STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020835	A. BUILDING: _____ B. WING _____	10/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE AT RED CEDAR CANYON	3001 HANLEY ROAD HUDSON, WI 54016

(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 10/08/2026, Surveyor conducted a standard licensure survey at Vista Prairie At Red Cedar Canyon. Data was collected through 10/13/2026. Two violations were identified. Census: 12	N 000		
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 in sufficient numbers were working to meet the needs of the residents. The provider had 1 staff working during the overnight shift while there were residents who required 2-person transferring assistance. Findings include: The facility is licensed to care for residents in the client groups advanced age, terminally ill, physically disabled, and irreversible dementia/Alzheimer's disease. On 10/08/2026, at approximately 12:58 PM, Surveyor interviewed Executive Director (ED) A, Nurse Manager (NM) B, and NM C. Surveyor asked about the staffing pattern. ED A, NM B, and NM C indicated there was typically 1 staff on duty at the community-based residential facility (CBRF) during the overnight shift. ED A, NM B, and NM C indicated that a staff member working at the residential care apartment complex	N 396		

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

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N 396	Continued From page 1 (RCAC) on the opposite side of the building would come and assist the overnight staff at the CBRF if needed. At approximately 1:35 PM, Surveyor interviewed Caregiver D. Caregiver D stated there was always 1 staff on duty during the overnight shift, which was from 10:00 PM to 6:30 AM. Surveyor reviewed the following resident and facility records: - Resident 1's individual service plan (ISP). The ISP indicated Resident 1 had been admitted on 11/04/2024. The ISP read, in part, "04/23/2026... [mechanical lift] 2 assist for all transfers...11/19/2024 Potential for Falls Requires 2 assist with transfers...Transfer: Assist of 2...One assist for toileting, two assist with transfer...01/05/2026 Toileting Plan Please check and change in bed, 2 assist for safety and comfort. Transfer with 2 assist into...chair for mobility...01/15/2026 Toileting plan Two assist with transfers for toileting..." - Resident 2's ISP. The ISP indicated Resident 2 had been admitted on 02/23/2026. The ISP read, in part, "...Safety check...3/17/2026 Two assist with transfers using [mechanical lift]...03/19/2026 Toileting plan Two assist for pad changes and pericare [sic]. Check and change in bed. [Mechanical lift] two assist if needed to get out of bed..." - A facility training document which outlined the proper use of mechanical lifts. The training document read, in part, "Core Personal Care Skills: Resident Transfer | [Mechanical Lift]...Always use two (2) staff to transfer with lifts..."	N 396		

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N 396	Continued From page 2 The provider did not ensure a minimum of 2 staff were working in the facility during the overnight shift to meet the needs of Resident 1 and Resident 2, who both required 2-person assistance with transferring.	N 396		
N 479	83.42(2) Resident records safeguarded. The licensee shall ensure all resident records are adequately safeguarded against destruction, loss or unauthorized access or use. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all resident records were adequately safeguarded against unauthorized access or use. Findings include: The provider is licensed to care for residents in the client groups advanced age, terminally ill, physically disabled, and irreversible dementia/Alzheimer's disease. On 10/08/2026, at approximately 1:00 PM, Surveyor observed that the door to the secure memory unit in the facility was accessible from the outside of the unit. During the course of the survey, Surveyor observed visitors entering the memory care unit to visit residents. From approximately 2:28 PM to 2:32 PM, Surveyor observed that there was a room off the main hallway in the memory care unit that contained resident records. Surveyor observed that the room had a single entrance consisting of a sliding wooden door, which was left open at the	N 479		

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N 479	Continued From page 3 time. Surveyor observed that the door did not latch or have a locking mechanism. Surveyor observed that there were resident hospice binders on a shelf in the room. Surveyor observed Nurse Manager (NM) C open an unsecured cabinet that contained resident records. At approximately 2:29 PM, Surveyor interviewed NM C. NM C stated resident records were kept in the room. NM C stated these resident records included face sheets, code status, admission paperwork, service agreements, medication consent forms, care plans, power of attorney (POA) paperwork, behavior charting, hospice orders, physician summaries, medication orders, laboratory paperwork, and insurance records. NM C stated that was how s/he compiled all the residents' charting. At approximately 3:55 PM, Surveyor interviewed NM C again. When asked how long the records had been stored in an unsecured room with a sliding, non-locking door, NM C stated that it had been that way for "years." NM C stated it had never come up until recently, when s/he and Executive Director (ED) A brought concerns regarding the unsecured records to upper management around June of 2026. The licensee did not ensure all resident records were adequately safeguarded against unauthorized access or use.	N 479		