STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE 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 09/26/2023, with information obtained through 10/10/2023, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit at Victory Vision Community Living North, a community-based residential facility (CBRF) located in Waterloo, WI. As a result of the survey, 9 deficiencies were identified. Six deficiencies were repeat deficiencies from Statement of Deficiency (SOD) 65W912, dated 04/21/2021, SOD 65W913, dated 07/22/2021, SOD 65W914, dated 02/04/2022, and SOD YUJP11, dated 04/12/2023. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 6	N 000		
N 188	83.13(3)(a) Posting license, deficiencies, revocations The CBRF shall post all of the following: CBRF license, any statement of deficiency, notice of revocation and any other notice of enforcement action as required under s. DHS 83.14(2)(h). This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that past Statement of Deficiency (SOD) YUJP11, issued on 07/05/2023, was posted. Findings include: On 09/26/2023, Surveyor reviewed Department	N 188		

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
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE STREET WATERLOO, WI 53594

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N 188	Continued From page 1 records for the facility and observed that the provider had been issued SOD YUJP11, containing 15 deficiencies, on 07/05/2023 via e-mail. On 09/26/2023, Surveyor conducted a verification visit. While touring the facility, from approximately 8:00 a.m. until 8:45 a.m., Surveyor did not observe SOD YUJP11 posted anywhere. At approximately 2:13 p.m., Surveyor interviewed Supervisors D and G. Supervisor G confirmed Surveyor's observation that the SOD was not posted anywhere. Supervisor G reported s/he didn't know that posting the SOD was a regulatory requirement and stated, "They never told us that."	N 188		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter	N 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

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N 239	Continued From page 2 medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 1 of 1 employee reviewed obtained all department approved training as required. Caregiver H did not have training in fire safety within 90 days after starting employment. This is a repeat deficiency. See Statement of Deficiency (SOD) YUJP11, dated 04/12/2023. Findings include: On 09/26/2023, Surveyor conducted a review of 1 employee to verify compliance with department approved training requirements. Surveyor requested training records from Supervisors D and G for Caregiver H. The record for Caregiver H, hired 06/12/2023, did not contain evidence of training or evidence of meeting an exemption for fire safety. On 09/26/2023, at approximately 9:40 a.m., Surveyor interviewed Caregiver H. Caregiver H reported s/he was first signed up for fire safety training sometime around July 2023 but had to drop out due to having a medical emergency. Caregiver H reported that s/he was signed up to take the class on 10/02/2023.	N 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 239	Continued From page 3 At approximately 2:13 p.m., Surveyor interviewed Supervisors D and G. Supervisor G reported that the provider has made 3 attempts to get Caregiver H into fire safety training, including the first attempt in which s/he had to drop out due to a medical emergency as well as the current attempt. When asked what the other attempt was, Supervisor G reported that Caregiver H had missed the second attempt to train in fire safety due to a miscommunication as to whether the training was supposed to be in person or virtual. On 09/26/2023, Surveyor verified that Caregiver H was not on the Community-Based Care and Treatment training registry for fire safety. On 10/03/2023, Surveyor observed that Caregiver H was on the Community-Based Care and Treatment training registry for fire safety with a completion date of 10/03/2023.	N 239		
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 that 2 of 2 residents reviewed received all prescribed medications in the dosage and at intervals prescribed by a practitioner.	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE STREET WATERLOO, WI 53594

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N 352	Continued From page 4	N 352		

Resident 1 did not receive his/her prescribed Vitamin D on 4 occasions that it was due in September 2023. Resident 1's insulin was held on 2 occasions contrary to his/her medical provider order.

Resident 3 did not receive his/her prescribed sliding scale insulin when it would have been due on 28 occasions in September 2023.

This is a repeat deficiency. See Statement of Deficiency (SOD) 65W913, dated 07/22/2021, SOD 65W914, dated 02/04/2022, and SOD YUJP11, dated 04/12/2023.

Findings include:

Example 1 - Resident 1

On 09/26/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 11/28/2022 with diagnoses including Vitamin D deficiency and type II diabetes mellitus. Surveyor reviewed Resident 1's prescriptions, which included the following:

- Vitamin D2 (ergocalciferol) capsules with a start date of 04/06/2023 and instructions to, "Take 1 capsule by mouth once weekly." Surveyor observed that the prescriber of Resident 1's Vitamin D was not the same as his/her documented primary care physician.

- Humalog KwikPen 100 units/mL with a start date 08/17/2023 and instructions to, "Inject 8 units subcutaneously three times daily before or after meals; give 5 units if [blood glucose] <100 prior to meal, +2 units for every 50>150 before meals...blood glucose is 151-200 +2 extra, blood glucose is 201-250 +4 extra, blood glucose is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE 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 352	Continued From page 5	N 352		

251-300 +6 extra, blood glucose is 301-350 +8 extra blood glucose is 351-400 +10 extra."

Surveyor observed Resident 1's medication administration record (MAR) from 09/01/2023 - 09/26/2023 and observed the following:

- Vitamin D2: Marked as held for 4 of 4 potential administrations (09/07/2023, 09/14/2023, 09/21/2023, and 09/28/2023). There was no other information in his/her MAR about the holding of his/her Vitamin D2.

- 09/09/2023 (8:58 a.m.): Humalog marked as held due to "No pass per vitals" with blood sugar documented as 103 (no hold parameters documented as part of orders)

- 09/18/2023 (9:40 a.m.): Humalog marked as held due to "No pass per vitals" with blood sugar documented as 121 (no hold parameters documented as part of orders)

At approximately 10:20 a.m., Surveyor interviewed Supervisor D. Supervisor D reported that the provider is waiting on the pharmacy to deliver Resident 1's Vitamin D, and that pharmacy staff claim they are waiting on Resident 1's medical provider to send an order for his/her Vitamin D. Supervisor D reported s/he had attempted to follow up via phone call with Resident 1's medical provider, but confirmed s/he had no documented evidence of this.

At approximately 10:40 a.m., Surveyor interviewed Supervisor G, who was the staff documented as holding Resident 1's Humalog on the above 2 occasions. After reviewing the MAR and Resident 1's Humalog order, Supervisor G confirmed s/he held Resident 1's insulin on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE 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 352	Continued From page 6	N 352		

above 2 occasions. Supervisor G said nothing further.

On 09/26/2023, at approximately 3:53 p.m., Surveyor interviewed Pharmacist I from the pharmacy that filled Resident 1's prescriptions. Pharmacist I reported that Resident 1's Vitamin D was last filled in March 2023 but they haven't been able to fill since due to his/her prescription running out and receiving no new prescription.

On 09/29/2023, at approximately 1:53 p.m., Surveyor interviewed Administrative Assistant J from Resident 1's medical provider office. Administrative Assistant J reported that the current medical provider became Resident 1's primary care provider in December of 2022 (approximately around the time of his/her admission to the provider). Administrative Assistant J reported that on the medication list received from the provider at that time, Vitamin D was listed but the medical provider prescribing it was a different medical provider. Administrative Assistant J reported that because of this, the current medical provider would not receive any notification for refills from the provider's staff since s/he was not the prescriber. Administrative Assistant J reported the provider's staff should have noticed this and worked with the medical provider's office to change over Resident 1's Vitamin D prescription if the other prescriber was no longer current. Administrative Assistant J reported that they had no other portal message, which was the provider's primary way of communicating with the medical provider's office, or other communication notes from the provider's staff attempting to solve this issue until 09/26/2023 (the day Surveyor was on site), when s/he received a portal message from Manager A letting him/her know that Resident 1's Vitamin D

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE STREET WATERLOO, WI 53594

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N 352	Continued From page 7	N 352		

prescription was sent to the wrong pharmacy. Administrative Assistant J reported that the prescription was just sent out from the medical provider that day.

Example 2 - Resident 3

On 09/26/2023, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 03/02/2019 with diagnoses including type 1 diabetes. Resident 3's prescriptions included the following:

- Humalog sliding scale (correction dose as part of an insulin-to-carb (ICR) ratio administration, but maintained as its own entry in Resident 3's medication list and MAR) with the following instructions: "Inject per sliding scale with meals: <150 = none, 151-200 = 2 units, 201-250 = 3 units, 251-300 = 4 units

- Humalog sliding scale at bedtime with the following instructions: "Inject per sliding scale at bedtime: 151-200 = 1 [unit]; 201-250 = 2 [units]; 251-300 = 3 [units]; 301-350 = 4 [units]; >350 = 5 units..."

On 09/26/2023, Surveyor reviewed Resident 3's MAR from 09/01/2023 - 09/26/2023 and observed the following 28 inconsistencies:

- 09/07/2023 (lunch): Blood sugar documented as 192 (within parameters to receive 2 units of insulin), sliding scale Humalog not administered with the annotation, "wrong sliding scale"

- 09/07/2023 (supper): Blood sugar documented as 191 (within parameters to receive 2 units of insulin), sliding scale Humalog not administered with the annotation, "wrong sliding scale"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE 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 352	Continued From page 8 - 09/07/2023 (bedtime): Blood sugar documented as 229 (within parameters to receive 2 units of insulin), sliding scale Humalog not administered with the annotation, "wrong sliding scale" - 09/08/2023 (lunch): Blood sugar documented as 200 (within parameters to receive 2 units of insulin), sliding scale Humalog not administered with the annotation, "wrong sliding scale" - 09/10/2023 (breakfast): Blood sugar documented as 158 (within parameters to receive 2 units of insulin), sliding scale Humalog not administered with the annotation, "wrong sliding scale" - 09/10/2023 (supper): Blood sugar documented as 178 (within parameters to receive 2 units of insulin), sliding scale Humalog not administered with the annotation, "wrong sliding scale" - 09/11/2023 (supper): Blood sugar documented as 219 (within parameters to receive 3 units of insulin), sliding scale Humalog not administered with the annotation, "wrong sliding scale" - 09/11/2023 (bedtime): Blood sugar documented as 230 (within parameters to receive 2 units of insulin), sliding scale Humalog not administered with the annotation, "wrong sliding scale" - 09/12/2023 (breakfast): Blood sugar documented as 162 (within parameters to receive 2 units of insulin), sliding scale Humalog not administered with the annotation, "wrong slideing[sic] scale" - 09/12/2023 (supper): Blood sugar documented as 274 (within parameters to receive 4 units of	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE 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 352	Continued From page 9	N 352		

insulin), sliding scale Humalog not administered with no annotation or other notes

- 09/12/2023 (bedtime): Blood sugar documented as 184 (within parameters to receive 1 unit of insulin), sliding scale Humalog not administered with no annotation or other notes

- 09/13/2023 (supper): Blood sugar documented as 172 (within parameters to receive 2 units of insulin), sliding scale Humalog not administered with no annotation or other notes

- 09/15/2023 (lunch): Blood sugar documented as 228 (within parameters to receive 3 units of insulin), sliding scale Humalog not administered with the annotation, "wrong sliding scale"

- 09/18/2023 (lunch): Blood sugar documented as 159 (within parameters to receive 2 units of insulin), sliding scale Humalog not administered with the annotation, "wrong sliding scale"

- 09/18/2023 (supper): Blood sugar documented as 247 (within parameters to receive 3 units of insulin), 4 units were documented as administered

- 09/19/2023 (lunch): Blood sugar documented as 156 (within parameters to receive 2 units of insulin), sliding scale Humalog not administered with the annotation, "wrong sliding scale."

- 09/20/2023 (lunch): Blood sugar documented as 254 (within parameters to receive 4 units of insulin), sliding scale Humalog not administered with the annotation, "wrong sliding scale"

- 09/20/2023 (supper): Blood sugar documented as 340 (within parameters to receive 5 units of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE 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 352	Continued From page 10	N 352		

insulin), sliding scale Humalog not administered with the annotation, "wrong sliding scale"

- 09/21/2023 (supper): Blood sugar documented as 262 (within parameters to receive 4 units of insulin), sliding scale Humalog not administered with the annotation "no humalog"

- 09/21/2023 (bedtime): Blood sugar documented as 185 (within parameters to receive 1 unit of insulin), sliding scale Humalog not administered with the annotation, "no humalog"

- 09/22/2023 (lunch): Blood sugar documented as 170 (within parameters to receive 2 units of insulin), sliding scale Humalog not administered with the annotation, "wrong sliding scale"

- 09/22/2023 (supper): Blood sugar documented as 224 (within parameters to receive 3 units of insulin), sliding scale Humalog not administered with the annotation, "wrong sliding scale."

- 09/23/2023 (lunch): Blood sugar documented as 173 (within parameters to receive 3 units of insulin), 0 units of sliding scale Humalog documented as administered

- 09/24/2023 (lunch): Blood sugar documented as 167 (within parameters to receive 2 units of insulin), sliding scale Humalog not administered with the annotation, "Wrong sliding scale."

- 09/24/2023 (supper): Blood sugar documented as 314 (within parameters to receive 5 units of insulin), sliding scale Humalog not administered with the annotation, "Wrong sliding scale."

- 09/25/2023 (lunch): Blood sugar documented as 214 (within parameters to receive 3 units of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE 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 352	Continued From page 11	N 352		

insulin), sliding scale Humalog not administered with the annotation, "wrong sliding scale."

- 09/25/2023 (supper): Blood sugar documented as 224 (within parameters to receive 3 units of insulin), sliding scale Humalog not administered with the annotation, "wrong sliding scale."

- 09/25/2023 (bedtime): Blood sugar documented as 175 (within parameters to receive 1 unit of insulin), sliding scale Humalog not administered with the annotation, "wrong sliding scale."

At approximately 11:51 a.m., Surveyor interviewed Supervisors D and G. Supervisor G confirmed that Resident 3 did not receive his/her sliding scale Humalog because staff were directed by Manager A not to administer it. Supervisor G reported that there was some confusion between Resident 3's generic insulin lispro and the brand name, Humalog. Supervisor G reported that staff didn't realize that Humalog was the name brand for insulin lispro, and that Manager A was reaching out to Resident 3's prescriber for clarification. Surveyor asked why it took a couple of weeks for Manager A to obtain this clarification. Supervisor G replied that s/he thought there was a lot going on. Surveyor asked how staff were handling Resident 3's sliding scale insulin now. Supervisor G replied that s/he would administer Resident 3 his/her sliding scale insulin if his/her blood sugar was above 200 but would hold it if his/her blood sugar was in the 150-200 range. Surveyor reviewed Resident 3's mealtime sliding scale insulin order with Supervisor G, which indicated that Resident 3 should receive 2 units of sliding scale insulin with meals when his/her blood sugar was between 151-200, and asked Supervisor G if s/he would still hold Resident 3's insulin despite his/her practitioner's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE 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 352	Continued From page 12 order. Supervisor G replied that s/he would because Resident 3 has issues with his/her blood sugar dropping too quickly and becoming symptomatic. Surveyor again reviewed Resident 3's physician orders and noted the following annotation within his/her sliding scale Humalog order: "Do not hold insulin - treat the low and do not include carbs for treatment with meal carb count." On 10/10/2023, at approximately 11:15 a.m., Surveyor interviewed Licensee C. Licensee C reported s/he was on call when s/he noticed staff's confusion with Resident 3's insulin prescription. Licensee C reported s/he contacted Resident 3's on-call medical provider the same day s/he noticed the issue and got the answer about his/her Humalog being the same thing as his/her insulin lispro. Licensee C reported s/he wasn't sure why Manager A didn't get an answer sooner.	N 352		
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.	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE 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 389	Continued From page 13	N 389		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that the individual service plan (ISP) was updated for 1 of 3 residents reviewed when there were changes in his/her needs or that the resident's legal representative signed the updated ISP for 1 of 3 residents reviewed.

Resident 1's ISP, last signed as reviewed by Manager A and his/her managed care organization representatives on 04/14/2023, was not signed by his/her legal guardian.

Resident 4's negative attitudes/behaviors towards other residents and staff, including strategies utilized by staff to mitigate these behaviors, were not documented in his/her ISP.

This is a repeat deficiency. See Statement of Deficiency (SOD) YUJP11, dated 04/12/2023.

Findings include:

Example 1 - Resident 1

On 09/26/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 11/28/2022 with diagnoses including vascular dementia, schizophrenia, and moderate intellectual disability. Resident 1 was documented as having a legal guardian since his/her admission. Surveyor reviewed Resident 1's current ISP, which was last signed as reviewed by Manager A and his/her managed care organization representatives on 04/14/2023. Surveyor did not observe any signature from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE STREET WATERLOO, WI 53594

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N 389	Continued From page 14 his/her guardian. At approximately 2:13 p.m., Surveyor interviewed Supervisors D and G. Supervisor G reported that s/he was unable to find anything in the provider's files showing that Resident 1's legal guardian signed his/her ISP. Surveyor asked if there was any documentation showing attempts made to obtain the legal guardian's signature. Supervisor D reported s/he was unable to find any. Example 2 - Resident 4 On 09/26/2023, at approximately 9:05 a.m., Surveyor interviewed Supervisors D and G. Supervisor D reported that Resident 4 was not currently in the home due to being in jail. Supervisor D reported that there was a report received from a resident at a separately licensed CBRF owned by the provider that Resident 4 was going to "beat up" another resident at that same CBRF and so on 09/23/2023 law enforcement came on site and arrested Resident 4. When asked if Resident 4 has any negative behaviors, Supervisor G replied that Resident 4 was known to argue with other residents and staff. Supervisor D reported that Resident 4 will sometimes pick on lower functioning residents of the home and that staff intervene to stop him/her. On 09/26/2023, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 07/13/2023 with diagnoses including autism, episodic mood disorder, and anxiety disorder. Surveyor reviewed Resident 4's observation notes from 09/01/2023 - 09/26/2023 and observed the following: - 09/01/2023 (10:15 p.m.): "i[sic] got here at 7pm and [s/he] has got gotten[sic] high outside..."	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE 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 389	Continued From page 15 - 09/04/2023 (3:15 p.m.): "Attitude all shift, taking staffs[sic] items, smoking in house, using house phone talking about drugs...Slamming doors...Bulling[sic] [his/her] housemates through words, laughing at staff and house mates." - 09/05/2023 (7:30 a.m.): "was very disrespectful when [s/he] came home, would not stop talking about another staff in a negative way, [s/he] was being very rude in the common area while on a phone conversation, staff asked [him/her] to lower [his/her] voice and stop swearing, but [s/he] ignored..." - 09/18/2023 (5:30 p.m.): "On many occasions was corrected, redirected, and [s/he] is ignoring staff and continuously vaping in the home in common area. Living room on bean bag. Multiple staff have attempted even on ams[sic]. All [s/he] has to saying is staff are on [expletive] and always harping on [him/her]." Surveyor reviewed Resident 4's ISP, last reviewed on 05/01/2023. The only negative behavior pattern observed documented by Surveyor was Resident 4's drug use, with the note, "[Resident 4] needs redirection and it is believed that [s/he] smokes marijuana vapes because of smells on [his/her] person. When asked, [s/he] has provided mixed messages. It has been discussed that street drugs and alcohol are not allowed on the premises of either home...will continue to monitor [Resident 4] regarding marijuana habits." At approximately 12:11 p.m., Surveyor discussed Resident 4's behaviors with Supervisors D and G. Both reported they did not feel like Resident 4 fit in well with the other residents of the home.	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE STREET WATERLOO, WI 53594

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N 389	Continued From page 16 Supervisor G reported that Resident 4 acts rude particularly towards Residents 1 and 3. When asked to clarify, Supervisor D reported that Resident 4 mocks Resident 3 by imitating the noises/utterances that s/he makes and also makes fun of Resident 3's lack of hair. Supervisor D reported that Resident 4 also made fun of Resident 1. Supervisors D and G acknowledged Surveyor's concern that Resident 4's negative behaviors towards other staff and residents, based on his/her observation notes and staff report, weren't documented in his/her ISP. Surveyor asked who was responsible for updating ISPs, to which Supervisor D reported that an offsite manager made ISPs based on observation note entries and staff report. Supervisor D reported s/he wasn't sure why Resident 4's behaviors were not documented on his/her ISP.	N 389		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE 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 415	Continued From page 17	N 415		

provider did not ensure that the person administering medication initialed off on administration and recorded medication dosages in the medication administration record (MAR) for 2 of 2 residents reviewed.

Resident 1's September 2023 MAR contained 24 blank entries across 19 days. Staff did not record the number of insulin units administered for any administrations of his/her insulin in which scheduled insulin and potentially sliding scale insulin were administered to Resident 1 from 09/01/2023 - 09/26/2023. On 2 occasions (bedtime on both 09/18/2023 and 09/24/2023), staff documented not administering Resident 1 his/her bedtime insulin, but did not document why.

Resident 3's September 2023 MAR contained 19 blank entries across 11 days.

This is a repeat deficiency. See Statement of Deficiency (SOD) 65W912, dated 04/21/2021, SOD 65W913, dated 07/22/2021, and SOD YUJP11, dated 04/12/2023.

Findings include:

Example 1 - Resident 1

On 09/26/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 11/28/2022 with diagnoses including type II diabetes mellitus with diabetic retinopathy, vascular dementia, and moderate intellectual disability. Surveyor reviewed Resident 1's prescriptions, which included the following:

- Levemir FlexPen 100 units/mL with instructions to "Inject 20 units subcutaneously nightly"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE 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 415	Continued From page 18	N 415		

- Humalog KwikPen 100 units/mL with instructions to "Inject 8 units subcutaneously three times daily before or after meals; give 5 units if [blood glucose] <100 prior to meal..." with the following sliding scale: 151-200 = 2 extra units; 201-250 = 4 extra units; 251-300 = 6 extra units; 301-350 = 8 extra units; 351-400 = 10 extra units
- Humalog KwikPen 100 unit/mL for bedtime sliding scale administration according to the following scale: 201-250 = 2 units; 251-300 = 4 units; 301-350 = 6 units; 351-400 = 8 units; >400 = 10 extra units and call medical provider

Surveyor reviewed Resident 1's MAR from 09/01/2023 - 09/26/2023 and observed the following 24 blank entries:

- Levemir: 09/15/2023
- Humalog (with meals): 09/15/2023 (breakfast), 09/16/2023 (supper), 09/18/2023 (lunch), 09/22/2023 (breakfast), 09/23/2023 (breakfast)
- Humalog (bedtime): 09/02/2023, 09/03/2023, 09/05/2023, 09/07/2023 through 09/10/2023, 09/13/2023 through 09/17/2023, 09/19/2023 through 09/23/2023, and 09/25/2023

Surveyor also observed that Resident 1 was documented as having been administered his/her Humalog on 68 occasions from 09/01/2023 - 09/26/2023. On none of these occasions were the number of units s/he received documented.

Surveyor also observed 2 occasions on which Resident 1's Humalog was documented as not administered, which included the following:

- 09/18/2023 (9:52 p.m.): "No pass reason: Other" with no other information, including blood sugar, documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE 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 415	Continued From page 19 - 09/24/2023 (10:56 p.m.): "No pass reason: Other" with no other information, including blood sugar, documented At approximately 2:13 p.m., Surveyor interviewed Supervisors D and G. Both acknowledged Surveyor's concern with the blank entries, especially for Resident 1's bedtime insulin where the entries appeared to be blank more than they appeared to be documented in. Supervisor G reported that s/he would have to talk with Licensee C about the issue. Example 2 - Resident 3 On 09/26/2023, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 03/02/2019 with diagnoses including type I diabetes mellitus and Down syndrome. Surveyor reviewed Resident 3's prescriptions, which included the following: - Insulin lispro KwikPen 100 units/mL (administered per insulin to carb ratio (ICR) with meals/snacks) - Humalog sliding scale (correction dose maintained as its own documented entry but tied to the insulin lispro order above) - Humalog sliding scale (bedtime) Surveyor reviewed Resident 3's MAR from 09/01/2023 - 09/26/2023. Surveyor observed three mealtime entries for the insulin documentation as well as an 8:00 p.m. entry. At approximately 11:11 a.m., Surveyor asked Supervisor D about the 8:00 p.m. entry, to which Supervisor D replied that it was on the MAR because Resident 3 typically consumed an evening snack, which often consisted of a shake.	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE STREET WATERLOO, WI 53594

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N 415	Continued From page 20 Surveyor observed the following 19 blank entries: - Insulin lispro (ICR), documented as its own set of entries: 09/02/2023 (lunch and supper), 09/05/2023 (supper), 09/07/2023 (breakfast and supper), 09/13/2023 (evening snack), 09/17/2023 (evening snack), 09/19/2023 (evening snack), 09/20/2023 (evening snack), and 09/25/2023 (evening snack) - Humalog sliding scale/correction dose, documented as its own set of entries: 09/03/2023 (lunch and supper) and 09/21/2023 (breakfast) - Humalog sliding scale at bedtime, documented as its own entry: 09/02/2023, 09/03/2023, 09/05/2023, 09/06/2023, 09/17/2023, and 09/20/2023 At approximately 2:13 p.m., Surveyor interviewed Supervisors D and G. Both acknowledged Surveyor's concern with the blank entries in Resident 3's MAR, and reported they would follow up with staff.	N 415		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that injectable medications were administered by 3 of 3	N 416		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE 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 416	Continued From page 21	N 416		

non-licensed employees as delegated by a registered nurse (RN).

The provider did not ensure that Supervisor D, Supervisor G, and Caregiver H, who all administered insulin, were delegated by a registered nurse to do so.

This is a repeat deficiency. See Statement of Deficiency (SOD) YUJP11, dated 04/12/2023.

Findings include:

On 09/26/2023, Surveyor reviewed the medication administration record (MAR) for Resident 1 from 09/01/2023 - 09/26/2023 and observed prescriptions for a Humalog 100 units/mL Kwikpen (3x daily with meals) and Levemir Flexpen 100 units/mL (nightly), both injectable insulin. Surveyor observed that Supervisor D signed off on administering each on the following 20 dates and times:

- 09/01/2023: Humalog (breakfast and lunch)
- 09/04/2023: Humalog (breakfast)
- 09/05/2023: Levemir and Humalog (breakfast and supper)
- 09/06/2023: Humalog (breakfast, lunch, and supper)
- 09/11/2023: Humalog (breakfast, lunch, and supper)
- 09/12/2023: Levemir and Humalog (breakfast, lunch, and supper)
- 09/13/2023: Levemir and Humalog (lunch and supper)
- 09/18/2023: Levemir

Surveyor observed that Supervisor G signed off on administering each on the following 38 dates and times:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE 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 416	Continued From page 22 - 09/01/2023: Levemir - 09/02/2023: Levemir and Humalog (breakfast, lunch, and supper) - 09/05/2023: Humalog (lunch) - 09/07/2023: Levemir and Humalog (breakfast, lunch, and supper) - 09/08/2023: Humalog (breakfast and lunch) - 09/10/2023: Humalog (breakfast, lunch, and supper) - 09/13/2023: Humalog (breakfast) - 09/14/2023: Humalog (breakfast) - 09/15/2023: Humalog (lunch and supper) - 09/16/2023: Levemir and Humalog (breakfast and lunch) - 09/17/2023: Humalog (breakfast, lunch, and supper) - 09/19/2023: Levemir and Humalog (breakfast, lunch, and supper) - 09/20/2023: Levemir and Humalog (breakfast, lunch, and supper) - 09/21/2023: Humalog (breakfast and lunch) - 09/22/2023: Levemir and Humalog (lunch and supper) Surveyor observed that Caregiver H signed off on administering each on the following 9 dates and times: - 09/24/2023: Levemir and Humalog (breakfast, lunch, and supper) - 09/25/2023: Levemir and Humalog (breakfast, lunch, and supper) - 09/26/2023: Humalog (breakfast) At approximately 9:55 a.m., Surveyor requested the nursing delegation for injectable medication for Supervisor D, Supervisor G, and Caregiver H from Supervisor G.	N 416		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE 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 416	Continued From page 23 Surveyor then reviewed 2 documents, provided by Licensee C. The first, titled "RN Delegation Authorization Protocol Overview" contained a summary of the regulation for delegation, information about standards of practice for registered nurses in relation to delegation, information on "Delegation Locations" and a section containing guidelines for RN delegation. The bottom of the protocol documented, "This protocol is only valid with the accompanying delegatee's completed training that is signed by the RN Delegate. Delegatee information can be found as part of the delegate training that each is required to complete under this protocol authorization." At the bottom of the document contained a signature with the initials "RN" behind it and a date of 06/26/2023. There was no information about which specific tasks were delegated by the RN and to which specific staff the task(s) were delegated to. Surveyor then reviewed the second document provided by Licensee C, titled, "Employee Completed Delegated Training List" which contained information regarding insulin administration. The document had a section called "Training Summary" which summarized how staff filmed themselves administering insulin and sent the videos "to the RN Delegate for approval." The last statement documented, "This list is accompanying the RN Delegate Protocol." Underneath that, a list of staff names were documented, which included Supervisors D and G and Caregiver H. There was no information on the document regarding the RN. At approximately 1:00 p.m., Surveyor interviewed Licensee C. Surveyor asked about the process utilized by the provider to delegate injecting medications. Licensee C reported that staff filmed	N 416		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE 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 416	Continued From page 24 themselves administering insulin and sent these videos to the provider's nurse for feedback. Surveyor asked if there was any document that specifically documented that the RN was delegating specific task(s) to specific caregiver(s) at a specific effective date. Licensee C reported s/he thought the 2 documents s/he provided earlier were sufficient. At approximately 2:05 p.m., Surveyor interviewed Supervisor D about the delegation process. Supervisor D reported that each staff was recorded administering insulin to either of the residents who receive prescribed insulin. Supervisor D reported that as they were being recorded, staff talked through what they were doing and what they were checking. Supervisor D reported that s/he recorded most of these videos, and that s/he thought the videos were sent to Licensee C who then sent them to the nurse. Supervisor D reported that the nurse then reviewed them and stated, "then I don't know from there." Surveyor asked Supervisor D if staff received any sort of feedback or training from the registered nurse as part of this process. Supervisor D replied s/he thought Licensee C may have gotten feedback and that it was mostly good, but s/he wasn't sure what it was.	N 416		
N 433	83.38(1)(i) Behavior management. 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: Behavior management. The CBRF shall provide	N 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE STREET WATERLOO, WI 53594

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N 433	Continued From page 25 services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide services to manage residents' behaviors that may be harmful to themselves or others. Resident 2's negative behaviors, which included becoming intoxicated, smoking in the house, and initiating verbal altercations with staff and other residents, were not being managed by staff. Findings include: On 09/26/2023, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 02/21/2021 with diagnoses including incomplete C1-C4 (cervical spine) quadriplegia. Resident 2 was documented as being his/her own legal representative. Surveyor reviewed Resident 2's observation notes from 09/01/2023 - 09/26/2023 and observed the following: - 09/04/2023: "...Staff went to check on [him/her], [his/her] room smells of alcohol..." - 09/05/2023: "came back to the house with beer." - 09/06/2023: "[S/he] went to the gas station twice came back with beer both times i[sic] asked [him/her] to please take the beer off the property [s/he] didn't [s/he] tried running me over with [his/her] electric scooter." Another entry that day documented, "came back with beer again wouldn't eave[sic] the property like staff asked so staff took beer away."	N 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018367	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION COMMUNITY LIVING NORTH	734 NORTH MONROE STREET WATERLOO, WI 53594

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N 433	Continued From page 26 - 09/07/2023: "Upon staff arrival at 8p resident came out into the garage to smoke a cigarette. [S/he] shortly after went back into house without actually smoking. When staff came back into house I could smell smoke. I knocked on [Resident 2]'s door and when opened [s/he] was found to be smoking in [his/her] room with the window open...[S/he] was cussing and yelling in [his/her] room...[S/he] woke up about 3am and began to vomit in [his/her] room staff tried to assist [him/her] and wash [him/her] up and clean up [his/her] room [s/he] yelled at staff to get the [expletive] out of [his/her] room and leave [him/her] alone...I let [him/her] know it was reported [s/he] had been drinking and kept trying to bring beer into the home..." Another entry that day documented, "went to the gas station and brought back beer." - 09/13/2023: "has been rude to staff and residents since [s/he] got home, [s/he] brought beer twice, [s/he] had a fall and 911 was called to assist, [s/he]'s been teasing and swearing at residents all evening...[s/he]'s also trying to get other residents to help [him/her] hide [his/her] beer." - 09/14/2023: "Drunk, angry..." - 09/15/2023: "[s/he] got mad cause[sic] staff took [his/her] beer away after we asked [him/her] nicely to please don't bring that in the house [s/he] did anyway then got mad at staff called us out of [his/her] name and then left for a[sic] hour." Surveyor reviewed Resident 2's current individualized service plan (ISP), most recently signed as reviewed on 04/25/2023, and observed the following:	N 433		

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N 433	Continued From page 27 - Under the "Dressing" section: "...Has history of being intoxicated 3-7 days a week will become incont[sic] of urine and [bowel movement] on [him/herself] and in [his/her] scooter or wheel chair. doesn't[sic] always change [his/her] clothes, especially when [s/he] is wet and/or drinking." Interventions included, "Monitor and provide cues when needed to assist with dressing and undressing. as[sic] needed when intoxicated, or incontinent, or when asked for help," and "Self/Staff to document as needed when needs assistance or refusing." - Under the "Self-Abusive Behavior" section: "Victory Vision will continue to monitor [Resident 2]'s behavior. However, it should be noted that if [Resident 2] starts to have excessive drinking episodes again, [s/he] may be asked to leave the home and will be taken to a homeless shelter. This has been addressed with [Resident 2] and [his/her] care team." Information about Victory Vision not being licensed to treat alcohol or drug abuse in residents and Resident 2 presenting with such was also documented. A subsection with the heading, "[Department of Health Services] Recommendations" documented recommendations for Resident 2 to be transferred to either a homeless shelter or a rehabilitation/detox center for 30-45 days. - Under the "Destructive/Abuse" section: "Victory Vision has attempted multiple ways to assist [Resident 2] with [his/her] alcohol addiction but has been unsuccessful. We will continue to provide care and supervision to the best of our ability as long as [s/he] continues to live in the home, which will be up to 30-days from 08/21/2023, unless [s/he] stops drinking."	N 433		

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N 433	Continued From page 28 At approximately 1:40 p.m., Surveyor interviewed Supervisor D, Supervisor G, and Caregiver H about Resident 2's behaviors. All 3 reported they felt like Resident 2 was disruptive to the other residents of the home. Supervisor D reported that the home was supposed to be a dry home (no alcohol allowed) and that residents were not permitted to smoke inside their rooms. Supervisor D provided Surveyor a list of the house rules, dated 06/27/2022, and Surveyor observed that the rules corroborated Supervisor D's report. Supervisor D reported that Resident 2 was still able to get away with drinking because staff were told by Resident 2's case management team that it would be a resident rights violation if they were to take alcohol from his/her room and that they were only allowed to confiscate the alcohol before Resident 2 got to his/her room with it. Surveyor read aloud the entry from Resident 2's observation notes regarding Resident 2 teasing and swearing at other residents and asked if that was common behavior. Supervisor G replied that that happens when Resident 2 has been drinking. Surveyor asked for clarification on how Resident 2 teases other residents. Supervisor G replied that Resident 2 is disrespectful towards them and will yell at Resident 1. Supervisor G also reported that Resident 2 will curse at Resident 3 and mimic his/her behaviors with the intention of making fun of him/her. Surveyor read aloud the entry from Resident 2's observation notes regarding Resident 2 trying to "run over" a staff member with his/her electric scooter and asked if this was a common occurrence. Supervisor G replied that Resident 2 has run into staff purposely with his/her scooter and that one time s/he chased Resident 3 around. When asked how staff intervene with these behaviors, Supervisor D replied that staff try to talk to Resident 2 about not making fun of other	N 433		

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N 433	Continued From page 29	N 433		

residents but that this doesn't work. Caregiver H reported that Resident 2 often yells and swears in his/her room when s/he's been drinking and that staff ignore it. Surveyor asked if Resident 2 had ever been transferred to a detox facility as indicated in his/her ISP. Supervisor D replied, "Not yet," and reported that most insurances wouldn't cover Resident 2 needing to stay more than 3 days. When asked what other interventions staff are expected to utilize to mitigate Resident 2's intoxication-related behaviors, Supervisor D reported that s/he didn't think there was anything more they could do for him/her.

On 10/10/2023, at approximately 11:15 a.m., Surveyor interviewed Licensee C. Licensee C confirmed s/he thought Resident 2 didn't seem like a good fit with the other residents. S/he reported that different alcohol rehabilitation centers in the state wouldn't take Resident 2 due to their facilities not being physically accessible. Licensee C reported that one facility accepted him/her, but only for a 7 day stay and that it required a lot of side work to switch insurances for Resident 2. Licensee C reported that the agreed upon plan between him/her and Resident 2's care team was to take Resident 2 to a homeless shelter if s/he continued with his/her intoxication and intoxicated-related behaviors, however, s/he reported s/he didn't want to do that. Licensee C acknowledged Surveyor's concern that s/he was continuing to accept the risk that Resident 2 posed to him/herself and other residents. Licensee C acknowledged Surveyor's concern that staff didn't seem to be provided with specific strategies for handling Resident 2's intoxication and intoxication-related behaviors as outlined in his/her ISP and reported s/he was taking notes to add more information to

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N 433	Continued From page 30 his/her ISP.	N 433		
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 that the living environment was safe, clean, comfortable, and homelike. This is a repeat deficiency. See Statement of Deficiency (SOD) YUJP11, dated 04/12/2023. Findings include: On 09/26/2023, from approximately 8:00 a.m. until 8:45 a.m., Surveyor toured the environment and observed the following: - In the activity / family room area, the air vents along the back wall (behind the exercise equipment) appeared covered in dust (see Photo 1.) - In the activity / family room area, the overhead fan/light combination appeared to have cobwebs hanging from the blades and light fixtures (see Photo 2.) - In the back bathroom (closest to the living area), the area of the wall along with window appeared	N 481		

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N 481	Continued From page 31	N 481		

to have patches of a different colored paint in various spots that covered approximately ½ of the lower wall (see Photo 3.)

- In the hallway off the kitchen, above the thermostat, the air vent appeared dusty (see Photo 4.)

- In the hallway off the kitchen, near the thermostat, there was an approximate quarter-sized hole in the wall that extended through the drywall (see Photo 5.)

- In the hallway closest to the office, the flooring was observed to not meet the bottom trim in several areas, leaving an approximate ¼" gap between the floor and the wall (see Photos 6 and 7.)

At approximately 2:13 p.m., Surveyor interviewed Supervisors D and G. Supervisor G reported s/he noticed the cobwebs on the fan/light combination earlier. Both Supervisors D and G acknowledged the patches of different colored paint in the back bathroom and Surveyor's concern that the wall continued to look like this since the last survey in April 2023. Supervisor G reported that maintenance staff must not have gotten around to addressing it. Supervisor D reported s/he thought the hole in the drywall was from a recent incident in which staff opened the closet door too forcefully, causing the door handle to impact the wall and make the hole. Supervisor D observed the flooring near the back office with Surveyor and acknowledged Surveyor's concern that the floor didn't meet the trim. Supervisor D reported s/he thought maintenance had previously addressed this. Supervisors D and G made notes of all the areas of concern discussed and reported they would follow up with staff to

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N 481	Continued From page 32 address them.	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 that 1 of 1 clothing dryers utilized vent tubing constructed of rigid material. Findings include: On 09/26/2023, at approximately 9:43 a.m., Surveyor toured the laundry area with Caregiver H. Surveyor observed that the dryer vent tubing for the provider's only dryer appeared to be constructed of flexible material. At approximately 2:13 p.m., Surveyor interviewed Supervisors D and G. Supervisor G asked Surveyor for clarification of flexible vs. dryer tubing material and said s/he would talk to maintenance staff about it.	N 488		