Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010890	A. BUILDING: _____ B. WING _____	C 04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA CARE PLAZA LANE AFH	**356 PLAZA LANE PLYMOUTH, WI 53073**

(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 03/31/2025, with information gathered through 04/01/2025, Surveyor investigated 2 complaints and conducted a standard survey. Two of 2 complaints were substantiated and one new deficiency was identified. Census 4	M 000		
M 610	88.11(1) REPORTING OF ABUSE AND NEGLECT A licensee or service provider who knows or has reasonable cause to suspect that a resident has been abused or neglected as defined in s. 46.90 or 940.285, Stats., shall immediately contact the licensing agency. Providing notice under this subsection does not relieve the licensee or other person of the obligation to report an incident to law enforcement authorities. If the licensee has reason to believe a crime has been committed, the incident shall immediately be reported to law enforcement authorities. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an allegation of abuse or neglect was reported to the licensing agency immediately. Findings Include:	M 610		

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

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M 610	Continued From page 1 On 11/14/2024 and 02/06/2025, the department received a complaint that alleged neglect occurred at the adult family home of Vista Care Plaza Lane. On 03/31/2025 at 8:48AM, Surveyor interviewed Adult Protective Services C (APS-C). APS-C reported s/he arrived at the Vista Care Plaza Lane adult family home on the morning of 10/25/2024. Upon arrival, APS-C knocked on the door several times until Resident 1 answered and invited him/her in. APS-B stated s/he did not see any caregivers upon initial observation. Resident 1 informed APS-C Caregiver B was in another room with a resident. APS-C observed Resident 1 making lunches for other the other residents to take to day program services. Resident 1 further explained to APS-C s/he was making lunches because Caregiver B fell asleep, and they were behind. APS-C expressed concern because there was a resident with an altered diet texture. APS-C then observed a resident requesting to go to the restroom. APS-C further observed Resident 1 attempting to transfer that resident to their wheelchair with the wheels in the unlocked position. APS-C reported Caregiver B did not pass medications and the bus driver would pass them upon arrival. When the bus driver arrived, a resident was left in the van while the bus driver assisted with medications. APS-C concluded the visit with a recommendation for residents to be relocated based on his/her findings. The managed care organizations for all residents in the home followed the recommendation until the adult family home was safe. APS-C stated all residents returned the following week once the adult family home and the managed care organizations put corrective actions in place.	M 610		

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M 610	Continued From page 2 On 03/31/2025, at 10:41AM, Surveyor received the provider's internal investigation about the allegations. Surveyor reviewed the document titled, "Vista Care ANE Investigation Packet," dated, 10/31/2025. The investigation substantiated the concerns identified by APS-C regarding Caregiver B. On 03/31/2025, at approximately 1:00PM, Surveyor reviewed the department's file containing provider reports to the Office of Caregiver Quality. Surveyor confirmed there was no report from Vista Care Plaza Lane. On 03/31/2025, at 1:45PM, Surveyor interviewed Regional Vice President A (RVP-A). RVP confirmed the allegation was not reported to the department upon completion of the provider's internal investigation.	M 610		