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 _____	C 01/21/2026

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 01/06/2026, with information gathered through 01/21/2026, Surveyor investigated 1 complaint, reviewed 1 self-report and conducted a standard survey. The complaint was substantiated. As a result of the survey 10 new deficiencies were identified. Three of the 10 deficiencies are repeat violations. Census 8	N 000		
N 301	83.28(3) Provide admission agreement as required. Admission agreement. Before or at the time of admission, the CBRF shall provide the admission agreement as required under s. DHS 83.29(2). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were provided with the admission agreement before or at the time of admission for Resident 2. Findings Include: On 01/06/2026, at approximately 12:30PM, Surveyor requested Resident 2's admission agreement from Residential Manager A (RM-A). RM-A reported s/he would search the provider's electronic record system for the admission agreement. On 01/12/2026, Surveyor received information from Resident 2's record, but there was no admission agreement. On 01/12/2026, Surveyor reviewed the resident roster. The roster documented Resident 2 was admitted on 03/05/2024.	N 301		

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

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N 301	Continued From page 1 On 01/21/2026, at 11:33AM, Executive Director D confirmed s/he could not locate Resident 2's admission agreement in the electronic record. Area Director D could not confirm if Resident 2 was provided an admission agreement.	N 301		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were screened within 90 days before or 7 days after admission by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse for clinically apparent communicable disease, including tuberculosis for Resident 2. Findings Include:	N 302		

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N 302	Continued From page 2 On 01/06/2026, at approximately 12:30PM, Surveyor requested Resident 2's communicable disease documentation from Residential Manager A (RM-A). RM-A reported s/he would search the provider's electronic record system for the communicable disease documentation. On 01/12/2026, Surveyor received information from Resident 2's record, but there was no communicable disease screening documentation. On 01/12/2026, Surveyor reviewed the resident roster. The roster identified Resident 2 was admitted on 03/05/2024. On 01/21/2026, Executive Director D confirmed s/he could not locate Resident 2's communicable disease screening in the electronic record. Executive Director D could not confirm if Resident 2 was screened for communicable diseases including tuberculosis.	N 302		
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 1. This requirement is being cited for a second time.	N 352		

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N 352	Continued From page 3 See Statements of Deficiency (SOD) V8O611, dated 06/30/2025. Findings Include: On 01/12/2026, Surveyor reviewed Resident 1's September 2025 Medication Administration Record (MAR). The MAR indicated Resident 1 was not administered his/her 8:00PM medications on 09/18/2025 and 09/23/2025. The MAR reflected the following: 09/18/2025 >Benztropine 1mg - take 1 tablet twice daily. The second dose on the MAR documented "R.1." The key on the MAR identified R.1 as "missed." >Diazepam 2mg tab - take 1 tab by mouth at bedtime. The MAR documented "R.2." The key on the MAR identified R.2 as "missed." >Divalproex 500mg ER - Take 4 tabs by mouth every night at bedtime. The MAR documented "R.3." The key on the MAR identified R.3 as "missed." >Itraconazole 100mg - take 2 caps by mouth once daily. The MAR documented "R.4." The key on the MAR identified R.4 as "missed." 09/23/2025 >Benztropine 1mg - take 1 tablet twice daily. The second dose on the MAR documented "X.1." The key on the MAR identified X.1 as "missed." >Diazepam 2mg tab - take 1 tab by mouth at bedtime. The MAR documented "X.2." The key on the MAR identified X.2 as "missed."	N 352		

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N 352	Continued From page 4 >Divalproex 500mg ER - Take 4 tabs by mouth every night at bedtime. The documented MAR "X.3." The key on the MAR identified X.3 as "missed." >Itraconazole 100mg - take 2 caps by mouth once daily. The MAR documented "X.4." The key on the MAR identified X.4 as "missed." On 01/20/2026, at 1:00PM, Surveyor interviewed Executive Director D. Executive Director D acknowledged the findings. No additional evidence was provided prior to the exit conference.	N 352		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure prompt and adequate treatment for Resident 1. Resident 1 had a history of substance abuse. Resident 1 returned home on 09/25/2025 and informed the caregiver s/he used illegal substances. On 09/26/2025, Resident 1 experienced an overdose and required emergency medical services (EMS). Findings Include:	N 353		

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 _____	C 01/21/2026

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VISTA CARE MEHRTENS AVENUE	1522 N 17TH STREET SHEBOYGAN, WI 53081

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N 353	Continued From page 5 On 01/06/2026, Surveyor reviewed a self-report, dated 09/30/2025, submitted to the department by Area Director B (AD-B). The self-report identified on 09/26/2025, at 10:30AM, Residential Manager A (RM-A) checked on Resident 1 in his/her room. Resident 1. RM-A found Resident 1 foaming at the mouth and nose and visibly shaking and confused. RM-B called emergency services and Resident 1 was admitted to the hospital for an overdose. On 01/06/2025, at approximately 10:30AM, Surveyor interviewed RM-A. RM-A advised Resident 1 had a past history of substance abuse, but due to recent sobriety, the county case manager allowed him/her to have unsupervised time in the community as long as s/he returned for his/her prescribed medications. RM-A confirmed on 09/26/2025, Resident 1 was taken by EMS to the hospital due to the discovery of him/her foaming from the mouth and nose. RM-A explained upon arrival to the home, s/he went door to door checking on residents. Resident 1 did not respond to the knock on his/her door. RM-A opened the door to check on Resident 1 and found him/her foaming a brown substance from the mouth and nose. RM-A reported Resident 1 was able to talk but was confused and shaky. RM-A advised s/he called 911 and EMS took Resident 1 to the emergency room. RM-A stated s/he did not work on 09/25/2025 and was unaware Resident 1 returned late at night on 09/25/2025 and reported to the caregiver s/he used illegal substances. RM-A reported s/he later learned information about Resident 1's condition through and email from AD-A to Resident 1's county manager. RM-A was included as a recipient to the email. RM-A explained the email identified once Resident 1 as at the hospital s/he	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VISTA CARE MEHRTENS AVENUE	1522 N 17TH STREET SHEBOYGAN, WI 53081

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N 353	Continued From page 6	N 353		

was found to have multiple substances in his/her system including fentanyl. Additionally, Resident 1 was treated for aspiration pneumonia. RM-A acknowledged the need to ensure interventions are implemented and followed when Resident 1 has admitted to, or is suspected to have engaged in substance abuse.

On 01/12/2026, Surveyor reviewed an email sent on 09/29/2025, at 8:29AM, from Area Director B (AD-B) to Sheboygan County Case Managers. The email stated, "Just an update on [Resident 1]. The update from the weekend is that [Resident 1] had adderall, alcohol and fentanyl in [his/her] system when [s/he] arrived at the hospital. [S/he] is/was in ICU (intensive care unit) for pneumonia due to aspiration. It was also possible that [s/he] had a heart attack as well ..."

On 01/12/2026, at 4:22PM, Surveyor interviewed County Case Manager (CCM-C). CCM-C confirmed Resident 1 is currently on a Chapter 51 commitment and his/her court ordered treatment was current. CCM-C also confirmed Resident 1 has a history of illegal substance usage. CCM-C reported s/he was off work when the incident occurred and was informed upon his/her return. CCM-C confirmed Resident 1 is allowed to have unsupervised time in the community as long as s/he is with family. CCM-C stated since s/he is on a Chapter 51 commitment, s/he would expect the provider would call the crisis center for intervention upon suspected substance use. CCM-A advised s/he was informed Resident 1 was found to have multiple substance in his/her system. CCM- stated s/he is updating Resident 1's recovery plan.

On 01/12/2026, Surveyor reviewed Resident 1's Individual Service Plan (ISP), dated 08/01/2025.

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 _____	C 01/21/2026

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

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N 353	Continued From page 7 The ISP identified Resident 1 was on a chapter 51 commitment. The ISP noted Resident 1 had a long history of substance abuse and s/he has not been "upfront and honest about." On 01/12/2026, Surveyor reviewed the document titled, "T-Log," dated 09/26/2025, at 1:38AM. The document noted the following: "At 11:45p [Resident 1] was dropped off by a cab driver. The driver reported to staff that [s/he] has had to cover for [Resident 1] in the past and has seen [him/her] in a similar state before. Upon arrival, [Resident 1] presented as sweaty and shaky. [His/her] behavior was noticeably different, [s/he] was overly complimentary towards staff and trying to talk about 'feelings.' [S/he] stated directly that [s/he] was high off 'dope' and reported to 'crash' within 10 minutes. Staff observed [Resident 1] closely for health and safety ..." On 01/12/2026, Surveyor reviewed the General Even Report (GER), dated 09/26/2025. The GER noted the following: "On 9/25/25 at 11:45PM, staff reported that [Resident 1] was dropped off at the home by a cab driver. At that time, [s/he] presented as sweaty and shaky, and [his/her] behavior was noticeably different ... [Resident 1] directly stated that [s/he] was high off of 'dope ...' This morning 9/26/25...At approximately 10:40 AM during routine checks, [Staff] and I attempted to knock on [Resident 1's] door with no response. While outside [his/her] room, we heard a gargling sound, which prompted us to enter. [Resident 1] was found asleep with brown foam coming from [his/her] nose, extending down [his/her] face, shoulder, and pillowcase. [Staff] and I immediately attempted to wake [him/her]; [s/he] was responsive but appeared confused and , embarrassed, attempting to clean [himself/herself] up ... I then promptly called 911.	N 353		

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	0018329	A. BUILDING: _____ B. WING _____	C 01/21/2026

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VISTA CARE MEHRTENS AVENUE	1522 N 17TH STREET SHEBOYGAN, WI 53081

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N 353	Continued From page 8 Emergency services arrived and transported [Resident 1] to Aurora Memorial for evaluation ...Ongoing staff training will reinforce recognition and response to medical emergencies and suspected substance use..." On 01/12/2026, Surveyor Reviewed Resident 1's Crisis Plan, dated 07/12/2022. The Crisis Plan noted upon Resident 1's return to the home, Resident 1 will be evaluated for "mental wellness and intoxication." The Crisis Plan further stated, "[Resident 1's] Case Manager, Back-Up Case Manager, and/or Behavioral Health Supervisors will be contacted during business hours or Sheboygan County Mobile Crisis after hours to determine the most appropriate response ... " Resident 1 has a history of substance abuse and was on a Chapter 51 commitment with a crisis plan to address substance use. On 09/25/2025, at 11:45PM, Resident 1 returned to the home by a cab and informed a caregiver s/he used illegal substances. The T-log written by the caregiver documented s/he observed Resident 1 was sweaty, shaky and behaving differently. On the following morning, 09/26/2025, RM-A discovered Resident 1 at approximately 10:40AM in his/her room with brown foam coming from his/her mouth and nose. Resident 1 was transported to the hospital by EMS. The hospital found Resident 1 had Adderall, alcohol and fentanyl in his/her system. Resident 1 was also treated for aspiration pneumonia and a possible heart attack. The crisis center was not contacted after Resident 1's admission of using "dope" and the caregiver's observation on 09/26/2025 at 11:45PM. Resident 1 did not receive medical intervention until the next morning at 10:40AM. Cross Reference N0389 DHS 83.35(3)(d) Service	N 353		

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	0018329	A. BUILDING: _____ B. WING _____	C 01/21/2026

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

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N 353	Continued From page 9 Plans Updated Annually or on Changes	N 353		
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 Resident 2. Findings Include: On 01/06/2026, at approximately 12:30PM, Surveyor requested Resident 2's ISP from Residential Manager A (RM-A). RM-A reported s/he would search the provider's records for the ISP. On 01/12/2026, Surveyor reviewed the resident roster. The roster documented Resident 2 was admitted on 03/05/2024.	N 386		

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 _____	C 01/21/2026

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 386	Continued From page 10 On 01/12/2026, Surveyor reviewed Resident 2's face sheet. The face sheet identified Resident 2 has a diagnosis of diabetes mellites due to underlying condition, schizoaffective disorder and bipolar disorder. On 01/12/2026, Surveyor received documentation from Resident 2's record. The documentation did not include the ISP. On 01/14/2026, Surveyor reviewed Resident 2's undated Residential Assessment Form. The document assessed Resident 2 needed assistance in the following areas: 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. Self-Harm: Past thoughts of taking his own life and needs social interaction Medication: Direct supervision/monitoring On 01/14/2026, Surveyor reviewed Resident 2's Sheboygan County Individual Service Plan, dated 02/14/2025. The plan was created by Resident 2's county case manager. The county's plan identified Resident 2 required assistance with independent living skills, activities of daily living, hygiene, cleaning his/her room, laundry, medication administration/monitoring and transportation for "accessing and connecting to community ..."	N 386		

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 _____	C 01/21/2026

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

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N 386	Continued From page 11 On 01/21/2025 at 11:33AM, Executive Director D confirmed s/he was unable to find Resident 2's ISP in the resident record. Executive Director D could not verify if a comprehensive ISP was developed. According to the provider's Residential Assessment, Resident 2 needed assistance with meal preparation, medications and verbal cues for toileting, showering, dressing appropriately for the weather, and interventions for his/her history of suicidal ideations. Resident 2's County Individual Service Plan identified s/he required assistance with transportation for accessing and connecting to community, medication administration, laundry, hygiene, housekeeping and activities of daily living. The provider did not develop an ISP to address all of Resident 2's assessed needs. Cross Reference N0435 DHS 83.38 (1)(k) Transportation	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.	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA CARE MEHRTENS AVENUE	1522 N 17TH STREET SHEBOYGAN, WI 53081

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N 389	Continued From page 12	N 389		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Individual Service Plans (ISP) were updated when there was a change in a resident's needs, or mental condition for Resident 1.

Resident 1 was on a Chapter 51 commitment and had a treatment plan. Resident 1 had a history of drug abuse. On 09/26/2025, Resident 1 experienced an overdose from ingesting illegal drugs. The ISP did not identify interventions regarding intoxication.

This requirement is being cited for a second time. See Statements of Deficiency (SOD) YYYH11, dated 05/23/2024.

Findings Include:

On 01/06/2026, Surveyor reviewed a self-report, dated 09/30/2025, submitted to the department by Area Director B (AD-B). The self-report identified on 09/26/2025, at 10:30AM, Residential Manager A (RM-A) checked on Resident 1 in his/her room.RM-A found Resident 1 foaming at the mouth and nose and visibly shaking and confused. RM-B called emergency services and Resident 1 was admitted to the hospital for an overdose.

On 01/12/2026, at approximately 10:00AM, Surveyor reviewed Resident 1's face sheet that identified Resident 1 was admitted on 07/12/2022.

On 01/12/2026, Surveyor reviewed the General

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 _____	C 01/21/2026

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

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N 389	Continued From page 13	N 389		

Even Report (GER), dated 09/26/2025. The GER noted Resident 1 returned home by a cab and reported to the caregiver s/he was high on "dope" and was expected to "crash" in 10 minutes. The GER further identified Residential Manager A (RM-A) and a caregiver discovered Resident in his/her bed gurgling with brown foam coming from his/her nose. RM-A initiated 911 and Resident 1 was taken to the hospital for treatment.

On 01/12/2026, at 4:22PM, Surveyor interviewed County Case Manager (CCM-C). CCM-C confirmed Resident 1 is currently on a Chapter 51 commitment and his/her has a court ordered treatment plan. CCM-C also confirmed Resident 1 has a history of illegal drugs usage and s/he was aware of the overdose incident on 09/26/2025. CCM-C stated in the event of intoxication, s/he would expect the provider to call the crisis center. Regarding Resident 1's supervision while in the community, CCM-C explained Resident 1 could be independent in the community any time s/he was with family, but when on his/her own the timeframe was 2-4 hours. After the incident occurred, Resident 1's independent community time was changed to only while s/he is with family.

On 01/12/2026, Surveyor Reviewed Resident 1's Crisis Plan, dated 07/12/2022. The Crisis Plan noted upon Resident 1's return to the home, Resident 1 will be evaluated for "mental wellness and intoxication." The Crisis Plan further noted, the mobile crisis center should be contacted to determine the appropriate response.

On 01/12/2026, Surveyor reviewed the Treatment Order, dated 06/01/2022, from Sheboygan County Circuit Court. The ordered noted the

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 _____	C 01/21/2026

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

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N 389	Continued From page 14 following: " ...The appropriate department imposes the following outpatient treatment plan and condition: ... Take all doses of psychotropic medication prescribed for me ... Refrain from any acts, attempts, or threats to harm myself or others ... Refrain from ingesting any controlled substances not prescribed for me ... Refrain from consuming alcoholic beverages " On 01/12/2026, Surveyor reviewed Resident 1's ISP, dated 08/01/2025. The ISP identified Resident 1 is on a chapter 51 commitment. The ISP noted Resident 1 had a long history of substance abuse and s/he has not been "upfront and honest about." The ISP did not identify how caregivers should monitor for signs of intoxication or interventions regarding how caregivers should respond to suspected intoxication. The information in the Crisis Plan was not included as an intervention. The ISP did not identify Resident 1's level of supervision when in the community. Further review of the ISP revealed it did not identify interventions for items identified in the Treatment Order, which included, possible occurrences of acts, attempts or threats to harm his/herself or others as identified in the treatment plan. The ISP was not updated after the overdose incident on 09/26/2025. On 01/20/2026, Surveyor interviewed Executive Director D regarding the ISP. Area Director D acknowledged the findings of updating the ISP to include information regarding interventions for Resident 1. Cross Reference N0353 DHS 83.32(3)(i) Rights Of Residents: Adequate Treatment	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 _____	C 01/21/2026

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N 394	Continued From page 15	N 394		
N 394	83.35(5)(b) Annual evaluation of evacuation limits Evaluation update. The CBRF shall evaluate each resident ' s mental or physical capability to respond to a fire alarm at least annually or when there is a change in the resident ' s mental or physical capability to respond to a fire alarm. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure annual evaluation of each resident's mental or physical capability to respond to a fire alarm for Resident 1 and Resident 2. This requirement is being cited for a second time. See Statements of Deficiency (SOD)YYYH11, dated 05/23/2024. Findings Include: On 01/06/2026, at approximately 12:30PM, Surveyor requested Resident 1's and Resident 2's annual Resident Evacuation Evaluation from Residential Manager A (RM-A). RM-A reported s/he would search the provider's electronic record system for the document. On 01/12/2026, Surveyor reviewed the provider's resident roster. The roster identified Resident 1 was admitted on 07/12/2022. On 01/12/2026, Surveyor received information from Resident 1's record that included the Resident Evacuation Evaluation dated 07/18/2022. On 01/12/2026, Surveyor received information from Resident 2's record that included the Resident Evacuation Evaluation dated 09/11/2024.	N 394		

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	0018329	A. BUILDING: _____ B. WING _____	C 01/21/2026

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

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N 394	Continued From page 16 On 01/12/2026, Surveyor reviewed the provider's resident roster. The roster identified Resident 2 was admitted on 03/05/2024. On 01/21/2026, at 11:33AM, Executive Director D confirmed s/he could not locate Resident 1's or Resident 2's annual Resident Evacuation Evaluations. Area Director D could not confirm if the evaluations were completed annually.	N 394		
N 435	83.38(1)(k) Transportation. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Transportation. The CBRF shall provide or arrange for transportation when needed for medical appointments, work, educational or training programs, religious services and for a reasonable number of community activities of interest. CBRFs that transport residents shall develop and implement written policies addressing the safe and secure transportation of residents. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure they provided transportation adequate to meet the needs of the residents for Resident 2. Findings Include:	N 435		

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VISTA CARE MEHRTENS AVENUE	1522 N 17TH STREET SHEBOYGAN, WI 53081

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N 435	Continued From page 17 On 10/31/2025, the department received a complaint alleging a resident was not transported home from the community. On 01/06/2026, at approximately 9:41AM, Surveyor interviewed Residential Manager A (RM-A) regarding the incident on 10/28/2025 when Resident 2 was left at Uptown Social. RM-A reported s/he began working with Resident 2 on 09/23/2025. RM-A was told Resident 2 attends Uptown Social twice a week at the recommendation of his/her therapist. RM-A reported Resident 2 requires time to process events before they happen; therefore, caregivers should inform him/her 2 hours prior to transporting him/her to Uptown Social. Before dropping Resident 2 off at Uptown Social, they should inform him/her of what time they will pick him/her up to return home. RM-A reported the day of the incident; the caregiver did not communicate to Resident 2 what time s/he would return to pick him/her up. RM-A explained Uptown Social closes at 4:00PM and the caregiver forgot to pick up Resident 2 from Uptown Social. RM-A further explained Uptown Social did not have the correct contact number to call Vista Care staff. Uptown Social eventually contacted Resident 2's county case manager. The case manager transported Resident 2 home. RM-A advised s/he has updated Uptown Social with the appropriate contacts and re-educated caregivers providing transportation for Resident 2. Note: Uptown Social is a recreational organization for adults. On 01/06/2026, at 11:45AM, Surveyor interviewed Resident 2 regarding the incident that occurred on 10/28/2025. Resident 2 reported s/he did not know when someone was going to pick him/her up from Uptown Social to go home. Resident 2	N 435		

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

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N 435	Continued From page 18 stated s/he did not know who or how to contact to get back home. On 01/12/2026, Surveyor reviewed Resident 2's face sheet. The face sheet identified Resident 2 has a diagnosis of diabetes mellites due to underlying condition, schizoaffective disorder and bipolar disorder. On 01/14/2026, Surveyor reviewed Resident 2's County Individual Service Plan, dated 02/14/2025. The plan was created by Resident 2's county case manager. The county's plan identified Resident 2 required assistance with transportation for "accessing and connecting to community ..." On 01/14/2026, Surveyor reviewed email communication dated 10/29/2025, at 9:25AM, from Resident 2's county case manager to Vista Care management including RM-A and Area Director B. The email stated the following: " ...I am reaching out to get more information regarding an incident that occurred yesterday evening involving [Resident 2]. At approximately 4:30 PM, I received a call from Uptown Social informing me that [Resident 2] had been dropped off earlier in the afternoon by Vista Care staff but had not been picked up. Staff (Uptown Social) reported that [Resident 2] had been waiting for about an hour. Although Uptown Social closes at 4:00 PM, staff (Uptown Social) remained with [Resident 2] while attempting to locate someone who could assist [him/her]. Uptown Social Staff did tell me they tried calling two different Vista Care numbers with no [sic] answering the phone. Fortunately, they were able to obtain my contact information and reached out so that I could pick [him/her] up. I immediately went to Uptown Social	N 435		

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VISTA CARE MEHRTENS AVENUE	1522 N 17TH STREET SHEBOYGAN, WI 53081

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N 435	Continued From page 19	N 435		

and brought [Resident 2] back to the group home. Upon returning, I asked staff if they were aware that [Resident 2] required transportation back; however, they were unable to provide an answer and advised me to follow up with you. This situation is very concerning, as [Resident 2] would not have been able to return home independently without the support of Uptown Social staff. [Resident 2] also was in a t-shirt with no jacket. Uptown Social staff allowed [Resident 2] to stay in the building with them they said [Resident 2] was cold. I would appreciate further clarification on how this occurred and what steps can be taken to ensure that similar situations do not happen in the future ..."

On 01/14/2026, Surveyor reviewed the provider's General Event Report (GER), dated 01/07/2026. The GER noted the following:

" ...On 10/28/25, [Resident 2] was transported to Uptown Social by Vista Care staff earlier in the afternoon. A pickup time was not clearly coordinated. At approximately 4:30 PM, Uptown Social staff contacted [Resident 2's] case manager after [Resident 2] had remained at the location for approximately one hour past closing time (Uptown Social closes at 4:00 PM). Uptown Social staff reported they attempted to contact Vista Care using phone numbers found online but were unable to reach anyone. Uptown Social staff remained with [Resident 2] inside the building due to concerns related to cold weather, as [Resident 2] was wearing a t-shirt and no jacket. [Resident 2's] case manager responded to the call, went to Uptown Social, and transported [Resident 2] back to the group home safely ... It was confirmed that a specific pickup time was not coordinated at the time of drop-off, which led to the missed transportation ... Management reviewed

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

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N 435	Continued From page 20 transportation and supervision expectations with involved RSS ... Transportation follow-ups will be implemented to ensure accountability for both drop-off and pickup. Staff will be reminded of the importance of confirming appropriate attire for weather conditions prior to community outings. Vista Care will update contact information with Uptown Social to ensure accurate and monitored phone numbers are available in the event of an urgent need ..." On 10/28/2025, Resident 2 was transported to Uptown Social by the provider's staff. Upon closing time, no one returned to transport Resident 2 back to his/her home. Uptown Social did not have appropriate contact information for the provider. Resident 2's county case manager was contacted approximately one hour after Uptown Social closed. While waiting for Resident 2's county case manager, Resident 2 stayed inside Uptown Social with their staff due to the cold weather conditions for which s/he was not appropriately dressed. Resident 2's county case manager returned Resident 2 to his/her home. Cross Reference N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan	N 435		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure tornado, flooding, or other emergency or disaster evacuation drills were	N 526		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA CARE MEHRTENS AVENUE	1522 N 17TH STREET SHEBOYGAN, WI 53081

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N 526	Continued From page 21 conducted at least semi-annually. Findings Include: On 01/06/2026, at approximately 12:30PM, Surveyor requested the other evacuation drills for 2024 and 2025 from Residential Manager A (RM-A). RM-A reported s/he would search the provider's records for the documentation. On 01/12/2026, Surveyor only received fire drill documentation. On 01/16/2026 and 01/20/2026, Surveyor requested other drills. On 01/21/2026, at 11:33AM, Executive Director D confirmed s/he could not find other drills for 2024 and 2025.	N 526		
N 538	83.48(3)(a) Fire detection systems inspected annually. After the first year following installation, fire detection systems shall be inspected, cleaned and tested annually by certified or trained and qualified personnel in accordance with the specifications in NFPA 72 and the manufacturer ' s specifications and procedures. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the fire detection system was inspected, cleaned and tested annually. Findings Include: On 01/06/2026, at approximately 12:30PM, Surveyor requested the annual fire detection system inspection from Residential Manager A (RM-A). RM-A reported s/he would search the	N 538		

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N 538	Continued From page 22 provider's records for the document. On 01/12/2026, Surveyor received the inspection and testing form dated, 10/16/2024. On 01/16/2026 and 01/20/2026, Surveyor requested the current inspection for 2025. On 01/21/2026, at 11:33AM, Executive Director D confirmed s/he could not find the 2025 inspection.	N 538		