STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019856	A. BUILDING: _____ B. WING _____	C 02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VESTA	5087 VESTA CT EAU CLAIRE, WI 54703

(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 01/26/2025, Surveyor conducted a standard licensure survey and 2 complaint investigations at Vesta. Data was collected through 02/17/2026 Two of 2 complaints were substantiated. Nine deficiencies were identified. Census: 4	M 000		
M 336	88.05(4)(b)2 SMOKE DETECTORS-TESTING AND MAINTENANCE The licensee shall maintain each required smoke detector in working condition and test each smoke detector monthly to make sure that it is operating. If a unit is found to be not operating, the licensee shall immediately replace the battery or have the unit repaired or replaced. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each required smoke detector was tested monthly to ensure the smoke detector was operating in 2024 and 2025. Findings include: This provider is licensed to care for up to 4 residents in the client groups of: emotionally disturbed/mental illness, physically disabled, traumatic brain injury, and developmentally disabled. On 01/26/2026 at approximately 1:45 p.m.,	M 336		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019856	A. BUILDING: _____ B. WING _____	C 02/17/2026

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VESTA	5087 VESTA CT EAU CLAIRE, WI 54703

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M 336	Continued From page 1 Surveyor interviewed Program Director (PD) B. Surveyor requested to review the monthly smoke detector checks for 2024 and 2025. PD B told Surveyor s/he was having difficulties finding this information on their electronic record system. PD B said s/he had paper copies at the office, and s/he would scan and email the paper copies to Surveyor on 01/27/2026. On 01/27/2026, PD B emailed Surveyor a fire drill that was completed 09/05/2024. This fire drill indicated all smoke detectors were checked. On 01/29/2026, Surveyor emailed Area Director (AD) A and requested additional information including any smoke detector checks that were completed in 2024 and 2025. On 02/12/2026, PD B emailed Surveyor with additional information. The email read, in part: "I have completed a thorough review of the program records and, unfortunately, was unable to locate evidence of additional fire drills/smoke detector checks. I recognize that these tasks must be performed simultaneously and documented within our system [electronic system] to remain compliant. To rectify this, I will be training our new lead, [name], immediately to ensure these safety checks are completed and logged consistently moving forward." The provider did not check each smoke detector monthly in 2024 and 2025 to ensure each smoke detector was operating properly.	M 336		
M 342	88.05(4)(d)1 FIRE SAFETY EVACUATION PLAN The licensee shall have a written plan for the immediate and safe evacuation	M 342		

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VESTA	5087 VESTA CT EAU CLAIRE, WI 54703

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M 342	Continued From page 2 of all occupants of the home in the event of a fire. The plan shall identify an external meeting place. This Rule is not met as evidenced by: Based on interview and record review, the licensee did not have a written plan for the immediate and safe evacuation of 1 of 2 residents reviewed. The provider did not have a plan for the immediate and safe evacuation of Resident 1 in the event of a fire when Resident 1 was in bed. Findings include: This provider is licensed to care for up to 4 nonambulatory residents in the client groups of: emotionally disturbed/mental illness, physically disabled, traumatic brain injury, and developmentally disabled. On 01/26/2026 at approximately 1:40 p.m., Surveyor interviewed Direct Service Professional (DSP) D. DSP D told Surveyor Resident 1 required the assist of 1 staff and a mechanical lift to transfer Resident 1 from his/her bed to his/her wheelchair. From 01/27/2026 to 01/29/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 10/30/2025. S/he had multiple diagnoses including: depression, anxiety, developmental disorder, hemiplegia and hemiparesis affecting his/her right dominant side, cognitive communication deficit, and dependence on wheelchair.	M 342		

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	0019856	A. BUILDING: _____ B. WING _____	C 02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VESTA	5087 VESTA CT EAU CLAIRE, WI 54703

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M 342	Continued From page 3 Resident 1's assessment, dated 10/29/2025, indicated Resident 1 was a "Point of Rescue" for the level of assistance needed to evacuate. Special instructions read, "Unlock window, close door and put towel/blanket under door and notify fire department of point of rescue." On 02/16/2026, Surveyor emailed Area Director (AD) A and Program Director (PD) B for additional information. Surveyor asked if Resident 1's assessment was accurate related to his/her point of rescue. On 02/17/2026, PD B replied via email, which read, in part: "[S/he] is Point of Rescue if in bed." The provider did not have a plan for the immediate and safe evacuation of Resident 1 in the event of a fire when Resident 1 was in bed.	M 342		
M 348	88.05(4)(d)2.c SEMI-ANNUAL FIRE DRILLS The licensee shall conduct semi-annual fire drills with all household members with written documentation of the date and the evacuation time for each drill maintained by the home. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure semi-annual fire drills were conducted in 2024 and 2025. Findings include: This provider is licensed to care for up to 4 residents in the client groups of: emotionally disturbed/mental illness, physically disabled, traumatic brain injury, and developmentally	M 348		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VESTA	5087 VESTA CT EAU CLAIRE, WI 54703

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M 348	Continued From page 4 disabled. On 01/26/2026 at approximately 1:45 p.m., Surveyor interviewed Program Director (PD) B. Surveyor requested to review the fire drills completed in 2024 and 2025. PD B told Surveyor s/he was having difficulties finding this information on their electronic record system. PD B said s/he had paper copies at the office, and s/he would scan and email the paper copies to Surveyor on 01/27/2026. On 01/27/2026, PD B emailed Surveyor a fire drill that was completed 09/05/2024 and a tornado drill completed 12/31/2024. On 01/29/2026, Surveyor emailed Area Director (AD) A and requested additional information including fire drills completed in 2024 and 2025. On 02/12/2026, PD B emailed Surveyor with additional information. The email read, in part: "I have completed a thorough review of the program records and, unfortunately, was unable to locate evidence of additional fire drills/smoke detector checks. I recognize that these tasks must be performed simultaneously and documented within our system [electronic system] to remain compliant. To rectify this, I will be training our new lead, [name], immediately to ensure these safety checks are completed and logged consistently moving forward." The provider did not ensure semi-annual fire drills were conducted in 2024 and 2025.	M 348		
M 404	88.06(3)(a) INDIVIDUAL SERVICE PLAN & ASSESSMENT	M 404		

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
VESTA	5087 VESTA CT EAU CLAIRE, WI 54703

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M 404	Continued From page 5 The licensee shall ensure that a written assessment and individual service plan is completed and developed for each resident within 30 days after placement. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an individual service plan (ISP) was developed within 30 days after admission for 1 (Resident 1) of 2 residents reviewed. Findings include: From 01/27/2026 to 01/29/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 10/30/2025. S/he had multiple diagnoses including: depression, anxiety, developmental disorder, hemiplegia and hemiparesis affecting his/her right dominant side, muscle weakness, repeated falls, cognitive communication deficit, unspecified convulsions, and dependence on wheelchair. Resident 1's assessment, dated 10/29/2025, indicated Resident 1 had a legal guardian. S/he was dependent on staff for activities of daily living (ADLs) other than eating. On 01/29/2026, Surveyor emailed Area Director (AD) A and requested additional information including Resident 1's ISP. On 02/12/2026, Program Director (PD) B emailed	M 404		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019856	A. BUILDING: _____ B. WING _____	C 02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VESTA	5087 VESTA CT EAU CLAIRE, WI 54703

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M 404	Continued From page 6 Surveyor additional information including a copy of Resident 1's ISP. Resident 1's ISP indicated PD B completed Resident 1's ISP on 02/12/2026. The ISP indicated Resident 1's last care meeting was held on 01/13/2026. On 02/17/2026 at approximately 3:30 p.m., Surveyor interviewed PD B on the phone. PD B confirmed that Resident 1's ISP was not developed until 02/12/2026. The provider did not ensure Resident 1's ISP was completed within 30 days after his/her admission.	M 404		
M 420	88.06(3)(d)5 SIGNED STATEMENT OF AGREEMENT A statement of agreement with the plan, dated and signed by all persons involved in developing the plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 individual service plans (ISP) reviewed included a statement of agreement with the plan, dated and signed by all persons involved with developing the plan. Resident 1's ISPs did not include a signed statement of agreement with all parties involved. Findings include: From 01/27/2026 to 01/29/2026, Surveyor reviewed Resident 1's record.	M 420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019856	A. BUILDING: _____ B. WING _____	C 02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VESTA	5087 VESTA CT EAU CLAIRE, WI 54703

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M 420	Continued From page 7 Resident 1 was admitted to the facility on 10/30/2025. S/he had multiple diagnoses including: depression, anxiety, developmental disorder, hemiplegia and hemiparesis affecting his/her right dominant side, muscle weakness, repeated falls, cognitive communication deficit, unspecified convulsions, and dependence on wheelchair. Resident 1 had a legal guardian. On 01/29/2026, Surveyor emailed Area Director (AD) A requesting additional information including Resident 1's ISP. On 02/12/2026, Program Director (PD) B emailed Surveyor a copy of Resident 1's ISP. The ISP indicated there was a meeting on 01/13/2026 for Resident 1. The ISP indicated PD B entered the ISP into the electronic system on 02/12/2026. Surveyor did not receive a signature sheet for the ISP. On 02/17/2026 at approximately 3:30 p.m., Surveyor interviewed PD B on the phone. PD B confirmed that Resident 1's ISP was not developed until 02/12/2026. S/he said Resident 1's managed care organization (MCO) team held the care meeting without him/her or Resident 1's guardian present. PD B said the MCO team recently changed all of their emails and the email they sent went to PD B's spam. PD B said s/he was out of state for a conference when they held the care team meeting. Surveyor did not receive a signature page for Resident 1's ISP to indicate who was all involved with developing the ISP and their agreement with the plan.	M 420		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VESTA	5087 VESTA CT EAU CLAIRE, WI 54703

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M 496	Continued From page 8	M 496		
M 496	88.09(1)(d)4 RESIDENT RECORD-SERVICE COORDINATOR The name, address and phone number of the placing agency, if any, and service coordinator, if any. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the record for 1 of 2 residents reviewed (Resident 1) contained the name, address, and phone number of the placing agency and service coordinator. Findings include: On 01/29/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 10/30/2025. Resident 1 had multiple diagnoses including a developmental disorder and cognitive communication deficit. Resident 1 had a legal guardian and was enrolled in a managed care organization (MCO). Resident 1's emergency data form, updated on 10/29/2025, indicated Person G was Resident 1's MCO case manager and Person H was Resident 1's MCO registered nurse. The emergency data form had contact phone numbers for Person G and Person H. On 01/29/2026 at 1:25 p.m., Surveyor called Person G's contact phone number. The voicemail box was for a different person. At 1:26 p.m., Surveyor called the contact number for Person H. Person H answered the phone. Person H said s/he was no longer Resident 1's nurse and has not been for a while. Person H told Surveyor Person G was not working for the MCO for "some	M 496		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019856	A. BUILDING: _____ B. WING _____	C 02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VESTA	5087 VESTA CT EAU CLAIRE, WI 54703

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M 496	Continued From page 9 time now." Person H gave Surveyor the names and phone numbers to Resident 1's current case manager, Person I, and registered nurse, Person J. On 01/29/2026, Surveyor emailed Area Director (AD) A and Program Director (PD) B. Surveyor requested additional information including where Resident 1's MCO team and contact information was located in Resident 1's record. On 02/12/2026, PD B emailed Surveyor with the contact names, phone numbers, and emails for Resident 1's MCO care team. The provider did not ensure Resident 1's record contained accurate names and phone numbers for Resident 1's placing agency.	M 496		
M 574	88.10(3)(n)1 Freedom From Seclusion and Restraints Except as provided in subd. 2, to be free from seclusion and from all physical and chemical restraints, including the use of an as-necessary (PRN) order for controlling acute, episodic behavior. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 1 was free from physical restraints. Findings include: The provider is licensed to care for 4 residents in	M 574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019856	A. BUILDING: _____ B. WING _____	C 02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VESTA	5087 VESTA CT EAU CLAIRE, WI 54703

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M 574	Continued From page 10	M 574		

the client groups of: developmentally disabled, emotionally disturbed/mental illness, physically disabled, and traumatic brain injury.

Wis. Admin. Code ch. 88 defines physical restraints as follows:

Wis. Admin. Code § DHS 88.02(24) - "Physical restraint" means any manual method or any article, device or garment interfering with the free movement of a resident or the normal functioning of a portion of the resident's body or normal access to a portion of the body, and which the individual is unable to remove easily, or confinement in a locked room.

On 01/26/2026 at approximately 1:00 p.m., Surveyor observed Resident 1 seated in his/her wheelchair. Resident 1 had a seat belt fastened across his/her lap in the wheelchair. At approximately 1:40 p.m., Surveyor observed Resident 1's room with Direct Service Professional (DSP) D. Resident 1 had full bed rails on both sides of his/her bed. Surveyor asked DSP D why Resident 1 had full bed rails. DSP D told Surveyor the bed rails were on his/her bed when Resident 1 was admitted to the facility. DSP D said Resident 1 did grab the rails when s/he was being turned in bed. The rails were in the down position when Surveyor observed Resident 1's room.

From 01/27/2026 to 01/29/2026, Surveyor reviewed Resident 1's record.

Resident 1 was admitted to the facility on 10/30/2025. S/he had multiple diagnoses including: depression, anxiety, developmental disorder, hemiplegia and hemiparesis affecting his/her right dominant side, muscle weakness,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019856	A. BUILDING: _____ B. WING _____	C 02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VESTA	5087 VESTA CT EAU CLAIRE, WI 54703

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M 574	Continued From page 11	M 574		

repeated falls, cognitive communication deficit, unspecified convulsions, and dependence on wheelchair.

Resident 1's assessment, dated 10/29/2025, indicated Resident 1 had a legal guardian. S/he was dependent on staff for activities of daily living (ADLs) other than eating. S/he required bed checks every 2 hours and was unable to self-propel his/her wheelchair and used a mechanical lift for all transfers. The assessment did not include use of full bed rails or a seat belt in his/her wheelchair.

On 01/29/2026, Surveyor emailed Area Director (AD) A and requested additional information including documentation related to Resident 1's seat belt and full bed rails and his/her individual service plan (ISP).

On 02/12/2026, Program Director (PD) B emailed Surveyor a copy of Resident 1's ISP. The ISP was dated 02/12/2026. The ISP did not include the full bed rails and when staff should use them. The ISP did not include Resident 1's use of a seatbelt. Surveyor did not receive any documentation related to Resident 1's use of full bed rails and his/her seatbelt.

On 02/16/2026, Surveyor emailed Person J, who was Resident 1's managed care organization (MCO) nurse. Surveyor asked what the purpose was for Resident 1's full side rails and if Resident 1 was able to remove his/her seat belt.

On 02/16/2026, Person J replied, via email, which read, in part: "I asked about the bed rails last month and staff told me that [Resident 1] uses the bed rails for bed mobility/repositioning and needs them for [his/her] safety. I'm not sure if a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VESTA	5087 VESTA CT EAU CLAIRE, WI 54703

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M 574	Continued From page 12 bed assist bar would be better in [his/her] situation so [s/he] doesn't have the full rail on there. I also had asked them about the seat belt and the staff told me [s/he] can undo the seatbelt." 02/17/2026 at approximately 3:30 p.m., Surveyor interviewed PD B on the phone. Surveyor asked if Resident 1 could release the seat belt on his/her own. PD B told Surveyor s/he did not think Resident 1 would have the cognitive ability to release the seatbelt. PD B said they were working on getting him/her a new wheelchair as Resident 1 has tipped over in his/her wheelchair when s/he was reaching for something. PD B said Resident 1 did not release the seatbelt in that situation. PD B said Resident 1's guardian told him/her that Resident 1 had the seatbelt for approximately 3 years. Surveyor asked PD B what the purpose was for Resident 1's full bed rails. PD B said to ensure s/he did not fall out of bed. PD B told Surveyor Resident 1 used the rails to grab when staff rolled him/her in bed to change him/her. Surveyor asked about Resident 1's diagnosis of convulsions. PD B told Surveyor Resident 1 did not have any seizures since s/he moved into the home. PD B told Surveyor s/he did not have a waiver for the seatbelt or full bed rails for Resident 1. The provider did not ensure Resident 1 was free from physical restraints.	M 574		
M 576	88.10(3)(n)2 Restraints In Emergency Physical restraints may be used in an emergency when necessary to protect the resident or other person from injury or to prevent physical harm to	M 576		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019856	A. BUILDING: _____ B. WING _____	C 02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VESTA	5087 VESTA CT EAU CLAIRE, WI 54703

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M 576	Continued From page 13	M 576		

the resident or another person resulting from the destruction of property, provided that law enforcement or other emergency assistance be summoned as soon as possible and the incident is reported to the licensing agency by the next business day with documentation of what happened, the actions taken by the adult family home and the outcomes.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not report to the Department after service providers physically restrained Resident 2 in an emergency to protect him/herself and others from getting injured.

Findings include:

On 01/29/2026, Surveyor reviewed Resident 2's record. Resident 2 had multiple diagnoses including: depression, mood disorder, generalized anxiety disorder, post-traumatic stress disorder, borderline personality disorder, and intellectual disability.

On 01/15/2026, staff documented the following incident:
"[Resident 2] called the house phone to tell staff, [Direct Service Professional (DSP) K], goodbye because [s/he] was going to hang [him/herself]. All staff dropped everything and ran to [his/her] room with the keys. Staff unlocked the door and saw [his/her] belt around [his/her] neck tied to a closet door. Staff stepped in and got their hands around the belt so [s/he] couldn't properly strangle [him/herself] with it. It seemed to calm down some so [DSP K], myself, had [DSP L]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019856	A. BUILDING: _____ B. WING _____	C 02/17/2026

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(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 576	Continued From page 14	M 576		

leave. I also texted [DSP D] to let [him/her] know there was a situation with [Resident 2]. I thought it was under control when [Resident 2] suddenly started grabbing at [his/her] clothing basket next to [him/her] to try to suffocate [him/herself] with the clothing. After somewhat of a struggle I shoved the basket away across the floor. [S/he] then tried biting my hand so I called [DSP L] back in to help. It kept escalating to the point that [s/he] was hitting and kicking us. When [DSP D] came in [Resident 2] was continuously hitting, kicking, pinching, and biting us. All three of us had to restrain [his/her] arms and legs so [s/he] would stop trying to harm [him/herself] and us. This continued for quite a while. Eventually [Resident 2] was able to calm down when [DSP D] called [Person M]. [DSP D] administered a PRN (as needed medication). Staff all proposed some strategies to calm down which thankfully [s/he] was then receptive to. [S/he] started with taking a shower, due to being sweaty from the struggle, when [s/he] then called staff into the bathroom to apologize for [his/her] behavior. The current situation is over, if there is more it will continue to be documented."

On 01/29/2026, Surveyor reviewed the Department's electronic file for the provider. The Department did not have a report on this incident. Surveyor did not locate an approved waiver or variance to use a restrictive hold on Resident 2.

On 01/29/2026, Surveyor emailed Area Director (AD) A and requested additional information. Surveyor asked if Resident 2 had any approved restrictive measures and if the incident related to 3 staff members restraining Resident 2 was reported to the Department.

On 02/12/2026, Program Director (PD) B emailed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019856	A. BUILDING: _____ B. WING _____	C 02/17/2026

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M 576	Continued From page 15 Surveyor. The email indicated Resident 2 did not have any approved restrictive measures. PD B attached a copy of the incident report. The email indicated notifications related to the incident were included in the report. The report did not indicate the Department was notified after an emergency restraint hold was used on Resident 2.	M 576		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 residents reviewed, Resident 1, received all prescribed medications in the dosage and at the intervals prescribed. Staff did not always administer Resident 1's Lantus insulin as prescribed. Findings include: On 11/14/2025, the Department received a complaint that alleged staff did not administer insulin correctly.	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 582	Continued From page 16 On 11/26/2025, the Department received a complaint that alleged medications were not always available. On 01/26/2026 1:30 p.m., Surveyor observed the medication storage areas with Direct Service Professional (DSP) D. DSP D told Surveyor Resident 1 was on insulin and had a continuous glucose monitoring system. DSP D told Surveyor Resident 1 received Novolog insulin 4 times a day per sliding scale and Lantus insulin every evening. On 02/16/2026, Surveyor reviewed Resident 1's medication administration record (MAR), blood sugars and insulin administration. Resident 1's MAR for Lantus insulin included the following instruction: "Inject 50 units under the skin at bedtime at 8 pm. Hold the Lantus if the blood sugar <110." On the following dates staff documented they administered 45 units of Lantus: 12/09/2025 12/10/2025 12/14/2025 12/15/2025 12/16/2025 12/17/2025 12/21/2025 12/23/2025 12/24/2025 12/28/2025 12/29/2025 12/30/2025 12/31/2025 01/05/2026 01/06/2026 01/07/2026 01/10/2026	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 582	Continued From page 17 01/11/2026 01/12/2026 01/14/2026 01/15/2026 01/17/2026 01/18/2026 On 01/27/2026, 01/28/2026, and 01/29/2026, staff documented the Lantus was not available to be administered. On 02/16/2026, Surveyor emailed Program Director (PD) B and requested Resident 1's prescription orders for his/her Lantus and asked why the Lantus was not available from 01/27/2026 to 01/29/2026. On 02/17/2026, PD B emailed Surveyor Resident 1's orders for Lantus. Resident 1's order was as written on the MAR to inject 50 units subcutaneously at bedtime at 8:00 p.m., and to hold if blood sugar was less than 110. Resident 1 did not have an order for staff to administer 45 units of Lantus. The email read, in part: "Staff did not advise Lantus was running low. A reminder of notifying pharmacy when there are 2 Lantus pens left has been addressed during a staff meeting on 2.5.26." On 02/17/2026 at approximately 3:30 p.m., Surveyor interviewed PD B on the phone. PD B told Surveyor s/he was unsure why staff administered 45 units of Lantus instead of the prescribed 50 units. PD B confirmed to Surveyor Resident 1 did not have an order for staff to administer 45 units of Lantus. The provider did not ensure Resident 1 received his/her Lantus insulin as prescribed.	M 582		