STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018167	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA CARE HELLER AVENUE	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 08/12/2026 with additional information obtained through 08/19/2026, Surveyor conducted a standard survey and a complaint investigation at Vista Care Heller Avenue. As a result, the complaint was substantiated and 11 deficiencies were identified. Three (3) of 11 deficiencies were repeat violations. See Statements of Deficiency (SOD) OSWC11, dated 06/30/2025 and SOD BI6G11, dated 05/23/2024. Census: 6	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 Resident 2 received medication in the dosage and intervals prescribed by the physician. This requirement is being cited for a second time. See Statement of Deficiency (SOD) OSWC11, dated 06/30/2025. Findings Include: On 08/12/2026, the department received an allegation residents were not receiving	N 352		

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

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N 352	Continued From page 1 medication as prescribed. On 08/13/2026, Surveyor reviewed Resident 2's medication administration record (MAR) for July and August 2026. Review of the MARs showed Resident 2 did not receive Cobenfy as prescribed by the physician on 07/28/2026. The dates were documented as "medication not present in program" for the following doses: Cobenfy 50-20mg twice a day (8:00 AM & 8:00 PM) for 3 days 07/28, 07/29, 07/30 Cobenfy 100-20mg twice a day (8:00 AM & 8:00 PM) for 7 days 07/31, 08/01, 08/02, 08/03, 08/04, 08/05, 08/06 Cobenfy 125-30mg twice a day (8:00 AM & 8:00 PM) 08/07, 08/08, 08/09, 08/10, 08/11, 08/12, 08/13, 08/14, 08/15, 08/16, 08/17 According to WebMD, "Cobenfy .... is commonly used to treat schizophrenia. Schizophrenia is a mental health disorder that affects a person's thinking, actions, emotions, perception of reality, and how they relate to others ..." Information obtained on 08/27/2026 at: https://www.webmd.com/drugs/cobenfy-xanomeline-trospium On 08/19/2026, Surveyor received an email from Pharmacy Technician C noting, ". ...This is a titrated medication. The Cobenfy 50-20mg was delivered on 08/17 to be taken for 3 days and then increased to 100-20mg and taken for 7 days (also delivered on the 17th) and lastly to be increased to Cobenfy 125-30mg. The Cobenfy 125-30mg is expected to process and go out for	N 352		

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N 352	Continued From page 2 delivery on 08/21, to be started on 08/28 ...." On 08/19/2026 at 3:25 PM, Surveyor interviewed Residential Manager B (RM B). RM B explained the medication prescribed for Resident 2 on 07/28/2026 required prior authorization, once approved by insurance the medication was received in the mail on 08/17/2026 and the first dose was administered at 8:00 PM. On 08/19/2026, at 3:30PM, Surveyor interviewed Area Director A (AD A). AD A advised the MARs and orders will be audited and reviewed for accuracy.	N 352		
N 370	83.34(3) More than $200 personal funds from resident Funds in excess of $200. A CBRF receiving more than $200 of personal funds from a resident shall deposit funds in excess of $200 in an interest-bearing account in the resident ' s name in a savings institution insured by an agency of, or a corporation chartered by, this state or the United States. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's funds in excess of $200 were placed in an interest-bearing account in Resident 1's name. Findings include: On 07/10/2026, the department received a complaint regarding concerns with resident funds. On 08/13/2026 at approximately 2:00 PM, Surveyor reviewed Resident 1's record. Resident	N 370		

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N 370	Continued From page 3 1 was admitted into the home on 05/24/2023. Resident 1's personal funds are managed by the provider who uses a non-interest-bearing account to manage resident funds. Statements indicated "Monthly Statement" and noted the following: 06/01/2026 Beginning available balance (06/01/2026): $51.20 Ending available balance (06/30/2026): $351.20 07/01/2026 Beginning available balance (07/01/2026): $351.20 Ending available balance (07/31/2026): $351.20 08/01/2026 Beginning available balance (08/01/2026): $351.20 Ending available balance (08/13/2026): $297.00 On 08/19/2026 at approximately 3:25 PM, Surveyor interviewed Area Director A. Area Director A acknowledged Resident 1's account had excess of $200 in personal funds and was not deposited in an interest-bearing bank account. Area Director A stated s/he began auditing resident records to ensure compliance moving forward.	N 370		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities	N 381		

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N 381	Continued From page 4 or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents' needs, abilities, and physical and mental condition was assessed prior to admitting residents for 2 of 2 residents reviewed, Resident 1 and Resident 2. Findings Include: On 05/11/2026, the department received a complaint alleging concerns with supervision. On 08/12/2026, at 10:45 AM, Surveyor interviewed Direct Support Professional D (DSP D). DSP D confirmed facility staff administers medication and manages personal funds for Resident 1 and Resident 2. On 08/12/2026, at 12:45 PM, Surveyor requested Resident 1 and Resident 2's comprehensive assessment from Area Director A (AD A). On 08/13/2026, Surveyor reviewed Resident 1 and Resident 2's record. The record identified: Resident 2's - Individual Service Plan (ISP) dated 06/27/2025, admitted on 05/18/2023 and s/he required assistance with medication administration and money management. Resident 1's record did not contain an ISP.	N 381		

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N 381	Continued From page 5 *Surveyor note: Resident 1 and Resident 2's records did not contain pre-admission or ongoing assessments. On 08/19/2026, at 3:00 PM, Surveyor interviewed AD A. AD A advised Resident 1 was admitted on 05/24/2023. AD A advised s/he could not find Resident 1 and Resident 2's assessments and could not confirm if it was completed. AD A advised s/he was in the process of auditing resident records and noticed some assessments were not completed before admission. AD A reported s/he is working to correct the issue. Cross Reference N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan Cross Reference N0389 DHS 83.35(3)(d) Service Plans Updated Annually or on Changes	N 381		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care.	N 386		

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N 386	Continued From page 6 This Rule is not met as evidenced by: Based on record review, observation, and interview, the provider did not ensure 1 (Resident 1) of 2 residents reviewed had a completed individualized service plan (ISP) within 30 days of admission. Findings include: On 05/11/2026, the department received a complaint alleging concerns with a resident's care needs not being met. On 08/12/2026, Surveyor requested Resident 1's record. Resident 1 was admitted to the facility on 05/24/2023. Resident 1's record did not contain an ISP. On 08/19/2026 at approximately 3:10 PM, Surveyor interviewed Area Director A. Area Director A could not find Resident 1's ISP and could not confirm if it was completed within 30 days of their admission. AD A advised s/he is currently auditing files to ensure ISPs are developed. Cross Reference N0389 DHS 83.35(3)(d) Service Plans Updated Annually or on Changes Cross Reference N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments	N 386		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual	N 389		

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N 389	Continued From page 7 service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 2's individual service plans (ISP) was updated annually and signed by the resident. This requirement is being cited for a second time. See statement of deficiency (SOD) BI6G11, dated 05/23/2024. Findings include: On 08/13/2026, Surveyor reviewed Resident 1's ISP dated 01/16/2025 and updated on 06/27/2025. The ISP does not show it was signed by Resident 1 and was not updated annually. On 08/19/2026, Surveyor interviewed Area Director A (AD A). AD A advised s/he has begun auditing resident records to identify ISPs that need updates and signatures. AD A reported s/he is working towards systems are put in place to ensure ISPs remain updated and signed. Cross Reference N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments Cross Reference N0386 DHS 83.35(3)(a)	N 389		

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N 389	Continued From page 8 Comprehensive Individualized Service Plan	N 389		
N 393	83.35(5)(a) Initial evaluation of evacuation limitations. Initial evaluation. The CBRF shall evaluate each resident within 3 days of the resident ' s admission to determine whether the resident is able to evacuate the CBRF within 2 minutes in an unsprinklered CBRF and 4 minutes in a sprinklered CBRF without any help or verbal or physical prompting, and what type of limitations that resident may have that prevent the resident from evacuating the CBRF within the applicable period of time. A form provided by the department shall be used for the evaluation. The resident ' s evaluation shall be retained in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 1 was evaluated for the ability to evacuate the CBRF in emergency situations. Resident 1 did not have a documented resident evacuation assessment. Findings include: On 08/12/2026 at 1:30 PM, Surveyor reviewed Resident 1's medical record. Resident 1 was admitted 05/24/2023. There was no documented resident evacuation assessment in Resident 1's file. On 08/19/2026 at approximately 3:15 PM, Surveyor interviewed Area Director A. Area Director A could not find Resident 1's evacuation assessment and could not confirm if it was	N 393		

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N 393	Continued From page 9 completed within 30 days of admission. AD A advised s/he is currently auditing files and would complete the evacuation assessment as soon as possible. Cross Reference N0394 DHS 83.35(5)(b) Annual Evaluation Of Evacuation Limits	N 393		
N 394	83.35(5)(b) Annual evaluation of evacuation limits Evaluation update. The CBRF shall evaluate each resident ' s mental or physical capability to respond to a fire alarm at least annually or when there is a change in the resident ' s mental or physical capability to respond to a fire alarm. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were evaluated annually of their mental or physical capability to respond to a fire alarm for Resident 2. This requirement is being cited for a second time. See statement of deficiency (SOD) BI6G11, dated 05/23/2024. Findings Include: On 08/13/2026, Surveyor reviewed Resident 2's record and identified s/he was admitted on 05/18/2023. On 08/13/2026, Surveyor reviewed Resident 2's Resident Evacuation Assessment dated 09/11/2024. Further review of the record revealed there was no updated assessment. On 08/19/2026, at 3:15 PM, Surveyor interviewed Area Director A who advised s/he could not locate	N 394		

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N 394	Continued From page 10 an updated assessment. Area Director A confirmed s/he would ensure all resident assessments would be updated. Cross Reference N0393 DHS 83.35(5)(a) Initial Evaluation Of Evacuation Limits	N 394		
N 404	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address. This Rule is not met as evidenced by: Based on interview and record review, the provider did not arrange on an annual basis, for a physician, pharmacist, or registered nurse to conduct an on-site review of the CBRF's	N 404		

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N 404	Continued From page 11 medication administration and medication storage systems for 2024 and 2025. Findings include: On 08/12/2026, Surveyor conducted a standard survey and requested annual reviews of the medication administration and storage review for 2024 and 2025 from Area Director A (AD A). AD A stated s/he would send the review via email. As of 08/19/2026 Surveyor did not receive annual reviews of the medication administration and storage review for 2024 and 2025. On 08/19/2026, Surveyor interviewed AD A who acknowledged the provider did not complete annual reviews of the medication administration and storage review for 2024 and 2025.	N 404		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential benefits and side effects of the medication. This Rule is not met as evidenced by: Based on record review and interview, the	N 407		

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N 407	Continued From page 12	N 407		

provider did not ensure scheduled psychotropic medications were reviewed at least quarterly for Resident 2.

Findings include:

The facility is licensed to provide services for up to 8 residents within the client groups of alcohol/drug dependent, emotionally disturbed/mental illness and developmentally disabled.

On 08/13/2026 at 1:30 PM, Surveyor reviewed Resident 2's records.

Resident 2 was admitted to the facility on 05/24/2023. Resident 2's record did not contain any scheduled psychotropic reviews completed in 2025 and Quarter 1 and Quarter 2 in 2026. Resident 2's June, July & August 2026 Medication Administration Records indicate s/he was prescribed the following scheduled psychotropic medications and their start dates:

- Olanzapine 03/20/2025
- Lybalvi 03/20/2025
- Rexulti 03/20/2025
- Trazodone 03/20/2025
- Bupropion 03/20/2025

On 08/19/2026 at approximately 3:25 PM, Surveyor interviewed Area Director A. Area Director A confirmed scheduled psychotropic medications were not reviewed quarterly in 2025 and in Quarter 1 and Quarter 2 of 2026. Area Director A advised s/he will contact the pharmacist to schedule a review of all psychotropic medications.

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N 481	Continued From page 13	N 481		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a living environment that was safe, clean, comfortable and homelike. Findings include: On 08/12/2026, Surveyors conducted an onsite visit to the facility and observed the following concerns: - Front door (Inside) is rusted along the bottom edge, scratched, and scraped leaving areas unpainted. - Back door is dirty, scratched, and scraped, leaving areas unpainted. - Hallway walls are dirty and appear to have spill or drip stains in several areas. - Seating area wall has 9 unpainted areas, each approximate size of a quarter. - Hallway ceiling vents are covered in a layer of dust, many cobwebs hanging from the ceilings onto the hallway walls. - Hallway corners are worn and missing plaster. - There are approximately 100 or more cigarette butts on the grass next to the back door. - Cardboard box containing dishes on the floor approximately 6 inches from the water heater in mechanical room.	N 481		

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VISTA CARE HELLER AVENUE	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 481	Continued From page 14 - Debris and dust throughout the floor and a "smoked" cigarette butt on the floor approximately 12 inches from the water heater in mechanical room. On 08/19/2026 at 3:30 PM, Surveyor interviewed Area Director A. AD A acknowledged that there were environmental issues and s/he would address the issues as soon as possible.	N 481		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the clothes dryer in the residential laundry room had vent tubing of rigid material. The facility's clothes dryer was equipped with vent tubing which was not constructed of rigid material. Findings include: On 08/12/2026, at approximately 12:45 PM, during a tour of the facility, Surveyor observed 1 laundry room with 1 dryer equipped with vent tubing which was not constructed of rigid material. On 08/19/2026, at approximately 2:00 PM, Surveyors interviewed Surveyor interviewed Area	N 488		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018167	A. BUILDING: _____ B. WING _____	C 08/19/2026

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N 488	Continued From page 15 Director A. Area Director A stated s/he was not aware the dryer venting was not constructed of rigid material. Area Director A confirmed s/he would have this replaced immediately.	N 488		