

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015844	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/11/2026
NAME OF PROVIDER OR SUPPLIER A NEW VISIONS AF LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 503 N 4TH AVE WAUSAU, WI 54401		
(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 On 03/10/2026, Surveyor conducted a complaint and self-report (x3) investigation at A New Visions AF LLC. Data collection continued through 03/11/2026. The complaint was substantiated. The self-reports were closed. One deficiency was identified. Census: 2	M 000		
M 436	88.07(2)(a) SERVICES The licensee shall provide or arrange for the provision of individualized services specified in a resident's individual service plan that are the licensee's responsibility. This Rule is not met as evidenced by: Based on record review and interview, Licensee A did not provide or arrange for the provision of individualized services specified in Resident 1's individual service plan (ISP). Findings include: Between 12/12/2025 and 12/26/2025, the Department received three self-reports and a complaint indicating Resident 1 eloped on three separate occasions and Licensee A was not providing supervision for Resident 1.	M 436		

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

TITLE

(X6) DATE

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M 436	Continued From page 1 The provider is licensed to care for up to 4 residents in the client groups of: developmentally disabled, irreversible dementia/Alzheimer's, advanced age, alcohol/drug dependent, traumatic brain injury, emotionally disturbed/mental illness. On 03/10/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 04/10/2024. Resident 1 was protectively placed and had a guardian. Resident 1 was discharged on 01/03/2026. According to records, Resident 1 eloped on 12/03/2025, 12/14/2025 and 12/20/2025. According to a self-report, Resident 1 eloped on 12/03/2025. Resident 1 was last seen at 7:00 PM and returned to the facility after 12:00 AM on 12/04/2025. According to AccuWeather (www.accuweather.com), the temperature on 12/03/2025 to 12/04/2025 ranged from 24 degrees Fahrenheit to 4 degrees Fahrenheit. Resident 1 was wearing a hat, gloves, shoes and 3 sweatshirts. Resident 1 had taken a taxi from the facility to his/her sister's/brother's home. Resident 1 returned to the facility unharmed on 12/04/2025. According to a self-report, Resident 1 eloped around 6:00 AM on 12/14/2025. Resident 1 had taken a taxi to his/her sister's/brother's home. According to AccuWeather (www.accuweather.com), the temperature on 12/14/2025 ranged from 6 degrees Fahrenheit to -12 degrees Fahrenheit. Resident 1 returned to the facility unharmed several hours after eloping on 12/14/2025. According to a self-report, Resident 1 eloped at 8:00 a.m. on 12/20/2025. The police were notified and Resident 1 was located 15 minutes later and returned to the facility unharmed via police. According to AccuWeather (www.accuweather.com), the temperature on 12/20/2025 ranged from 30 degrees Fahrenheit to 5 degrees Fahrenheit. Resident 1's ISP (dated 04/10/2024 and updated	M 436		

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M 436	Continued From page 2 on 11/12/2024) noted that Resident 1 required "twenty-four-hour supervision and cannot be left alone." The ISP indicated, "[S/He] is under protective custody of state." On 03/10/2026 at approximately 10:00 AM, Surveyor interviewed Licensee A. Licensee A verified that Resident 1 eloped on 12/03/2025, 12/14/2025 and 12/20/2025. Licensee A stated, "I got rid of [him/her] because I couldn't take care of [him/her]. [S/He] kept running away." Licensee A reported the following: "I put bells and alarms on the doors and [s/he] would sneak out when I was in the bathroom; [Resident 1] kept eloping to [his/her] [sister's/brother's] home; [S/He] was protectively placed; [S/He] smoked cigarettes outside and I kept an eye on [him/her]; [Resident 1] would leave in the morning while I was sleeping." Licensee A commented that Licensee A put door alarms on the doors and Licensee A would set his/her alarm at 12:00 AM and 6:00 AM to check on Resident 1. Licensee A confirmed that Licensee A was the only staff member. Surveyor asked Licensee A about Resident 1's ISP. Licensee A indicated that Resident 1's ISP was not updated since admission because "There was nothing to update." On 03/10/2026 at approximately 2:00 PM, Surveyor interviewed Case Worker B via telephone. Surveyor asked about Resident 1's care and supervision. Case Worker B reported that Resident 1 was admitted on 04/10/2024 and discharged to another facility on 01/03/2026. Case Worker B verified that Resident 1 eloped on at least 3 separate occasions in December 2025. Case Worker B indicated that Resident 1 wanted to see his/her family member. Case Worker B reported that Resident 1 required twenty-four hour supervision and there was no "awake staff	M 436		

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M 436	Continued From page 3 on overnights." Case Worker B commented, "I think [Licensee A] did his/her best, but was unable to meet [Resident 1's] needs (and) was not equipped to care for [Resident 1]." Surveyor asked Case Worker B about staffing. Case Worker B reported that Licensee A was the only staff member at the facility. On 03/11/2026 at approximately 9:30 AM, Surveyor interviewed Licensee A via telephone. Surveyor asked Licensee A about the supervision of Resident 1. Licensee A reported that Resident 1 was not considered an elopement risk at the time of admission. Licensee A indicated that Resident 1's Guardian did not want Resident 1 to visit his/her sister/brother, but Resident 1 eloped on at least 3 separate occasions in December 2025 to visit his/her sister/brother. Licensee A reiterated that despite installing door alarms (and bells on the doors) and setting an alarm to wake up at 12:00 AM and 6:00 AM, Licensee A did not know what else to do to prevent Resident 1's elopements. Licensee A reported that moving forward, Licensee A would not admit anyone "with behaviors like [Resident 1]" in the future. Licensee A did not provide or arrange for the provision of individualized services specified in Resident 1's ISP.	M 436		