STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016776	A. BUILDING: _____ B. WING _____	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA CARE SOUTH 42ND ST	4114 4116 ROCK ST MANITOWOC, WI 54220

(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 An abbreviated survey was conducted at Vista Care South 42nd Street on 10/22/2024 with information gathered through 10/23/2024. As a result of this survey 1 deficiency was identified. Census: 3	M 000		
M 604	88.10(5)(c)4 Information About Advocacy Organization To have available in the home the name, address and phone number of organizations providing advocacy assistance for the type of individual served by the adult family home, and the name, address and phone number of the licensing agency. This Rule is not met as evidenced by: Based on observation and staff interview the provider did not post a grievance procedure, resident rights, the name and number of the State Licensing Agency or information about the Ombudsman in a prominent public place available to residents, employees, and guests. Findings include: On 10/22/2024 Surveyor conducted a tour with RM (Resident Manager) - A at approximately 12:10 pm. There was no evidence of providing advocacy assistance by posting an Ombudsman poster in the facility, resident rights, and no evidence of a Grievance Procedure posted including the name and number of the State Licensing Agency. RM - A was unable to locate a posting of any of these documents.	M 604		

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