

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014822	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/04/2025
NAME OF PROVIDER OR SUPPLIER VISTA POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE W180 N8200 TOWN HALL ROAD MENOMONEE FALLS, WI 53051		
(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 12/04/2025, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit at Vista Pointe, a community-based residential facility (CBRF) located in Menomonee Falls, WI. As a result of the survey, 0 deficiencies were identified. All previous deficiencies from Statement of Deficiency (SOD) EU0311, dated 09/18/2025, were corrected. Under statutory provisions of Wis. Stat. Chapter 50, a \$200 revisit fee is being assessed. Census: 19	{N 000}		

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

TITLE

(X6) DATE