STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018368	A. BUILDING: _____ B. WING _____	R 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING EAST	968 E MADISON STREET WATERLOO, WI 53594

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{N 000}	Initial Comments On 08/26/2025, with information obtained through 08/27/2025, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit at Victory Vision Community Living East, a community-based residential facility (CBRF) located in Waterloo, WI. As a result of the survey, 5 deficiencies were identified. Four deficiencies are repeat deficiencies from Statement of Deficiency (SOD) N7X613, dated 11/08/2024, SOD N7X612, dated 05/16/2024, and SOD N7X611, dated 10/27/2023. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 6	{N 000}		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that an incident where Resident 13 fell and required staple placement for a laceration sustained on his/her head was reported to the Department within 3 working days. Findings include:	N 165		

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

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N 165	Continued From page 1 On 08/26/2025, at approximately 11:05 a.m., Surveyor interviewed Caregiver Coordinator C regarding residents' needs and abilities. In discussing Resident 13's seizures, Caregiver Coordinator C reported that Resident 13 recently experienced a seizure that caused him/her to fall. Caregiver Coordinator C reported that Resident 13 was taken to the emergency room for staple repair of a laceration s/he sustained on his/her head as a result of the fall. Caregiver Coordinator C reported that this occurred on 07/16/2025. On 08/26/2025, Surveyor reviewed Department records for the provider. There was no evidence of a report having been submitted to the Department with information regarding the above incident. On 08/27/2025 at approximately 1:13 p.m., Surveyor e-mailed Caregiver Coordinator C requesting evidence that a report regarding the above incident was submitted to the Department. At approximately 2:33 p.m., Licensee B e-mailed Surveyor and reported that staff did not typically submit a self-report for accidental falls unless it involved a caregiver creating an unsafe situation that contributed to the fall. Surveyor then reviewed the reporting requirement with Licensee B, to which Licensee B replied, "Thank you for this information, moving forward I will make sure to report accordingly."	N 165		
{N 283}	83.26(1) Documentation of required employee training The CBRF shall maintain documentation of all employee training under s. DHS 83.21 and task	{N 283}		

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{N 283}	Continued From page 2 specific training under s. DHS 83.22 and shall include the name of the employee, the name of the instructor, the dates of training, a description of the course content, and the length of the training. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that documentation of employee training completed by 2 of 3 caregivers reviewed was maintained. There were no records indicating that Caregivers A and P were trained in all the required orientation training topics or the provision of personal cares. This is a repeat deficiency. See Statement of Deficiency (SOD) N7X613, dated 11/08/2024. Findings include: On 08/26/2025, Surveyor conducted a review of 3 employees to verify compliance with task-specific and orientation training requirements. At approximately 10:55 a.m., Surveyor interviewed Caregiver Coordinator C about staffing. Caregiver Coordinator C confirmed that Caregivers A and P had worked shifts alone at the provider's CBRF. Surveyor requested all training records for Caregivers A and P from Caregiver Coordinator C. The training records for Caregiver A, hired 06/02/2025, consisted of Hoyer lift training. There was no evidence of Caregiver A having completed orientation training in all the required topics or training in the provision of personal cares.	{N 283}		

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{N 283}	Continued From page 3 The training records for Caregiver P, hired 07/15/2025, consisted of medication administration-related training. There was no evidence of Caregiver P having completed orientation training in all the required topics or training in the provision of personal cares. At approximately 11:15 a.m., Surveyor interviewed Caregiver Coordinator C. Regarding Caregiver A, Caregiver Coordinator C confirmed that Caregiver A was trained in using a Hoyer lift and had also been trained in residents' needs. Caregiver Coordinator C confirmed there were no other training records for Caregiver A and reported, "That's on me." Caregiver Coordinator C reported that Caregiver A had been trained but s/he just didn't have updated training records for him/her. Regarding Caregiver P's training, Caregiver Coordinator C reported that Caregiver P had all the same training as other new staff, and showed Surveyor a training packet template, which outlined all required orientation topics and personal cares training. Caregiver Coordinator C confirmed s/he did not have any other training records for Caregiver P.	{N 283}		
{N 387}	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care	{N 387}		

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{N 387}	Continued From page 4 agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 11, who was his/her own legal decision maker, signed his/her individual service plan (ISP) acknowledging his/her involvement in, understanding of, and agreement with the plan. This is a repeat deficiency. See Statement of Deficiency (SOD) N7X613, dated 11/08/2024. Findings include: On 08/26/2025, Surveyor reviewed Resident 11's record. Resident 11 was admitted to the provider on 07/15/2025. Resident 11 was documented as being his/her own legal decision maker. Surveyor reviewed Resident 11's ISP, which was not signed or dated as reviewed. At approximately 12:05 p.m., Surveyor interviewed Supervisor N. Supervisor N reported s/he thought s/he had Resident 11 sign his/her ISP last week, but confirmed s/he was unable to find evidence of it. At approximately 2:10 p.m., Surveyor interviewed Caregiver Coordinator C and Supervisor N. Caregiver Coordinator C confirmed that in looking	{N 387}		

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{N 387}	Continued From page 5 at Resident 11's electronic record s/he couldn't find evidence of a signed ISP or any evidence that it was reviewed by him/her. Surveyor requested the phone number for Resident 11, who was out in the community for the day, in order to interview him/her directly regarding his/her ISP. Both Caregiver Coordinator C and Supervisor N reported they didn't have Resident 11's phone number.	{N 387}		
{N 432}	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not provide medication administration services appropriate to Resident 12's needs. When administered as prescribed, 1 bottle of Resident 12's fluticasone nasal spray, which contained 120 metered sprays, would last 30 days. On 08/26/2025, Surveyor observed that staff were still administering Resident 12's fluticasone from a bottle that was dispensed on 04/01/2025 and was still approximately 10% full.	{N 432}		

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{N 432}	Continued From page 6 Staff initialed off on 168 administrations from 05/05/2025 - 08/26/2025 for a total of 336 sprays. However, the only other fluticasone bottle dispensed after 04/01/2025 was dispensed on 08/25/2025 (1 day before the survey). This is a repeat deficiency. See Statement of Deficiency (SOD) N7X613, dated 11/08/2024, SOD N7X612, dated 05/16/2024, and SOD N7X611, dated 10/27/2023. Findings include: On 08/26/2025, at approximately 11:55 a.m., Surveyor reviewed the medication cart with Supervisor N. Surveyor reviewed a baggie with a bottle inside. The pharmacy label on the baggie as well as a label on the bottle itself within the baggie indicated that the bottle contained fluticasone 50 mcg nasal spray, prescribed to Resident 12, that was dispensed on 04/01/2025. The prescription instructions on the label directed to, "Spray 1 spray in each nostril twice daily..." The bottle appeared to be approximately 10% full (Photos 1 and 2). The manufacturer's label on the bottle indicated that the bottle contained 120 metered sprays' worth of fluticasone. From the above observations, Surveyor noted that when administered as prescribed, Resident 12's fluticasone would last approximately 30 days (4 sprays total per day from a bottle containing 120 sprays' worth of medication). While observing the medication cart, Surveyor also observed another baggie of fluticasone prescribed to Resident 12. The pharmacy label on that baggie indicated that the bottle was dispensed on 08/25/2025 (day before the survey, Photo 3). The bottle was full. The prescription	{N 432}		

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{N 432}	Continued From page 7 instructions were the same as on the bottle from 04/01/2025. While observing the fluticasone, Surveyor interviewed Supervisor N. Supervisor N denied that Resident 12 was known to frequently refuse his/her fluticasone, but reported s/he had been out for an extended time period in the hospital a couple of months ago. On 08/26/2025, Surveyor reviewed Department records for the provider. The records documented that a period of correction extension from the last survey, SOD N7X613, was granted which showed the provider's date of compliance being 05/06/2025. At approximately 1:45 p.m., Surveyor interviewed Caregiver Coordinator C and Supervisor N. Supervisor N reported s/he did not think any other bottles of fluticasone had been used for Resident 12's administration because it was not an automatically-refilled medication. Caregiver Coordinator C reported that Resident 12 moved in on 11/12/2024 and had been out of the provider's facility during the following timeframes due to hospitalization: 04/25/2025 - 05/29/2025 and 06/28/2025 - 07/02/2025. Surveyor noted that even with the gaps in Resident 12's residency and in consideration of the provider's review period, that his/her fluticasone, when administered as prescribed, still should have been out around approximately 07/03/2025. Both Caregiver Coordinator C and Supervisor N reported understanding of Surveyor's concern. On 08/27/2025, Surveyor Resident 12's record. Resident 12 was admitted to the provider on 11/12/2024 with diagnoses including allergic rhinitis and acute bronchospasms. The	{N 432}		

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{N 432}	Continued From page 8 medication administration records (MARs) for Resident 12, reviewed from 05/06/2025 - 08/26/2025, showed staff initialing off on administration of Resident 12's fluticasone on 168 occasions (for a total of 336 sprays). On 08/27/2025, at approximately 2:38 p.m., Surveyor interviewed Director of Operations (Director) Q, from the pharmacy that dispensed Resident 12's medications. Director Q confirmed that Resident 12's fluticasone was not dispensed between 04/01/2025 and 08/25/2025 and that the only other time his/her fluticasone prescription was filled was on 11/20/2024 (Surveyor noted this was shortly after Resident 12's admission).	{N 432}		
{N 640}	83.59(2)(b) Solid core wood doors or equivalent A solid core wood door or an equivalent fire resistive door shall be provided at any interior stair between the basement and the first floor. The door shall have a positive latch and an automatic closing device and normally shall be kept closed. Enclosed furnace and laundry areas with self-closing doors in a split level home may substitute for the self-closing door between the first and second levels. Enclosed furnace and laundry areas shall have self-closing solid core wood doors or an equivalent fire resistive door when located on a common level with resident bedrooms. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that the door at the interior stair between the basement and first floor was able to close and latch automatically. This is a repeat deficiency. See Statement of	{N 640}		

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{N 640}	Continued From page 9 Deficiency (SOD) N7X613, dated 11/08/2024. Findings include: On 08/26/2025, while touring the environment, Surveyor observed the door on the first floor that separated the first floor from the stairs leading to the basement. An automatic closing device was observed on the door. Upon testing the door from the fully opened position, Surveyor observed that the door did not fully close and latch (Video 1). Surveyor tested the door again with the same result. While observing the door, Surveyor interviewed Supervisor N. Supervisor N reported that "just yesterday" s/he had seen the door close and fully latch. Supervisor N confirmed Surveyor's observations that the door did not fully close and latch.	{N 640}		