

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/24/2026
NAME OF PROVIDER OR SUPPLIER VINTAGE ON THE PONDS		STREET ADDRESS, CITY, STATE, ZIP CODE N4901 DAM ROAD DELAVAN, WI 53115		
(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 03/24/2026, Surveyor conducted a standard licensing survey and complaint investigation at Vintage on the Ponds, a CBRF located in Delavan, WI. As a result of the survey, 2 violations of Chapter DHS 83 were issued. The complaint was unsubstantiated. Census: 55	N 000		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Caregiver B was screened by a physician, physician assistant, clinical nurse practitioner or licensed registered nurse for communicable disease including tuberculosis (TB). Caregiver B did not have a TB test, chest x-ray or statement from a medical	N 220		

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: 0018011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 03/24/2026
NAME OF PROVIDER OR SUPPLIER VINTAGE ON THE PONDS			STREET ADDRESS, CITY, STATE, ZIP CODE N4901 DAM ROAD DELAVER, WI 53115		
(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 220	Continued From page 1 professional indicating s/he was free from communicable disease. Findings include: On 03/24/2026 at 9:00 AM, Surveyor reviewed Caregiver B's employee file. Caregiver B was hired 04/07/2024. There was no documented test or screen for communicable disease including TB. On 03/24/2026 at 9:30 AM, Surveyor interviewed Licensee A. Licensee A acknowledged that each employee must be screened for communicable disease including TB prior to being hired. Licensee A stated that Caregiver B must have a TB screen as s/he has worked in nursing homes before being hired at the facility. Surveyor gave Licensee A until 03/25/2026 at noon to provide further information. As of 03/25/2026 at noon, no further information was provided.	N 220			
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully	N 239			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/24/2026
NAME OF PROVIDER OR SUPPLIER VINTAGE ON THE PONDS		STREET ADDRESS, CITY, STATE, ZIP CODE N4901 DAM ROAD DELAVER, WI 53115		
(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 239	Continued From page 2 complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 2 of 3 employees reviewed had completed Department Approved Training Courses. Caregiver B and Caregiver C did not have documented completed training in Fire Safety or First Aid and Choking. Findings include: First Aid and Choking On 03/24/2026, Surveyor reviewed Caregiver B's employee file. Caregiver B was hired 04/07/2024. There was no evidence that Caregiver B had completed training in first aid and choking. There was no evidence found in the file indicating that Caregiver B was exempt from this training. On 03/24/2026 at 9:45 AM, Surveyor interviewed Administrator A. Administrator A confirmed that Caregiver B works as a caregiver and would have to administer first aid and respond to choking emergencies.	N 239		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/24/2026
NAME OF PROVIDER OR SUPPLIER VINTAGE ON THE PONDS		STREET ADDRESS, CITY, STATE, ZIP CODE N4901 DAM ROAD DELAVER, WI 53115		
(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 239	Continued From page 3 On 03/24/2026, Surveyor verified Caregiver B was not on the Community-Based Care and Treatment training registry for first aid and choking. On 03/24/2026, Surveyor reviewed Caregiver C's employee file. Caregiver C was hired 07/02/2025. There was no evidence that Caregiver C had completed training in first aid and choking. There was no evidence found in the file indicating that Caregiver C was exempt from this training. On 03/24/2026 at 9:45 AM, Surveyor interviewed Administrator A. Administrator A confirmed that Caregiver C works as a caregiver and would have to administer first aid and respond to choking emergencies. On 03/24/2026, Surveyor verified Caregiver C was not on the Community-Based Care and Treatment training registry for first aid and choking. Fire Safety On 03/24/2026, Surveyor reviewed Caregiver B's employee file. Caregiver B was hired 04/07/2024. There was no evidence that Caregiver B had completed training in fire safety. There was no evidence found in the file indicating that Caregiver B was exempt from this training. On 03/24/2026 at 9:45 AM, Surveyor interviewed Administrator A. Administrator A confirmed that Caregiver B works as a caregiver and would have to respond to fire emergencies. On 03/24/2026, Surveyor verified Caregiver B	N 239		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/24/2026
---	---	--	--

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

VINTAGE ON THE PONDS **N4901 DAM ROAD**
DELAVER, WI 53115

(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 239	Continued From page 4 was not on the Community-Based Care and Treatment training registry for fire safety. On 03/24/2026, Surveyor reviewed Caregiver C's employee file. Caregiver C was hired 07/02/2025. There was no evidence that Caregiver C had completed training in fire safety. There was no evidence found in the file indicating that Caregiver C was exempt from this training. On 03/24/2026 at 9:45 AM, Surveyor interviewed Administrator A. Administrator A confirmed that Caregiver C works as a caregiver and would have to respond to fire emergencies. On 03/24/2026, Surveyor verified Caregiver C was not on the Community-Based Care and Treatment training registry for fire safety.	N 239		