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
	0011410	A. BUILDING: _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA CARE FALLS ROAD AFH	**743 OLD COUNTY RD PP SHEBOYGAN FALLS, WI 53085**

(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 06/13/2025, Surveyor investigated one complaint at Vista Care Falls Road. The complaint was substantiated and 1 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 report a suspected allegation of physical abuse for 1 of 1 Resident (Resident 1). Findings Include: On 03/14/2025, the department received a	M 610		

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
	0011410	A. BUILDING: _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA CARE FALLS ROAD AFH	743 OLD COUNTY RD PP SHEBOYGAN FALLS, WI 53085

(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 610	Continued From page 1 complaint regarding alleged abuse to a resident. On 06/13/2025, at 8:29AM, Surveyor interviewed Residential Manager A (RM-A). RM-A explained there was an incident where a caregiver witnessed Caregiver B hit Resident 1. Caregiver C immediately asked Caregiver B to leave, called the police and reported it to the previous residential manager. RM-A advised the police took Caregiver B into custody and there is a pending court case scheduled for July 2025. RM-A did not know if it was reported to the department. On 06/13/2025 at 8:51AM, Surveyor reviewed the provider's investigation of the allegation conducted on 02/02/2025 through 02/06/2025. The investigation noted the incident occured on 02/02/2025. It was alleged Caregiver B slapped Resident 1 in the face. The investigation concluded the allegation was inconclusive and pending the court hearing regarding the verdict on the charge of battery for Caregiver B. On 06/13/2025, at approximately 8:40M, Surveyor interviewed Special Projects Director-Quality D (SPD-D). SPD-D explained if the incident was not reported to the department, it could be because Caregiver B's hearing has not concluded. SPD-D confirmed Caregiver B was removed from the schedule and has not worked since the allegation. Once Caregiver B's hearing has concluded, human resources will decide if s/he can return to work or not. On 06/13/2025, at 11:50AM, Surveyor reviewed the Wisconsin Circuit Court Access search and found Caregiver B is pending a status conference hearing on 07/24/2025 for the charge of battery-misdemeanor A.	M 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011410	A. BUILDING: _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA CARE FALLS ROAD AFH	**743 OLD COUNTY RD PP SHEBOYGAN FALLS, WI 53085**

(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 610	Continued From page 2 On 06/13/2025, at 11:55AM, Surveyor reviewed the department's files and noted there was no misconduct incident report filed with the Office of Caregiver Quality.	M 610		