re-direct along [sic] since there are always 2 staff on that they need to be more aware of where resident is at so they can intervene before resident is able to get out of building." - 04/13/2024 at 2:30 PM: Resident 1 eloped. "Additional actions recommended: 2 staff on at all times. Staff to redirect resident before [s/he] gets to the doors. Resident still has 1 hour safety checks." - 04/13/2024 at 6:00 PM: Resident 1 eloped. "Additional actions recommended: 2 staff on at all times. One staff member out in the common areas where they can intervene and redirect [him/her]. If a resident is in need of two staff, I have put in place what to do so one staff member can be around." - 04/17/2024 at 3:10 PM: Resident 1 eloped and	N 426		

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 08/28/2024

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 426	Continued From page 28	N 426		

was going through the neighborhood knocking on doors asking for cigarettes, including off-duty Caregiver J's house. Caregiver J let Resident 1 and the staff running after Resident 1 (Caregiver D) inside. The report read, "[Resident 1] is very smart and stealth-like and [s/he] can figure things out like door alarms and how they function and what [s/he] needs to do to get around them. [S/he] reads the notes on the doors even though for [him/her] they are backwards and has figured out that [s/he] can hold the door handle down for 15 seconds... Additional actions recommended: Staff have been instructed by ED [Executive Director] that a staff member needs to be near [him/her]. Also will be getting an alarm for [his/her] door to let staff know when [s/he] is coming out of [his/her] room."

On 06/03/2024 at 1:20 PM, Surveyor interviewed Caregiver F. Caregiver F stated Resident 1 went to the ER that morning because s/he became unresponsive at breakfast; s/he had not returned.

Caregiver F said Resident 1 had lung cancer and was declining, but s/he continued to be fixated on his/her cigarettes. Surveyor asked if there were triggering events to Resident 1's elopements. Caregiver F stated Resident 1 would elope if s/he ran out of cigarettes. Caregiver F stated s/he could tell if Resident 1 was about to elope because s/he would become fixated on having a cigarette, become agitated, put on his/her jacket, or stare at the door. Caregiver F said the exits were equipped with delayed egress, but Resident 1 knew to hold the door until it released. Caregiver F said some of the exits were also equipped with motion sensor alarms that would go off if someone got too close.

On 06/03/2024 at 3:20 PM, Surveyor interviewed

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 08/28/2024

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 426	Continued From page 29	N 426		

Executive Director (ED) A and Clinical Nurse Director (CND) B. Surveyor asked how Resident 1's elopement interventions listed on the incident reports were communicated to staff. ED A stated they should have been added to Resident 1's ISP but because management failed to print or save a copy of Resident 1's ISP after each revision, there was no way to see if the interventions were added to the ISP. ED A stated the edits made to Resident 1's ISP on 05/20/2024 overrode past edits, and there was no way to see when each intervention on the current ISP was added.

CND B stated s/he was new to the administrator position (hired 02/06/2024 and fully stepped into his/her role around the end of February/early March). CND B shared that the provider experienced a complete turnover in management and lost many staff with the change between April and May 2024. CND B stated s/he worked on the floor with Resident 1 and felt 2 staff was not necessary at the facility. CND B stated that as management and staff changes occurred, s/he continued to educate staff on being more present on the floor and proactive with Resident 1's behavior.

On 06/18/2024 at 2:00 PM, Surveyor interviewed ED A and CND B. Surveyor asked if there were 2 staff at the facility per Resident 1's interventions listed on his/her incident reports. ED A believed they did not fully implement this intervention until a staff meeting on 04/17/2024 that happened to end at the same time Resident 1 eloped; staff were instructed at this meeting to have 1 staff always keep line-of-sight on Resident 1. ED A stated there should have been always 2 staff at the facility until 04/24/2024 when the intervention ended. ED A and CND B could not confirm that 2 staff were always at the facility because

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 08/28/2024

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 426	Continued From page 30 schedules were not maintained. CND B informed Surveyor that Resident 1 passed away on 06/16/2024. Cross references: N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule	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 interview, observation, and record review, the provider did not ensure a daily activity program was provided to residents. Findings include: The provider is licensed to care for 16 residents in the client groups advanced aged, terminally ill,	N 427		

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 08/28/2024

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 427	Continued From page 31	N 427		

physically disabled, and irreversible dementia/Alzheimer's disease.

On 04/30/2024, the Department received a complaint about activities.

On 06/03/2024 at approximately 12:00 PM, Surveyor reviewed a printed activity schedule provided by Assistant Executive Director (AED) B. The schedule indicated the morning activity was ball toss, the afternoon activity was BINGO, and the evening activity was music.

At approximately 1:20 PM, Surveyor reviewed an activity calendar posted in the dining room of the facility on a dry erase poster. The schedule indicated a rock painting activity was planned for 2:00 PM.

At approximately 1:30 PM, Surveyor interviewed Caregiver F. Caregiver F stated s/he was the only caregiver working at the facility. Surveyor inquired about activities. Caregiver F stated it was difficult to do activities at the facility because residents had varying degrees of interest and abilities.

At 1:35 PM, Surveyor interviewed AED B. AED B stated s/he was new to his/her position (hired 05/08/2024), but s/he understood that it was his/her responsibility to develop an activity program. AED B stated s/he was told to mimic the activity schedule that the Spooner location created but it was not realistic for the facility's residents. AED B stated s/he was unsure where to even find the Spooner activity schedule. Surveyor referenced the activity posted on the dry erase calendar in the dining room, and asked AED B if they had supplies to paint rocks. Caregiver F, who was in the same room, stated they did that activity a couple weeks ago. AED B

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 08/28/2024

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 427	Continued From page 32 stated s/he was unsure who wrote the activity calendar in the dining room, but s/he guessed it was the schedule for May. Surveyor left the facility at approximately 2:10 PM. Surveyor did not observe any activities at the facility while on site.	N 427		