STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018329	A. BUILDING: _____ B. WING _____	R-C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA CARE MEHRTENS AVENUE	1522 N 17TH STREET SHEBOYGAN, WI 53081

(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 08/05/2026, with information gathered through 08/11/2026, Surveyor reviewed 1 self-report, investigated 2 complaints, and conducted a verification visit at Vista Care Mehrtens Avenue. Two of 2 complaints were substantiated. Seven of 10 previous deficiencies were corrected and 3 were recited. Two new deficiencies were identified. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census 7	{N 000}		
{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 residents received medications in the dosage and intervals prescribed by the practitioner for Resident 2. Resident 2 did not receive Oxybutynin for urinary incontinence as prescribed for the months of May, June, July and August of 2026 as prescribed. Resident 2 missed several doses of other prescribed medications. This requirement is being cited for a third time. See Statements of Deficiency (SOD) V8O611,	{N 352}		

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

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{N 352}	Continued From page 1 dated 06/30/2025 and SOD MXIN11, dated 01/21/2026. Findings Include: On 06/05/2026, the department received an allegation regarding a resident's urinary incontinence not being addressed. On 08/07/2026, Surveyor reviewed Resident 2's medication administration record (MAR) for May, June, July and August 2026. Review of the MARs showed Resident 2 did not receive Oxybutynin as prescribed in May, June, July and August. The dates and exceptions were documented as follows: Oxybutynin 5mg - take ½ tab twice daily >AM Dose: 05/01 through 05/13, 05/14, AND 05/15 through 08/07/2026 - on hold medication not in house >PM Dose: 05/01 through 05/14 through 08/07/2026 - on hold med not in house According to Mayo Clinic, "Oxybutynin is used to treat symptoms of an overactive bladder, such as incontinence (loss of bladder control) or a frequent need to urinate ..." Information obtained on 08/10/2026 at: https://www.mayoclinic.org/drugs-supplements/oxybutynin-oral-route/description/drg-20065229 On 08/05/2026, at 10:38AM, Surveyor interviewed Direct Support Professional E (DSP-E). DSP-E explained Resident 2 is incontinent at times. DSP-E advised the incontinence occurs when s/he is trying to get to the bathroom but does not make it time. DSP-E reported there are occasions of incontinence at	{N 352}		

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{N 352}	Continued From page 2 night. Resident 2 missed this medication May, June, July and August of 2026. Further review of the MARs on 08/07/2026 revealed additional missed administration of medications. The medications, dates and exceptions were documented as follows: Fluvoxamine 100mg - take 1 tab twice daily >AM Dose 05/01: med is not here 05/02: missed 06/08: missed Lamotrigine 150mg - take 1 tablet twice daily >AM Dose 05/01 - on hold/medication not in program dosage changed 05/02 - missed 05/03 - on hold wrong dose 05/0 - on hold wrong dose 05/05 - on hold out >PM Dose 05/01 - on hold medication has not arrived from pharmacy 05/02 - med is not here Amlodipine 10mg - take 1 tab daily 06/08, 06/25, 06/27, 06/28 - missed Benztropine 2mg - take 1 tab by mouth twice daily >AM Dose: 06/08, 07/20 - missed Clozapine 100mg - take 1 tab by mouth every morning 06/01 - on hold not available 06/02, 06/03, 06/07, 06/08, 06/09, 06/11, 06/12,	{N 352}		

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{N 352}	Continued From page 3 06/20, 06/21, 06/22, 06/23, 06/24, 06/25 - Missed 06/14, 06/15, 06/16 - medication not available Docusate Sod 250mg - take 1 twice daily 06/08 - missed Eliquis 5mg - take 1 tab daily 06/08 - missed Lamotrigine - take 1 tab twice daily >AM Dose: 06/08 - missed GNP Earwax Sol Removal - instill 5 drops in both ears twice daily >AM Dose: 06/08 - missed PEG 3350 POW 510g - mix 17g in 4 oz to 8oz of water and take daily 06/08, 06/27, 06/30, 07/01, 07/02, 07/03, 07/04, 07/05, 07/06, 07/07, 07/10, 07/11, 07/12, 07/13, 07/14, 07/19, 07/20, 07/21, 07/22, 07/25, 07/26, 07/27, 07/28, 07/29 - missed Midodrine 5mg - take 1 tab three times daily before meals >AM Dose: 07/22, 07/25, 07/26, - missed >Noon Dose: 07/09, 07/16, 07/22, 07/23, 07/24, 07/25, 07/26, 07/27, 07/28. 07/29, 07/30, 07/31 - missed >PM Dose: 07/13, 07/23, 07/24, 07/26, 07/29 - missed. 07/27, 07/28 - medication was not in house On 08/11/2026, at 2:00PM, Surveyor interviewed Area Director F (AD-F). AD-F advised the MARs and orders will be audited and reviewed for accuracy.	{N 352}		

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N 358	Continued From page 4	N 358		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were safeguarded from environmental hazards. On 05/10/2026, the facility experienced a fire on the exterior side of the southwest corner caused by a cigarette discarded in the dry mulch bed. The facility did not ensure residents followed the smoking policy or that staff followed the emergency and disaster plan. Findings Include: The provider is licensed as a class CNA non-ambulatory to provide care for 8 residents who are developmentally disabled, emotionally disturbed and alcohol/drug dependent. On 08/05/2026, Surveyor reviewed the self-report, dated 05/11/2026 for a fire that occurred on 05/10/2026. The self-report stated Resident 3 and Resident 5 found a fire on the southwest corner of the house. The self-report identified the fire appeared to occur due to a cigarette being discarded into the dry mulch bed.	N 358		

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N 358	Continued From page 5 The fire was contained but there was damage to the siding. On 08/05/2026, at 10:25AM, Surveyor observed the southwest side of the house. The siding was repaired; however, Surveyor observed several cigarette butts in the mulch bed next to the repaired siding. Surveyor went to the opposite side of the building and noted a 2nd mulch bed with bushes. The 2nd mulch bed also had several discarded cigarette butts. Surveyor observed a cigarette butt receptacle off the front porch and 2 in the back of the building. On 08/05/2026, at 10:38AM, Surveyor interviewed Direct Support Professional E (DSP-E). DSP-E advised Resident 3 noticed the fire and put it out with a water hose. DSP-E stated residents were not evacuated because the fire was extinguished. DSP-E confirmed the s/he notified the previous executive director, Executive Director D (ED-D).DSP-E reported ED-D advised him/her not to call the fire department because the fire was put out. DSP-E clarified ED-D no longer works for Vista Care. On 08/10/2026, Surveyor reviewed the General Event Report (GER), dated 05/10/2026. The GER noted the following: "Two residents discovered the southwest corner of the house on fire and they quickly jumped into action to put the fire out and yelled for staff. Staff contacted [ED-D] as soon as as [sic] staff realized what was happening. The fire started from a lit cigarette butt. Staff questioned all the residents that smoke and educated them on the seriousness of the fire. All the residents denied being responsible for the fire. Staff does suspect [Resident 4] of starting the fire.	N 358		

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N 358	Continued From page 6 On 08/05/2026, Surveyor reviewed the provider's tobacco use policy, dated 05/05/2026. The policy identified the following: " ...Each facility will have a designated smoking/tobacco use location. Tobacco use may only occur in this location ...The designated area must have a designated commercial grade smoking receptacle/outdoor ashtray for discarding cigarette butts ...All people smoking or using tobacco must clean up any cigarette buts and other tobacco use materials and dispose of them in the proper receptacle ...." On 08/10/2026, Surveyor reviewed the provider's Emergency and Disaster Plan dated 12/15/2025. The plan noted the following regarding fires: "A. In the event of a fire, call 911 immediately ...C. Refer to the exit diagram for emergency exits ...D. Refer to Policy 1300 Fire Safety and Evacuation Procedures." On 08/10/2026, at 3:15PM, Surveyor interviewed Area Director A (AD-F). AD-F identified 4 out of 7 residents were smokers. On 08/11/2026, at 2:00PM, Surveyor interviewed AD-A. AD-F advised s/he has already begun re-educating staff on the smoking and emergency policy. Additionally, AD-F reported s/he has already spoke to staff about supervising residents and ensuring cigarettes are discarded appropriately. Cross Reference N0389 DHS 83.35(3)(d) Service Plans Updated Annually or on Changes	N 358		

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N 381	Continued From page 7	N 381		
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 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 residents' needs, abilities, and physical and mental condition was assessed prior to admitting residents for 3 of 4 residents reviewed (Resident 3, Resident 4 and Resident 5). In addition, Resident 3 was not assessed for his/her level of supervision. Resident 3 spent the night away from the facility and was given his/her medication to self-administer while away. Resident 3's individual service plan identified s/he required assistance with medication administration. Findings Include: On 02/27/2026, the department received a complaint alleging concerns with supervision. On 08/06/2026, Surveyor reviewed Resident 3,	N 381		

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N 381	Continued From page 8	N 381		

Resident 4 and Resident 5's records. The records identified:
Resident 3 was admitted to the facility on 01/03/2022.
Resident 4 was admitted to the facility on 01/21/2021.
Resident 5 was admitted to the facility on 11/21/2025.

On 08/10/2026 at 11:07AM, Surveyor requested Resident 3, Resident 4 and Resident 5's comprehensive assessment from Area Director F (AD-F).

On 08/10/2026, at 3:15AM, Surveyor interviewed AD-F. AD-F advised s/he could not find Resident 3, Resident 4 and Resident 5's assessments and could not confirm if they were completed. AD-F reported s/he recently began an audit of resident files and has not yet found Resident 3, Resident 4 or Resident 5's assessments.

RESIDENT 3

On 08/05/2026, at 10:38AM, Surveyor interviewed Direct Support Professional E (DSP-E). DSP-E confirmed in February 2026, Resident 3 spent the night away from the facility with his/her romantic partner. DSP-E reported Resident 3 would inform staff when s/he was going to do so and took medications with him/her. DSP-E advised this has not occurred since February 2026. DSP-E confirmed when Resident 3 was at home, the staff administered his/her medications.

On 08/05/2026 at 12:17PM, Surveyor interviewed Family Member G. FM-G explained Resident 3 does not make safe choices. FM-G reported Resident 3 likes to help people, but those people

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N 381	Continued From page 9	N 381		

often take advantage of him/her. FM-G advised when Resident 3 lived independently, s/he had friends that took advantage of him/her by persuading him/her to give them all his/her money. FM-G reported on 02/16/2026 and 02/24/2026 Resident 3 spent the night with his/her romantic partner. Resident 3 was sent with his/her medication to self-administer while away.

On 08/10/2026 at 10:42AM, Surveyor interviewed Resident 3's guardian, Guardian G. Guardian G advised Resident 3 had disabilities, but functions at a high level. Guardian G explained despite Resident 3's higher level of functioning, s/he does not always "keep the best company." Guardian G stated s/he would have concerns if Resident 3 were to self-administer his/her medications.

On 08/07/2026, Surveyor reviewed Resident 3's February 2026 medication administration record (MAR). The MAR showed Resident 3 was on a leave of absence for the following medication administration times:
02/16 - evening medications
02/17 - morning medications
02/24 - evening medications
02/25 - evening medications

On 08/07/2026, Surveyor reviewed Resident 3's individual service plan dated 08/05/2026. The ISP identified Resident 3 required assistance with medication administration but did not have any information regarding supervision needs.

On 08/11/2026, at 2:00PM, Surveyor interviewed AD-F. AD-F advised s/he was in the process of auditing resident records and noticed some assessments were not completed before admission. AD-F reported s/he is working to

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N 381	Continued From page 10 correct the issue. Cross Reference N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan Cross Reference N0389 DHS 83.35(3)(d) Service Plans Updated Annually or on Changes	N 381		
{N 386}	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not develop a comprehensive individual service plan (ISP) for 2 of 4 residents reviewed, Resident 2 and Resident 5. This requirement is being cited for a second time. See Statements of Deficiency (SOD) SOD MXIN11, dated 01/26/2026. Findings Include:	{N 386}		

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{N 386}	Continued From page 11 On 06/05/2026, the department received a complaint alleging concerns with a resident's hygiene. On 08/05/2026, Surveyor arrived to conduct a verification visit for SOD MXIN11, dated 01/21/2026. RESIDENT 2 On 08/05/2026, at 10:38AM, Surveyor interviewed Direct Support Professional E (DSP-E). DSP-E explained Resident 2 was incontinent at times. DSP-E advised the incontinence occurs when s/he is trying to get to the bathroom but does not make it time. DSP-E reported there are occasions of incontinence at night. On 08/05/2026, at 1:56PM Surveyor interviewed Therapist I. Therapist I identified s/he sees Resident 2 at home and provides therapy in home and in the community. Therapist I described there are times when s/he arrives to work with Resident 2 and s/he puts on dirty clothes or is wearing clothes that are saturated with incontinence. Therapist I reported there are some staff that are better at assisting Resident 2 than others. On 08/05/2026 at 10:32AM, Surveyor observed Resident 2 in his/her room. Surveyor noted a faint urine like odor and a pile of dirty clothes in his/her floor. On 08/07/2026, Surveyor reviewed Resident 2's medication administration record (MAR). The MAR noted Resident 2 had the following diagnosis: diabetes mellites, schizoaffective	{N 386}		

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{N 386}	Continued From page 12 disorder and bipolar disorder. The survey from 01/26/2026, revealed Resident 2's undated assessment identified several tasks Resident 2 required assistance to complete. The tasks were as follows: Eating: Needs meals prepped/prepared for him/her. Bathroom/Toileting: Needs cues to use the bathroom before bed. Washing Up/Showering: Needs cues s/he completes the task of showering. Oral Care: Needs verbal cueing Dressing: Needs verbal cueing to dress appropriately for the weather and ensure clothes are not soiled with urine. On 08/07/2026, Surveyor reviewed Resident 2's current ISP dated 04/12/2026. The ISP was only updated to include information regarding assisting Resident 2 with medication administration. The ISP did not include information on all other assessed needs including needing cues to use the bathroom or wearing clothes free of urine. On 08/11/2026, at 2:00PM, Surveyor interviewed Area Director F (AD-F). AD-F advised s/he was in the process of auditing resident records and noticed the ISPs needed more information than what they had. AD-F reported s/he is working to correct the issue. RESIDENT 5 On 08/06/2026, Surveyor reviewed Resident 5's record. The record identified Resident 5 was admitted to the facility on 11/21/2025. Resident 5's record revealed no comprehensive ISP. On 08/10/2026, at 3:15PM, Surveyor interviewed	{N 386}		

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{N 386}	Continued From page 13 AD-F. AD-F reported Resident 5 did not have a comprehensive ISP developed by Vista Care and only had a plan provided by the county. AD-F advised s/he is currently auditing files to ensure ISP's are developed. Cross Reference N0389 DHS 83.35(3)(d) Service Plans Updated Annually or on Changes Cross Reference N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments	{N 386}		
{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. This Rule is not met as evidenced by: Based on record review and interview and interview, the provider did not ensure individual service plans (ISP) were updated upon change in condition and were signed by the resident or resident's legal guardian for 3 out of 4 residents reviewed, Resident 2, Resident 3, and Resident 4.	{N 389}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018329	A. BUILDING: _____ B. WING _____	R-C 08/11/2026

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{N 389}	Continued From page 14 This requirement is being cited for a second time. See Statements of Deficiency (SOD) YYYH11, dated 05/23/2024 and SOD MXIN11, dated 01/26/2026. On 05/10/2026, a fire started on the exterior southwest corner of the home. The General Event Report dated 05/10/2026 identified staff suspected Resident 4 started the fire due to not disposing of his/her cigarette butt appropriately. Resident 4's ISP was not updated after the fire to include interventions regarding smoking safely. Resident 2, Resident 3, Resident 4 and Resident 5's ISPs were not signed by the resident or legal guardian. Findings include RESIDENT 4 On 08/05/2026, Surveyor reviewed the self-report, dated 05/11/2026 for a fire that occurred on 05/10/2026. The self-report noted the fire was on the southwest corner of the house and appeared to be caused by a cigarette being discarded into the dry mulch bed. The fire was contained but there was damage to the siding. On 08/05/2026, Surveyor observed the southwest side of the house. The siding was repaired; however, Surveyor observed several cigarette butts in the mulch bed next to the repaired siding. On 08/10/20206, Surveyor reviewed Resident 4's ISP dated 03/23/2026. The ISP noted Resident 4 had a history of starting fires when in the community and should not possess lighters or matches. Staff should assist Resident 4 with lighting his/her cigarette. The ISP was not	{N 389}		

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{N 389}	Continued From page 15 updated to include interventions to ensure Resident 4 discarded his/her cigarettes safely. Further review of the ISP revealed it was not signed by the resident or legal guardian. On 08/10/2026, Surveyor reviewed the General Event Report (GER), dated 05/10/2026. The GER noted the following: Two residents discovered the southwest corner on fire...The fire started from a lit cigarette butt ...Staff does suspect [Resident 4] of starting the fire. On 08/11/2026, Surveyor interviewed Area Director F (AD-F). AD-F advised s/he was auditing resident records and confirmed Resident 4's ISP needed to be updated to include safety interventions and be signed by Resident 4 and/or the legal guardian. AD-F advised s/he has already spoken to staff about supervising Resident 4 while smoking to ensure s/he discards the cigarette butt appropriately. RESIDENT 2 On 08/07/2026, Surveyor reviewed Resident 2's ISP dated 04/12/2026. The ISP had no signatures. RESIDENT 3 On 08/07/2026, Surveyor reviewed Resident 3's ISP. The ISP had no signatures. On 08/10/2026, at 10:42AM, Surveyor interviewed Guardian H. Guardian H identified s/he is Resident 3's legal guardian. Guardian H reported s/he did not sign the ISP. On 08/11/2026, at 2:00PM, Surveyor interviewed AD-G. AD-G advised s/he was auditing resident	{N 389}		

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{N 389}	Continued From page 16 records and noted ISPs were not signed. AD-G advised s/he is working toward obtaining signatures. Cross Reference N0358 DHS 83.32(3)(n) Rights of Residents: Safe Environment	{N 389}		