

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0010890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/18/2026
NAME OF PROVIDER OR SUPPLIER VISTA CARE PLAZA LANE AFH		STREET ADDRESS, CITY, STATE, ZIP CODE 356 PLAZA LANE PLYMOUTH, WI 53073		
(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
M 000	INITIAL COMMENTS On 02/17/2026, with additional information gathered through 02/18/2026, Surveyor investigated 1 complaint at Vista Care Plaza Lane. The complaint was substantiated and 2 new deficiencies were identified. Census 4	M 000		
M 412	88.06(3)(d)1 DESCRIPTION OF SERVICES A description of services the licensee will provide to meet the assessed need. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the individual service plan (ISP) included a description of the services to be provided to meet the assessed need for Resident 1. Findings Include: On 02/17/2026, Surveyor reviewed Resident 1's Emergency Data Form dated, 02/13/2025. The form noted Resident 1 was admitted on 02/13/2025. On 02/17/2026, Surveyor reviewed Resident 1's Residential Assessment Form, dated 08/29/2025. The assessment documented Resident 1's diagnosis as: Autism, constipation, urinary incontinence, and Epilepsy. The assessment identified the following needs for Resident 1:	M 412		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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M 412	Continued From page 1 Diet: "Bite Size Chopped." Bathroom/Toileting: " ...needs cues to use the rest room [sic] ... Incontinent ...has been wearing [incontinence product] all day with a liner for extra absorption ..." Washing up/Shower: " ...needs cues to take a shower ...[s/he] will need prompts and assistance to get areas [s/he] cant [sic] reach like [his/her] back side ..." Oral Care: " ...will need supervisionand [sic] some help setting up [his/her] oral care ..." Dressing: "Picking out appropriate clothing and putting on shoes ..." Cognition and Ability to Make Decision: "needs a routine day with activities structure ..." Medication Management: "Can individual self-administer: No - Direct supervision/monitoring ... Takes meds [medications] whole with applesauce or yogurt" Self Harm: " ...will at times hit [him/herself] in the face or head.." Violent Behaviors: " ...has grabbed staffs [sic] hands or arms before when [s/he] was in a panic ..." (1) a description of the services to be provided to meet the assessed need, (2) identification of the level of supervision required in the home and community and (3) descriptions of services provided by outside agencies	M 412		

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M 412	Continued From page 2 On 02/17/2026, at 8:12PM, Surveyor interviewed Caregiver B. Caregiver B reported Resident 1 attends a day program daily and has a one-to-one caregiver. At approximately 8:20AM, Surveyor observed Resident 1's one-to-one caregiver arrive to transport him/her to the day program. On 02/17/2026, Surveyor reviewed Resident 1's ISP. The only information documented in the ISP stated: "[Resident 1] has time [sic] where [s/he] will grab staff or individual's [sic]. [Resident 1] does not like people wearing hoodie sweaters. [Resident 1] will pace and constantly ask for soda. Triggers may be 'saying no', yelling or taking things away. [Resident 1] is more likely to have a behavior when [s/he] can't express [him/herself]. The ISP did not include information regarding the assistance Resident 1 required for toileting, showers, oral care, dressing or medication management. The ISP did not include information about Resident 1 requiring structured activities, routine or how caregivers should redirect Resident 1's behaviors. Additionally, the ISP did not include information regarding Resident 1's level of supervision or day program services. On 02/18/2026, at 1:30PM, Surveyor interviewed Residential Manager A. Residential Manager A stated s/he would ensure the ISP was updated. Residential Manager A acknowledged the findings regarding the missing information in the ISP.	M 412		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months	M 424		

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M 424	Continued From page 3 by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the individual service plan (ISP) was updated when there was a change in needs for Resident 1. Findings Include: On 12/29/2025, the department received an allegation regarding aggressive behaviors not being addressed. On 02/17/2026, at 8:12AM, Surveyor interviewed Caregiver B. Caregiver B reported Resident 1 has had an increase in behavioral episodes. Caregiver B recalled Resident 1 would lunge at caregivers and grab them by their shirt and/or hair. Caregiver B identified Resident 1 has grabbed other residents in the home. Caregiver B	M 424		

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M 424	Continued From page 4 explained there was a time when Resident 1 grabbed him/her by the shirt and pulled him/her down to the ground. Caregiver B described when Resident 1 starts pacing or saying phrases such as, "I am the [gender] with the book ..." s/he knows Resident 1 will potentially become behavioral. Caregiver B discussed difficulties managing other residents' needs, such medications, toileting and preparing meals because s/he does not know when Resident 1 will need interventions. Caregiver B reported when Resident 1 grabs someone, s/he must speak calmly. After some time, Resident 1 will eventually let go. Caregiver B could not recall if Resident 1 had a behavior support plan. Caregiver B identified there is a document that lists some interventions, but they do not work in "real time." Caregiver B could not located the document. On 02/17/2026, at 8:31AM, Surveyor interviewed Residential Manager A (RM-A). RM-A reported Resident 1 has lived at the home for approximately 1 year and recently started showing grabbing behaviors around October or November 2025. RM-A advised s/he has worked at the home often with Resident 1. RM-A reported Resident 1 has grabbed caregivers by the shirt and by the hair. RM-A explained Resident 1 will eventually let go if s/he is spoken to calmly and sometimes counting to 3 helps. RM-A reported s/he has been working with Resident 1's family and managed care organization to obtain funding for a one-to-one caregiver. RM-B advised Resident 1 has a one-to-one caregiver while at his/her day program and Resident 1's guardians are paying a private caregiver to provide a one-to-one caregiver after s/he returns from day program for a couple of hours.	M 424			

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M 424	Continued From page 5 On 02/17/2026, Surveyor reviewed Resident 1's Positive Support Plan (PSP), dated 06/05/2025. The PSP was developed by the managed care organization. The PSP provided the following information: Common Triggers: changes in routine, things not happening as expected, boredom, times of transition and overstimulation. Coping Tools: keeping a routine, walking, taking a car ride, using fidget/sensory items, exercising, having a snack, distractions (watching videos or looking at items of interest, asking him/her to use his/her words and deep breathing. The PSP also mentioned creating a visual schedule. Additionally, the PSP advised to remain calm and help him/her communicate why s/he is upset. On 02/17/2026, Surveyor reviewed Resident 1's General Event Reports. The reports identified the following behavioral occurrences: 01/27/2026: The report noted Resident 1 grabbed the caregiver by the shirt and hit him/her with a full soda can. 02/05/2026: The report noted Resident 1 grabbed his/her privately paid one-to-one caregiver by the hair multiple times and attempted to grab him/her by the neck. After the privately paid one-to-one caregiver left, Resident 1 grabbed RM-A by the hair and attempted to grab him/her by the neck. The report documented Resident 1's behaviors was "not easily redirected." 02/06/2026: The report indicated Resident 1 charged at the RM-A and grabbed his/her shirt. On 02/17/2026, Surveyor reviewed the	M 424		

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M 424	Continued From page 6 documents titled, "T-Log" (caregiver notes). The T-logs identified the following behavioral occurrences: 01/12/2026: The T-log noted as Resident 1 walked by the table, s/he grabbed another resident by the shirt. 01/13/2026: The T-log noted Resident 1 attempted to grab another resident, but the caregiver intervened, and s/he grabbed the caregiver instead. On 02/18/2026, Surveyor reviewed Resident 1's managed care organization's case manager notes. The case manager's notes identified the following behavioral occurrences: 12/05/2025: The case manager was notified of Resident 1's increase in behaviors. RM-A reported to the case manager on 12/04/2025, Resident 1 aggressively approached caregivers and residents. One resident sustained a bruise on the chest area. 12/16/2025: The case manager was informed on 12/11/2025, Resident 1 had a behavioral episode where s/he grabbed 3 people. On 12/12/2025, additional staff were required to ensure safety. On 12/15/2025 Resident 1 grabbed a caregiver when s/he was trying to prevent Resident 1 from grabbing another resident. During this episode, Resident 1 pulled the caregiver to the floor by the head. 01/30/2026: The case manager was informed the adult family home staff called the police due to Resident 1's behavior and others were fearful of him/her.	M 424		

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M 424	Continued From page 7 02/10/2026: The case manager was updated by RM-A that Resident 1 attacked his/her privately paid one-to-one staff which resulted in injuries requiring medical attention. RM-A planned to call the psychiatrist regarding these concerns. On 02/17/2026, Surveyor reviewed Resident 1's ISP. The ISP stated, "[Resident 1] has time [sic] where [s/he] will grab staff or individual's [sic]. [Resident 1] does not like people wearing hoodie sweaters. [Resident 1] will pace and constantly ask for soda. Triggers may be 'saying no', yelling or taking things away. [Resident 1] is more likely to have a behavior when [s/he] can't express [him/herself]. On 02/18/2026, at 1:30PM, Surveyor interviewed RM-A. RM-A advised s/he is meeting with the caregivers working the home later today to provide education on the PSP and behavioral interventions. RM-A reported s/he will also provide education to other caregivers that provide coverage for the home. RM-A confirmed a visual schedule has not been developed for Resident 1, but s/he plans to implement one soon. RM-A stated s/he will ensure the ISP is updated. According to interviews with RM-A and Caregiver B, Resident 1 started to show an increase in behavioral episodes including lunging at caregivers, grabbing staff by the shirt and grabbing other residents. Resident 1's General Event Reports, T-logs and case manager notes also identified the increase in behaviors. Resident 1's managed care organization developed a PSP on 06/05/2025, that outlined Resident 1's triggers, coping tools and suggested making a visual schedule. The ISP identified Resident 1's behaviors and triggers but was not updated to identify interventions to be used during a	M 424		

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M 424	Continued From page 8 behavioral episode. Additionally, the ISP was not updated to reflect Resident 1's PSP which included interventions to prevent and redirect the behaviors.	M 424			