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-C 06/02/2026

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

(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 05/28/2026, with information obtained through 06/02/2026, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit and standard licensing survey at Victory Vision Community Living East, a community-based residential facility (CBRF) located in Waterloo, WI. As a result of the survey, 12 deficiencies were identified. Seven deficiencies are repeat deficiencies from Statement of Deficiency (SOD) N7X615, dated 12/12/2025, SOD N7X614, dated 08/27/2025, SOD N7X613, dated 11/08/2024, SOD N7X612, dated 05/16/2024, SOD N7X611, dated 10/27/2023, SOD F1EK12, dated 05/09/2023, and SOD F1EK11, dated 02/22/2023. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 5	{N 000}		
N 191	83.13(3)(d) Posting activity schedule. The CBRF shall post all of the following: Activity schedule as required under s. DHS 83.38(1)(c). This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the activity schedule was posted. Findings include: On 05/28/2026, at approximately 10:04 a.m., Surveyor observed a calendar posted in the	N 191		

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

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N 191	Continued From page 1 kitchen area. The calendar was for April 2026 and consisted mostly of what appeared to be resident initials with certain time ranges associated with them (e.g. On 04/08/2026, the calendar listed "[Resident 13 initials]: 10A-2P," (Photo 15). While touring the home throughout the day, Surveyor did not observe any other activity schedule posted. At approximately 12:00 p.m., Surveyor asked Supervisor N about the activity schedule. Supervisor N reported that it was typically posted. Surveyor requested Supervisor N show him/her where the activity schedule was posted. After looking in the home's common areas, Supervisor N reported s/he did not see it. When asked about the April 2026 calendar posted, Supervisor N clarified that that was the calendar for the provider's day programming but not the home. On 06/02/2026, at approximately 11:26 a.m., Surveyor discussed the lack of observed activity schedule posting with Licensee B. Licensee B reported that staff typically get the schedules posted but must have missed posting the most recent one.	N 191		
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:	N 352		

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N 352	Continued From page 2 Based on observation, record review, and interview, the provider did not ensure that Resident 12 received all prescribed medications in the dosage and at intervals prescribed by his/her practitioner. Staff signed off on administering 28 of 28 potential doses of Resident 12's polyethylene glycol powder between 05/01/2026 - 05/28/2026 from a container that was opened on 04/30/2026 and contained 30 doses of powder when administered as prescribed. The container was observed onsite on 05/28/2026 to be approximately 25% full, more than the expected 2 capfuls left if staff had administered it as documented. On 2 occasions there was no evidence of staff having administered Resident 12's glipizide tablet. This is a repeat deficiency. See Statement of Deficiency (SOD) N7X612, dated 05/16/2024, and SOD N7X611, dated 10/27/2023. Findings include: On 05/28/2026, at approximately 11:35 a.m., Surveyor observed the provider's sole medication cart with Supervisor N. Surveyor observed 1 container of polyethylene glycol powder prescribed to Resident 12. The pharmacy label on the container indicated a directive for Resident 12 to be administered 17 grams (1 capful) once daily. The manufacturer's label on the container indicated that 1 bottle contained 30 once-daily doses. A handwritten annotation in marker near the top of the container identified that the bottle was opened on 04/30/2026. Upon inspection, Surveyor observed that the container appeared to	N 352		

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N 352	Continued From page 3	N 352		

be approximately 25% full. Surveyor showed Supervisor N and Supervisor N agreed with the estimated amount remaining. Surveyor shared his/her observation that if Resident 12's polyethylene glycol powder was administered as prescribed since 05/01/2026 (the day after the container was opened), there would only be 2 or 3 capfuls of powder left in the container, which conflicted with the remaining amount observed. Supervisor N reported understanding of Surveyor's concern.

On 05/29/2026, Surveyor reviewed Resident 12's record. Resident 12 was admitted to the provider on 11/12/2024 with diagnoses including constipation and type II diabetes mellitus. Resident 12 was documented as having an activated power of attorney for healthcare (POA). Resident 12's current individual service plan (ISP), dated as last reviewed on 09/09/2025, documented his/her need for staff to administer his/her medications.

Resident 12's prescriptions included polyethylene glycol 3350 powder, active since at least 03/12/2026, with instructions to, "Mix 17 grams (fill cap to line) in 4-8 oz liquid, stir well and drink once daily for constipation." Surveyor reviewed Resident 12's medication administration records (MARs) from 04/01/2026 - 05/28/2026 and observed that from 05/01/2026 (the day after Resident 12's polyethylene glycol was marked as being opened) through 05/28/2026, staff signed off on 28 of 28 potential administrations. Surveyor noted that for the 05/28/2026 administration, the staff who signed off on administering it had left the home at the end of his/her shift before Surveyor observed the medication cart, indicating that Resident 12's polyethylene glycol was documented as administered prior to Surveyor's

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N 352	Continued From page 4 having observed the polyethylene glycol container. Surveyor noted that based on this, 2 doses of polyethylene glycol powder (2 capfuls) should have been left in the container observed onsite, which conflicted with the amount of remaining powder observed (approximately 25% of the bottle). Resident 12's prescriptions also included glipizide 5 mg tablets with instructions to, "Take 1/2 tablet (2.5 mg) by mouth every other day for type 2 diabetes mellitus." Though Resident 12's prescription instructions did not change, multiple entries of his/her glipizide were observed the MARs showing various start and end dates that, in totality, still directed for continuous every-other-day administration across the review period (e.g. one order was active from 04/01/2026 - 04/03/2026, the next order was active from 04/03/2026 - 04/17/2027, the next order was active from 04/17/2026 - 04/21/2026, and so on). Surveyor observed no evidence that Resident 12's glipizide was administered on 04/19/2026 or 05/23/2026. On 06/02/2026, at approximately 11:26 a.m., Surveyor discussed the concerns regarding Resident 12's polyethylene glycol and glipizide administration with Licensee B. Licensee B reported s/he would further look into it.	N 352		
{N 388}	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the	{N 388}		

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{N 388}	Continued From page 5	{N 388}		

provider did not ensure that the individual service plan (ISP) for 2 of 2 residents reviewed was implemented and followed as written.

Resident 12's ISP directed for staff to monitor and document his/her bowel movements and meal intake. His/her bowel movement tracking records missed 2 dates of tracking and his/her meal intake tracking records missed 19 meals across 12 days of tracking.

Resident 14's ISP directed for staff to monitor and document his/her bowel movements. His/her bowel movement tracking records missed 3 dates of tracking.

This is a repeat deficiency. See Statement of Deficiency (SOD) N7X615, dated 12/12/2025, SOD N7X613, dated 11/08/2024, and SOD N7X611, dated 10/27/2023.

Findings include:

Example 1 - Resident 12

On 05/28/2026, at approximately 10:45 a.m., Surveyor interviewed Supervisor N regarding the needs of Resident 12. Supervisor N reported that Resident 12 required both his/her bowel movements and meal intake to be monitored.

On 05/28/2026, Surveyor reviewed Resident 12's record. Resident 12 was admitted to the provider on 11/12/2024 with diagnoses including constipation and type II diabetes mellitus. Resident 12 was documented as having an activated power of attorney for healthcare (POA). Resident 12's current individual service plan (ISP), dated as last reviewed on 09/09/2025, documented the following needs:

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{N 388}	Continued From page 6 - Under the "Eating" heading: " ...Staff to document consumption monitoring per meal ..." - Under the "Toileting" heading and "[Bowel Movement] Monitoring and Toilet Checks" subheading: " ...Monitor and document their bowel movement ...Staff to monitor and document bowel movements ..." On 05/28/2026, at approximately 1:18 p.m., Surveyor e-mailed Licensee B and requested tracking records for Resident 12's bowel movements and nutritional intake from 04/01/2026 - 05/28/2026. On 05/29/2026, at approximately 8:26 a.m., Surveyor e-mailed Licensee B and again requested tracking documents between 04/01/2026 - 05/28/2026 that showed meal intake tracking and bowel movement tracking. On 05/29/2026, Surveyor reviewed the records provided. From the bowel movement tracking records sent, Surveyor observed 2 dates - 04/15/2026 and 05/03/2026 - missing with no entries. From the meal intake tracking records, Surveyor observed 19 meals across 12 days that were missing, including the following: - 04/11/2026 (lunch and dinner) - 04/15/2026 (breakfast and dinner) - 04/17/2026 (breakfast and dinner) - 04/18/2026 (dinner) - 04/25/2026 (dinner) - 05/03/2026 (breakfast, lunch, and dinner) - 05/08/2026 (dinner) - 05/09/2026 (dinner) - 05/18/2026 (breakfast) - 05/21/2026 (breakfast and lunch)	{N 388}		

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{N 388}	Continued From page 7 - 05/23/2026 (lunch) - 05/26/2026 (breakfast and lunch) On 06/02/2026, at approximately 11:26 a.m., Surveyor interviewed Licensee B. Licensee B acknowledged Surveyor's concerns that there were gaps in Resident 12's tracking records. Licensee B reported that meal intake tracking and bowel movement tracking had been applied to Resident 12 because s/he thought it was a state regulation to track both for all residents. Example 2 - Resident 14 On 05/28/2026, at approximately 1:18 p.m., Surveyor e-mailed Licensee B to request components of Resident 14's record and requested tracking records for any routine monitoring tasks that staff completed for him/her, including bowel movements and nutritional intake. On 05/29/2026, Surveyor reviewed Resident 14's record. Resident 14 was admitted to the provider on 03/02/2026. Resident 14 was documented as having a guardian. Resident 14's current individual service plan (ISP), dated as last reviewed on 03/04/2026, documented the following directive under the "Toileting" heading, "BM Monitoring and Toilet Checks" subheading: " ...Monitor and document their bowel movement ...Staff to monitor and document bowel movements." On 05/30/2026, at approximately 9:06 p.m., Surveyor e-mailed Licensee B and requested Resident 14's bowel movement tracking records from 04/01/2026 - 05/28/2026. On 06/02/2026, Surveyor reviewed the records provided. From the bowel movement tracking	{N 388}		

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{N 388}	Continued From page 8 records sent, Surveyor observed 3 days missing - 04/08/2026, 04/17/2026, and 05/03/2026. On 06/02/2026, at approximately 11:26 a.m., Surveyor interviewed Licensee B. Licensee B acknowledged Surveyor's concerns that there were gaps in Resident 14's tracking records. Licensee B reported that meal intake tracking and bowel movement tracking had been applied to Resident 14 because s/he thought it was a state regulation to track both for all residents.	{N 388}		
{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 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, observation, and interview, the provider did not ensure that the individual service plan (ISP) for 2 of 2 residents reviewed was updated when there were changes in their needs, abilities, and physical condition. Resident 12's ISP was not updated to reflect	{N 389}		

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{N 389}	Continued From page 9	{N 389}		

his/her bowel incontinence, catheter use and related care needs, his/her hospice services and the split responsibilities between the provider's staff and hospice agency's staff for showering, and lack of leg brace use. The current/most recent ISP provided during the survey did not reflect his/her Broda chair use and sit-to-stand use for transfers, and though an "Active Cares" list provided after the survey exit detailed these needs as of 02/12/2026, there was no evidence of an updated ISP reflecting these needs having been provided to Resident 12's legal representative for review and signature after the needs were implemented into his/her ISP.

Resident 14's ISP was not updated to reflect his/her increased independence with toileting.

This is a repeat deficiency. See Statement of Deficiency (SOD) N7X615, dated 12/12/2025, SOD N7X611, dated 10/27/2023, and SOD N7X612, dated 05/16/2024.

Findings include:

Example 1 - Resident 12

On 05/28/2026, at approximately 9:40 a.m., Surveyor arrived onsite to conduct a survey. Surveyor observed Resident 12 sitting in a Broda chair in the living area, with a catheter bag near his/her leg. Resident 12 was not observed with any braces on his/her lower extremities.

At approximately 10:45 a.m., Surveyor observed Supervisor N feeding Resident 12 pudding for a snack.

After the above observation, Surveyor interviewed Supervisor N about the needs of Resident 12.

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{N 389}	Continued From page 10 Supervisor N reported that Resident 12 had been receiving hospice services for approximately the past year. Supervisor N reported that Resident 12 required a sit-to-stand lift for all transfers and had used a Broda chair for ambulation for a little less than the past year. Supervisor N reported that Resident 12 required total assistance for nearly all cares but was able to participate in steps of dressing. Supervisor N reported that Resident 12 required to be fed by staff for all meals and that s/he required his/her foods to be pureed. Supervisor N reported that Resident 12 had a catheter since his/her admission for which s/he just used a larger Foley bag (no leg day bag). Supervisor N reported that Resident 12's showering needs were addressed by both the provider's staff and Resident 12's hospice agency staff. Supervisor N reported that sometimes Resident 12 was continent of his/her bowel movements and could vocalize the need to go, but sometimes s/he was incontinent. At approximately 11:56 a.m., Surveyor observed a posting in the staff office. The posting identified shower days for residents, and specifically identified that Resident 12 received a shower provided by hospice agency staff on Thursdays and a shower provided by the provider's staff on Sundays (Photo 16). At approximately 12:15 p.m., Surveyor observed outside staff who introduced themselves as being from Resident 12's hospice agency preparing to give Resident 12 a shower. The hospice staff then took Resident 12 into the bathroom. At approximately 1:45 p.m., Surveyor observed Caregiver F transfer Resident 12 to the toilet. Caregiver F was observed to use a sit-to-stand lift to transfer Resident 12.	{N 389}		

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{N 389}	Continued From page 11 On 05/28/2026, at approximately 1:00 p.m., Surveyor requested from Licensee B the current ISP for Resident 12 and "all signed ISPs since admission." On 05/29/2026, Surveyor reviewed Resident 12's record. Resident 12 was admitted to the provider on 11/12/2024. Resident 12 was documented as having an activated power of attorney for healthcare (POA). In reviewing the most recent ISP provided for Resident 12, dated 09/09/2025, Surveyor observed the following: - Mobility: "Provide full assistance to resident with walking needs ...Typically a few steps getting in and out of bed, during toilet transfers, and transfers to furniture. (No information was observed about his/her Broda chair use.) - Transferring: "Provide full assistance with transferring to/from wheelchair, chair, bed, standing position, etc ..." (No information was observed about his/her sit-to-stand use.) - No information about bowel incontinence - No information about his/her catheter use, including the assistance required by staff to manage its care - No information about his/her hospice services, including the split duties of his/her showering by his/her hospice agency's staff and the provider's staff. The ISP documented that only the provider's staff was responsible for Resident 12's showers. - Under the "Physical Disabilities" heading: "Resident is paraplegia wears a leg brace on R	{N 389}		

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light [sic] when awake and in wheelchair." (Of note, Surveyor did not observe a leg brace on either of Resident 12's lower extremities throughout the onsite survey.)

On 06/02/2026, at approximately 11:26 a.m., Surveyor shared the concern with Licensee B that Resident 12's ISP did not appear to be updated to reflect his/her current needs and abilities, including as it related to his/her mobility, transfers, incontinence, catheter cares, hospice (with related hospice care provision), and leg brace use. When asked if Resident 12 was supposed to be using a leg brace, Licensee B reported s/he did not recall him/her using a leg brace.

At approximately 1:35 p.m., after Surveyor conducted the exit interview with Licensee B, Surveyor received an e-mail from Manager G. In the e-mail, Manager G wrote, "After you and [Licensee B] completed your exit interview [s/he] called to follow up with me, and after further investigation it was noted that the broda chair for [Resident 12] is in [his/her] careplan [sic] however it's showing up in a different area on our program. We will follow up with [electronic record platform company] to get a better understanding as to why it is not showing up on the care plan assessment we went [sic] you." Attached to the e-mail was a picture of what appeared to be the provider's electronic device showing a screen titled "Active Cares" from the provider's electronic record system. The same mobility information as documented above was still in the "Active Cares" list with the addition, "update 2/12/26 mobility has been very scarce as [s/he] is in a brodha [sic] chair and uses a sit to stand to transfer when strong enough to bare [sic] weight." Of note, from the records sent by Licensee B earlier showing

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{N 389}	Continued From page 13 Resident 12's ISP being sent for signature to his/her POA, there was no evidence that this information from 02/12/2026 was either signed or provided to Resident 12's POA for signature in his/her ISP. Example 2 - Resident 14 On 05/28/2026, at approximately 10:45 a.m., Surveyor interviewed Supervisor N regarding the needs of Resident 14. Supervisor N reported that Resident 14 required staff assistance in the form of prompts and cues for dressing, physical assistance for bathing, and physical assistance for car transfers. Supervisor N reported that Resident 14 was independent for toileting and was not known to have incontinence. Supervisor N reported that Resident 14 independently walked using his/her walker and independently transferred. On 05/28/2026, at approximately 1:00 p.m. Surveyor requested from Licensee B the current ISP for Resident 14 and "all signed ISPs since admission." On 05/29/2026, Surveyor reviewed Resident 14's record. Resident 14 was admitted to the provider on 03/02/2026. Resident 14 was documented as having a guardian. In reviewing the most recent ISP provided for Resident 14, dated 03/04/2026, Surveyor observed that Resident 14 was documented as requiring "full assistance" for toileting, "including physical and verbal assistance with toileting needs. Hands-on assistance with undressing/dressing, washing/wiping and any physical assistance necessary." Surveyor observed that this conflicted with Supervisor N's report of Resident 14 being able to independently toilet.	{N 389}		

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{N 389}	Continued From page 14 On 06/02/2026, at approximately 11:26 a.m., Surveyor shared the concern with Licensee B that Resident 14's ISP did not appear to be updated to reflect his/her current lack of toileting assistance needs. Licensee B reported that when Resident 14 was first admitted his/her paperwork indicated him/her needing physical assistance for toileting. Licensee B confirmed that since his/her admission, Resident 14 had shown signs of being able conduct toileting independently. Licensee B confirmed the ISP was not updated to reflect this ability.	{N 389}		
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 that 1 of 1 resident reviewed, Resident 12, was evaluated at least annually for his/her ability to respond to a fire alarm. Findings include: On 05/28/2026, at approximately 1:00 p.m., Surveyor e-mailed Licensee B and requested "all evacuation assessments since admission" for Resident 12. No evacuation assessments were received. On 05/29/2026, at approximately 8:26 a.m., Surveyor e-mailed Licensee B to let him/her know	N 394		

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N 394	Continued From page 15 that, "[Resident 12]'s evacuation assessments since [his/her] admission" were still needed. In reviewing the records sent, Surveyor observed the most recent evacuation evaluation as having been dated 03/31/2025. Another evaluation sent contained Resident 12's name, Resident 12's room number, and the facility name, but the rest of the document was blank. On 06/02/2026, at approximately 11:26 a.m., Surveyor shared the concern with Licensee B that Resident 12's last evacuation evaluation was completed on 03/31/2025 (approximately 14 months from the survey date). Licensee B replied, "Oh yeah, it probably was."	N 394		
N 399	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written schedule for staffing the CBRF was maintained, including the employee's full name, job assignment, and time worked. Findings include: On 05/28/2026, at approximately 10:10 a.m., Surveyor interviewed Licensee B over the phone. Surveyor requested the staff schedules from 04/01/2026 - 05/28/2026.	N 399		

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N 399	Continued From page 16 At approximately 12:24 p.m., Surveyor e-mailed Licensee B to confirm that the staff schedule had not yet been received. In reviewing the records then sent, Surveyor observed that other than one shift, 05/23/2026 (10:00 a.m. - 6:00 p.m.), no staff were shown as working Saturdays or Sundays during the entire period reviewed. Surveyor also observed coverage holes during the non-weekend days in which no staff were documented as having worked, including: - 04/01/2026: 8:00 a.m. - 10:00 a.m. - 04/03/2026: From 8:00 p.m. - remainder of the night - 04/06/2026: From 12:00 a.m. - 8:00 a.m. - 04/10/2026: From 8:00 p.m. - remainder of the night - 04/13/2026: From 12:00 a.m. - 8:00 a.m. - 04/17/2026: From 8:00 p.m. - remainder of the night - 04/22/2026: From 8:00 p.m. until 8:00 a.m. on 04/23/2026 - 04/24/2026: From 8:00 p.m. - remainder of the night - 04/27/2026: from 12:00 a.m. - 10:00 a.m. - 04/28/2026: From 8:00 a.m. - 10:00 a.m. - 05/01/2026: From 8:00 p.m. - remainder of the night - 05/04/2026: From 12:00 a.m. - 10:00 a.m., then from 8:00 p.m. until 8:00 a.m. on 05/05/2026 - 05/08/2026: From 8:00 p.m. - remainder of the night - 05/11/2026: From 12:00 a.m. - 6:00 a.m., 7:00 a.m. - 10:00 a.m., and 8:00 p.m. until 6:00 a.m. on 05/12/2026 - 05/12/2026: From 7:00 a.m. - 8:00 a.m. then from 8:00 p.m. until 8:00 a.m. on 05/13/2026	N 399		

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N 399	Continued From page 17 - 05/15/2026: From 8:00 p.m. - remainder of the night - 05/18/2026: From 12:00 a.m. - 10:00 a.m. - 05/20/2026: From 8:00 p.m. - 8:00 a.m. on 05/21/2026 - 05/21/2026: From 8:00 p.m. - 8:00 a.m. on 05/22/2026 - 05/22/2026: From 8:00 p.m. - 10:00 a.m. on 05/23/2026 - 05/25/2026: From 12:00 a.m. - 10:00 a.m., then from 8:00 p.m. until 8:00 a.m. on 05/26/2026 - 05/26/2026: From 8:00 p.m. - 8:00 a.m. on 05/27/2026 On 06/02/2026, at approximately 11:26 a.m., Surveyor interviewed Licensee B about the staffing schedule. When asked who worked weekends, Licensee B reported that leadership staff typically rotated weekend shifts. Licensee B reported the provider used a messaging application to coordinate who would cover what shifts. Licensee B confirmed that the information for who covered which shifts was in the messaging application but not documented on a staffing schedule. Licensee B reported that his/her salaried staff typically covered the open shifts observed by Surveyor on the schedule but since they were salaried and did not have set hours s/he didn't typically document their work times. Licensee B reported s/he understood Surveyor's concern that the staffing schedule was not maintained.	N 399		
N 409	83.37(1)(j) Proof-of-use record. Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats, that	N 409		

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N 409	Continued From page 18 contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a proof-of-use record was maintained for 1 of 1 schedule II drug reviewed. Findings include: On 05/28/2026, at approximately 11:35 a.m., Surveyor observed the medication cart with Supervisor N. Surveyor observed 1 card of as needed (PRN) oxycodone 5 mg tablets with a pharmacy label on the card indicating they were prescribed to Resident 12. The pharmacy label indicated that the card, containing 5 tablets, was dispensed on 07/03/2025. Surveyor observed all 5 tablets still in their respective bubble packs. While observing the card, Surveyor interviewed Supervisor N. Supervisor N reported that staff typically conducted medication counts on the provider's electronic record system platform. At approximately 1:00 p.m., Surveyor e-mailed Licensee B to request the "counts done for [Resident 12]'s oxycodone since 04/01/2026." At approximately 10:12 p.m., Surveyor received an e-mail from Licensee B in which s/he reported s/he was reviewing Surveyor's record request to ensure everything was sent and realized s/he missed Resident 12's oxycodone counts. Licensee B wrote, "Please find attached	N 409		

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[Resident 12]'s Counts for Oxycodone from 4/1/26 to 5/28/26. It should be noted that this medication is only administered by directive from the Hospice Nurse if it is believed that [Resident 12] is in pain or discomfort - this count has been static."

In reviewing the document sent, Surveyor observed the addition of Resident 12's 5 oxycodone tablets, dated 07/04/2025, but did not observe any other entries showing daily auditing.

On 05/29/2026, at 8:26 a.m., Surveyor e-mailed Licensee B and wrote, " ...is there a document that shows staff's signatures or initials on having completed at least daily counts from 04/01/2026 - 05/28/2026? If so, please send."

Nothing further was sent.

On 06/02/2026, at approximately 11:26 a.m., Surveyor interviewed Licensee B. Surveyor confirmed that nothing was sent showing the daily audits of Resident 12's oxycodone tablets. Licensee B replied that staff conduct daily counts and that s/he would send the record to Surveyor.

While conducting the interview, Surveyor reviewed the document sent by e-mail from Licensee B. Surveyor observed several gaps in the auditing of Resident 12's oxycodone, including missing audits conducted on: 04/05/2026, 04/11/2026, 04/12/2026, 04/18/2026, 04/19/2026, 04/25/2026, 04/26/2026, 05/02/2026, 05/03/2026, 05/09/2026, 05/10/2026, 05/16/2026, 05/17/2026, and 05/24/2026. When asked about the missing entries, Licensee B reported that some entries were missing because staff were having issues with the provider's wireless internet which then caused access issues for the

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N 409	Continued From page 20 provider's electronic record system. Licensee B reported that on these occasions staff were expected to conduct counts on paper. Licensee B reported s/he believed the paper copy counts were at the provider's home and asked if staff could send the counts to Surveyor. Surveyor reported that any additional count records would have to be received during the current interview. Licensee B reported s/he believed the paper count records had gotten confusing and that Lead Caregiver C was in the process of trying to reconcile the counts. At the end of the interview, Licensee B reported s/he did not think additional count records would be provided due to them not being organized.	N 409		
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 the environment was safe and clean. This is a repeat deficiency. See Statement of Deficiencies (SOD) N7X613, dated 11/08/2024, and SOD F1EK11, dated 02/22/2023. Findings include: On 05/28/2026, Surveyor conducted a standard	N 481		

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N 481	Continued From page 21	N 481		

licensing survey and verification visit at the home.

- At approximately 9:54 a.m., Surveyor observed the west bathroom (bathroom located closest to the door to the basement) with no toilet paper (Photo 4). The toilet seat appeared stained (Photo 5) and the floor vent near the toilet was observed caved in, exposing a gap of approximately 1" at its widest point (Photo 6). At approximately 1:53 p.m., Surveyor observed the bathroom again. The toilet seat appeared with the same stains and there was still no toilet paper observed (Photo 7).

- At approximately 10:00 a.m., Surveyor observed the floor vent within Resident 12's room, near his/her doorway. The vent was unsecured to the wall on one side, causing the vent to stick out into Resident 12's doorway (Photo 8).

- At approximately 10:24 a.m., Surveyor observed Resident 14's room. The doors to Resident 14's sliding door closet were off the tracks and leaning against the interior shelf and hanging rod, blocking approximately half the closet (Photo 9).

- At approximately 10:33 a.m., Surveyor observed the air vent on the wall across from the laundry room, which appeared dusty (Photo 10).

- From approximately 10:32 a.m. - 1:44 p.m., Surveyor observed some of the sprinkler heads within the provider's home. The sprinkler escutcheons (fixtures that help tightly seal the sprinkler to the wall and thus prevent any delay in sprinkler activation from smoke escaping in gaps between the sprinkler and wall) for sprinkler heads observed in Resident 13's room (above his/her closet), in Resident 8's room, in the east bathroom (above the door), and next to the

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N 481	Continued From page 22 laundry room (Photos 11, 12, 13, and 14) did not appear to be flush with the wall, with observed gaps as wide as a finger-width in some sections. On 06/02/2026, at approximately 11:26 a.m., Surveyor discussed the above areas of concern with Licensee B. Licensee B reported the cleaning was typically done at night but that s/he would speak with staff about doing more frequent checks for bathroom cleanliness. Regarding the bathroom floor vent, Licensee B reported that it was a continuous issue due to resident wheelchairs bumping into the vent. Licensee B reported that s/he has had to replace the vent several times already. Regarding the vent in Resident 12's room, Licensee B reported understanding of Surveyor's concern. Regarding Resident 14's closet doors, Licensee B reported s/he would have to look further into it and see why the doors were either not on the tracks or stored elsewhere. Licensee B acknowledged Surveyor's concern about the sprinkler escutcheons.	N 481		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping	N 525		

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N 525	Continued From page 23 hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that at least one fire evacuation drill for 2025 was held that simulated the conditions during usual sleeping hours. Findings include: On 05/28/2026, at approximately 10:10 a.m., Surveyor interviewed Licensee B over the phone. Surveyor requested all fire drills completed for 2025 and 2026. Licensee B reported that the records would be e-mailed to Surveyor. On 05/29/2026, at approximately 8:26 a.m., Surveyor e-mailed Licensee B. In the e-mail, Surveyor confirmed receipt of one fire drill having been sent in the requested timeframe. Surveyor noted, "If any other drills were conducted in 2025 or 2026, please send those records." In reviewing all the fire drill records then sent, there was no evidence that a drill in 2025 was held simulating the conditions during usual sleeping hours. On 06/02/2026, at approximately 11:26 a.m., Surveyor interviewed Licensee B. Surveyor confirmed there was no evidence of a fire drill in 2025 having been done simulating the conditions of usual sleeping hours. Licensee B reported s/he understood Surveyor's concern.	N 525		

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N 612	83.55(3) Bath and toilet areas: hand drying. Hand drying. All sink areas shall have dispensers for single use paper towels, cloth towel dispensing units that are enclosed for protection against being soiled or electric hand dryers. This requirement does not apply to sink areas located in toilet rooms accessed directly from a resident bedroom. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that a sink area located within the staff restroom had dispensers for single use paper towels, cloth dispensing units that were enclosed for protection against being soiled, or electric hand dryers. This is a repeat deficiency. See Statement of Deficiencies (SOD) N7X613, dated 11/08/2024. Findings include: On 05/28/2026, at approximately 12:27 p.m., Surveyor observed the staff bathroom, located within the staff office. The paper towel dispensing unit was observed open with the stack of paper towels within observed exposed (Photo 2). At approximately 1:47 p.m., Surveyor observed the staff bathroom again. The paper towel dispenser remained unchanged from Surveyor's previous observation (Photo 3). On 06/02/2026, at approximately 11:26 a.m., Surveyor discussed the above concern with Licensee B. Licensee B reported s/he believed staff were having issues with pulling out multiple paper towels at once and so they had opened it to more easily pull a single paper towel at a time	N 612		

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	0018368	A. BUILDING: _____ B. WING _____	R-C 06/02/2026

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VICTORY VISION COMMUNITY LIVING EAST	968 E MADISON STREET WATERLOO, WI 53594

(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 612	Continued From page 25 out. Licensee B reported understanding of Surveyor's concern that this did not protect the remaining paper towels from being soiled.	N 612		
N 627	83.58(1)(c) Self-closing 1-3/4-inch solid core wood door Attached garage. A self-closing 1-3/4-inch solid core wood door or an equivalent self-closing fire-resistive rated door shall protect openings between an attached garage and the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that the solid core wood door protecting the opening between the CBRF and its attached garage was self-closing. This is a repeat deficiency. See Statement of Deficiencies (SOD) F1EK12, dated 05/09/2023. Findings include: On 05/28/2026, at approximately 10:02 a.m., Surveyor observed the door from the home's garage to the home's interior. Upon opening and allowing the door to close on two different trials, Surveyor did not observe the door to fully close (Video 1). On 06/02/2026, at approximately 11:26 a.m., Surveyor discussed the above concern with Licensee B. Licensee B reported s/he took notes of the concern and would look into the issue.	N 627		
N 640	83.59(2)(b) Solid core wood doors or equivalent A solid core wood door or an equivalent fire	N 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 640	Continued From page 26	N 640		

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 enclosed laundry area's solid core wood door was self-closing.

This is a repeat deficiency. See Statement of Deficiencies (SOD) N7X614, dated 08/27/2025, and SOD N7X613, dated 11/08/2024.

On 05/28/2026, at approximately 10:18 a.m., Surveyor observed the laundry room door. The laundry room was located on a common level with all the resident bedrooms. Upon opening and allowing the door to close, Surveyor did not observe the door to fully close (Video 2).

At approximately 1:43 p.m., Surveyor observed the laundry room door. The door was observed not fully closed, in a similar position as to how it was when left to close on its own (Photo 1).

On 06/02/2026, at approximately 11:26 a.m., Surveyor discussed the above concern with Licensee B. Licensee B reported s/he took notes of the concern and would look into the issue.