

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018167	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/30/2025
NAME OF PROVIDER OR SUPPLIER VISTA CARE HELLER AVENUE		STREET ADDRESS, CITY, STATE, ZIP CODE 1528 NORTH 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 06/27/2025, with additional information gathered through 06/30/2025, Surveyors investigated one complaint at Vista Care Heller Avenue. The complaint was substantiated and 2 new deficiencies were identified. Census 8	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 were administered medications as prescribed for Resident 1. Findings Include: On 03/19/2025, the department received a complaint alleging a resident was not administered medication. On 06/27/2025, at 10:54AM, Surveyor interviewed Resident 1. Resident 1 confirmed s/he was without the medication Clozaril (clozapine) sometime in March 2025. Resident 1 recalled s/he was out of the medication for approximately a week. On 06/27/2025, Surveyor reviewed Resident 1's	N 352		

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

TITLE

(X6) DATE

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018167	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/30/2025
NAME OF PROVIDER OR SUPPLIER VISTA CARE HELLER AVENUE			STREET ADDRESS, CITY, STATE, ZIP CODE 1528 NORTH 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 352	Continued From page 1 March 2025 medication administration record (MAR). Review of the MAR revealed missed administration of medications as follows: Clozapine 100mg tablets - take 1 tab every day at 12:00PM 03/20/2025: Missed Clozapine 50mg tablet - take 1 by mouth every evening at 4:00PM 03/20/2025: Missed 03/21/2025: No med on cart 03/22/2025: This medication is not in the house/not sure if it has been DC'd 03/23/2025: No longer takes [note: no discontinue order noted] 03/24/2025: Missed 03/25/2025: Out Clozapine 200mg tablet - take 2 tablets every night at bedtime 03/27/2025: Missed AM Dose Divalproex 500mg tablet - take 1 tablet twice daily 03/20/2025: Missed PM Dose Divalproex 500mg tablet - take 1 tablet twice daily 03/20/2025: Missed PM Dose Cobenfy Cap 50-20mg - take 1 capsule twice daily for 2 weeks then increase. Start 03/20/2025 and End 03/30/2025. 03/21/2025: not filled 03/22/2025: not filled 03/23/2025: not sent by pharmacy On 06/27/2025, 11:12AM, Surveyor interviewed Residential Manager A (RM-A). RM-A explained	N 352			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018167	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/30/2025
NAME OF PROVIDER OR SUPPLIER VISTA CARE HELLER AVENUE		STREET ADDRESS, CITY, STATE, ZIP CODE 1528 NORTH 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 352	Continued From page 2 the provider switched pharmacies in March 2025 and had some issues receiving Resident 1's prescribed medications including clozapine. RM-A confirmed this caused Resident 1 to miss doses of clozapine. RM-A reported when the clozapine was received, Resident 1 had to titrate up to the therapeutic dose.	N 352		
Y3245	50.09(1)(m) Choice of Provider (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (m) Use the licensed, certified or registered provider of health care and pharmacist of the resident's choice. This Rule is not met as evidenced by: Based on record review and interviews, residents and/or legal representatives were not given the choice of pharmacy provider. In January 2025, the provider switched to a new pharmacy and did not inform the residents and/or legal representatives of a change in pharmacy provider. The lack of notification did not allow residents and/or legal representatives to choose a different pharmacy. This affected 8 of 8 residents. Findings include:	Y3245		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018167	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/30/2025
NAME OF PROVIDER OR SUPPLIER VISTA CARE HELLER AVENUE		STREET ADDRESS, CITY, STATE, ZIP CODE 1528 NORTH 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
Y3245	Continued From page 3 On 03/19/2025, the department received a concern regarding a change in pharmacy and medication administration. On 06/27/2025 at 10:05 AM, Surveyor spoke with RM (Residential Manager)-A. RM-A indicated the home changed pharmacies in January 2025 from Glander Pharmacy to Tarrytown Pharmacy because the company (Vista Care) wanted to have a universal medication system in all the homes nationwide. RM-A verified the home currently contracts and utilizes Tarrytown pharmacy services for all eight (8) residents in the home. On 06/27/2025, Surveyors were provided a list of residents in the home. Residents 1, 2, 4, 5, 6, and 7 were their own decision makers and Resident 3 had a guardian. All seven residents resided in the home prior to 01/2025 and had their medications managed and administered by staff. Resident 8 admitted on 05/02/2025, after the change in pharmacy. On 06/27/2025 at 10:15 AM, Surveyor spoke with RM-A. Surveyor asked RM-A how the residents and/or legal representatives were informed of the change in pharmacy services. RM-A indicated s/he was not sure how they were or if they were informed. RM-A stated, "I know residents' funding sources were made aware of the switch through an email I sent them." RM-A provided Surveyor the email s/he sent to all eight (8) residents' funding sources dated, 01/23/2025 which read, "I wanted to take time to inform everyone that Vista Care is now using a new pharmacy. We now have all medication coming from Tarrytown. We are no longer going through Glander. If you have any questions, please let	Y3245		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018167	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/30/2025
NAME OF PROVIDER OR SUPPLIER VISTA CARE HELLER AVENUE		STREET ADDRESS, CITY, STATE, ZIP CODE 1528 NORTH 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
Y3245	Continued From page 4 me know." Surveyor again asked if the residents and/or legal representatives were given a choice of pharmacy when the home switched pharmacy providers. RM-A indicated s/he wasn't involved in any resident and/or legal representative notification of the change in pharmacy providers. RM-A stated s/he would call VP (Vice President)-C. On 06/27/2025 at 10:40 AM, Surveyor spoke with Area Director B. Area Director B indicated s/he was not involved in any notification (letters) of the change in pharmacy provider that occurred in January 2025. Area Director B stated the pharmacy change occurred before s/he became the Area Director. On 06/27/2025 at 10:55 AM, RM-A approached Surveyor and stated, "[VP-C] told me [s/he] had meetings with residents' funding sources and guardians in January 2025. [VP-C] discussed the pros of the new pharmacy provider (Tarrytown) and let them know they could go through another pharmacy." Surveyor then asked RM-A if s/he had any documentation to show residents and/or legal representatives were given a choice of pharmacy. RM-A was unable to locate any evidence residents and/or legal representatives were given a choice of pharmacy or record of informing them of the change. As of 06/30/2025, no additional information or documentation was sent to the Surveyors.	Y3245		