

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017737	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 01/23/2026
NAME OF PROVIDER OR SUPPLIER VISTA CARE 5TH AVE		STREET ADDRESS, CITY, STATE, ZIP CODE 175 WESTFIELD OSHKOSH, WI 54902		
(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 A verification visit was conducted at Vista Care 5th Ave on 01/21/2026 with additional information gathered through 01/23/2026. As a result of this visit the previous deficiencies were corrected and no new deficiencies were identified during the visit. Per state statutes a \$200.00 revisit fee was assessed. Census: 3	{M 000}		

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

TITLE

(X6) DATE