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 04/16/2024

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 04/10/2024, with information obtained through 04/16/2024, 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, 4 deficiencies were identified. Four 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, SOD YUJP11, dated 04/12/2023, and SOD YUJP12, dated 10/10/2023. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 6	{N 000}		
{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}		

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
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{N 352}	Continued From page 1 From 03/01/2024 - 04/10/2024, the incorrect amount of insulin was administered to Resident 1 on 20 occasions. From 03/01/2024 - 04/10/2024, the incorrect amount of insulin was administered to Resident 3 on 6 occasions. This is a repeat deficiency. See Statement of Deficiency (SOD) 65W913, dated 07/22/2021, SOD 65W914, dated 02/04/2022, SOD YUJP11, dated 04/12/2023, and SOD YUJP12, dated 10/10/2023. Findings include: Example 1 - Resident 1 On 04/10/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 11/28/2022 with diagnoses including type 2 diabetes mellitus. Resident 1's prescriptions included the following: - (Active from 12/19/2023 - 03/29/2024) Humalog KwikPen 100 units/mL with instructions to, "Inject 7 units subcutaneously three times daily before meals; give 5 units if [blood glucose] <100 prior to meal, +2 units for every 50 > 150 before meals..." - (Active since 03/29/2024) Humalog KwikPen 100 units/mL with instructions to, "Inject 5 units subcutaneously three times daily before meals (subtract 2 units if [blood glucose] <100 prior to meal and add 2 units for every 50 > 150)" - (Active since 02/12/2024) Humalog KwikPen 100 units/mL with instructions to, "And +2 units for every 50>200 at bedtime..." The phrasing for this order changed slightly with a new order on 03/28/2024: "Inject subcutaneously 2 units for	{N 352}		

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 352}	Continued From page 2 every 50>200 at bedtime..." Surveyor reviewed Resident 1's medication administration records (MARs) from 03/01/2024 - 04/10/2024 and observed the following 20 discrepancies: - 03/03/2024 (5:11 p.m.): Blood sugar documented as 121, 5 units documented as administered (despite being within parameters for 7 units) - 03/09/2024 (7:18 a.m.): Blood sugar documented as 100, 5 units documented as administered (despite being within parameters for 7 units) - 03/09/2024 (5:17 p.m.): Blood sugar documented as 225, 7 units documented as administered (despite being within parameters for 9 units) - 03/10/2024 (7:45 a.m.): Blood sugar documented as 100, 5 units documented as administered (despite being within parameters for 7 units) - 03/10/2024 (5:35 p.m.): Blood sugar documented as 100, 5 units documented as administered (despite being within parameters for 7 units) - 03/11/2024 (5:06 p.m.): Blood sugar documented as 215, 7 units documented as administered (despite being within parameters for 9 units) - 03/16/2024 (5:39 p.m.): Blood sugar documented as 100, 5 units documented as administered (despite being within parameters for 7 units) - 03/17/2024 (5:50 p.m.): Blood sugar documented as 173, 9 units documented as administered (despite being within parameters for 7 units) - 03/19/2024 (9:15 p.m.): Blood sugar	{N 352}		

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 352}	Continued From page 3	{N 352}		

documented as 201, 4 units documented as administered (despite being within parameters for 2 units)
- 03/22/2024 (5:41 p.m.): Blood sugar documented as 151, 9 units documented as administered (despite being within parameters for 7 units)
- 03/23/2024 (5:13 p.m.): Blood sugar documented as 123, 5 units documented as administered (despite being within parameters for 7 units)
- 03/24/2024 (8:00 a.m.): Blood sugar documented as 110, 5 units documented as administered (despite being within parameters for 7 units)
- 03/24/2024 (5:30 p.m.): Blood sugar documented as 100, 5 units documented as administered (despite being within parameters for 7 units)
- 03/26/2024 (8:39 a.m.): Blood sugar documented as 82, 7 units documented as administered (despite being within parameters for 5 units)
- 03/26/2024 (5:15 p.m.): Blood sugar documented as 210, 7 units documented as administered (despite being within parameters for 9 units)
- 04/07/2024 (7:47 a.m.): Blood sugar documented as 132, 2 units documented as administered (despite being within parameters for 5 units)
- 04/07/2024 (12:46 p.m.): Blood sugar documented as 100, 2 units documented as administered (despite being within parameters for 5 units)
- 04/07/2024 (5:00 p.m.): Blood sugar documented as 120, 2 units documented as administered (despite being within parameters for 5 units)
- 04/08/2024 (1:32 p.m.): Blood sugar

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 4	{N 352}		

documented as 130, 7 units documented as administered (despite being within parameters for 5 units)
- 04/08/2024 (5:32 p.m.): Blood sugar documented as 131, 7 units documented as administered (despite being within parameters for 5 units)

At approximately 2:45 p.m., Surveyor interviewed Manager A and Lead G. Manager A confirmed the insulin order as written, which instructed staff to subtract Resident 1's scheduled units only when his/her blood sugars were less than 100 and not equal to 100. Manager A reported that staff had been re-trained recently in insulin administration. Manager A reported that staff had been auditing the MARs to see if Resident 1 was being administered the correct amount of insulin during each administration, but that most of the above occasions identified by Surveyor were not previously caught.

Example 2 - Resident 3

On 04/10/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 03/02/2019 with diagnoses including type 1 diabetes mellitus. Resident 3's prescriptions included the following:

- (Active since 02/29/2024) Insulin lispro KwikPen 100 units/mL with instructions of, "Per [insulin to carb ratio] 1 unit: 20 [grams] carb meals/snacks + correction starting at 2 units and going up by 1 unit for every 50 points > 150..151-200 = 2 units, 201-250 = 3 units, 251-300 = 4 units, 301-350 = 5 units, 351-400 = 6 units, >400 = 7 units..."
- (Active since 03/03/2024) Humalog sliding scale: "1 unit for every 50 points > 150 at 9pm Correction scale, <150 = 0, 151-200 = 1 unit,

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{N 352}	Continued From page 5 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, >400 = 6 units..." Surveyor reviewed Resident 3's MARs from 03/01/2024 - 04/10/2024 and observed the following 6 discrepancies: - 03/01/2024 (5:36 p.m.): Blood sugar documented as 195, 2 units for carbs + 4 units for sliding scale documented as administered (despite being within parameters for 2 units of sliding scale) - 03/14/2024 (12:53 p.m.): Blood sugar documented as 105 with 55 grams of carbs documented as consumed. Five units for carbs + 0 units for sliding scale were documented as administered (despite being within parameters for 3 units for carbs) - 03/16/2024 (12:41 p.m.): Blood sugar documented as 138, 2 units for carbs + 2 units for sliding scale documented as administered (despite being within parameters for 0 units of sliding scale) - 03/17/2024 (11:32 a.m.): Blood sugar documented as 124, 3 units for carbs + 2 units for sliding scale documented as administered (despite being within parameters for 0 units of sliding scale) - 04/02/2024 (9:05 p.m.): Blood sugar documented as 238, 3 units documented as administered (despite being within parameters for 2 units) - 04/05/2024 (7:06 a.m.): Blood sugar documented as 316, 4 units for carbs + 3 units for sliding scale documented as administered (despite being within parameters for 5 units of sliding scale) At approximately 2:45 p.m., Surveyor interviewed Manager A and Lead G. Manager A reported that	{N 352}		

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{N 352}	Continued From page 6 staff had been re-trained recently in insulin administration. Manager A reported that staff had been auditing the MARs to see if Resident 3 was being administered the correct amount of insulin during each administration, but that most of the above occasions identified by Surveyor were not previously caught.	{N 352}		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. 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) for Resident 1, who was prescribed and being administered as needed (PRN) Lorazepam, included a rationale for its use and a	N 408		

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N 408	Continued From page 7	N 408		

detailed description of the behaviors indicating the need for its administration.

This is a repeat deficiency. See Statement of Deficiency (SOD) 65W912, dated 04/21/2021, SOD 65W913, dated 07/22/2021, and SOD 65W914, dated 02/04/2022.

Findings include:

On 04/10/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 11/28/2022 with diagnoses including schizophrenia. Resident 1's prescriptions included the following:

- Lorazepam 0.5 mg tablets, with a start date of 03/02/2024 and instructions to, "Take one tablet by mouth every two hours as needed for anxiety or nausea."

- Hydroxyzine HCl 25 mg tablets, with a start date of 03/18/2024 and instructions to, "Take one tablet by mouth twice daily as needed for anxiety."

Surveyor reviewed Resident 1's medication administration record (MAR) from 03/01/2024 - 04/10/2024 and observed the following 12 administrations of Resident 1's lorazepam:

- 03/03/2024 (9:13 a.m.)
- 03/04/2024 (6:30 p.m.)
- 03/05/2024 (11:36 a.m.)
- 03/06/2024 (1:15 p.m.)
- 03/07/2024 (12:10 p.m.)
- 03/08/2024 (6:09 p.m.)
- 03/11/2024 (9:50 a.m. and 4:34 p.m.)
- 03/12/2024 (10:06 a.m. and 7:47 p.m.)
- 03/14/2024 (10:34 a.m.)

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N 408	Continued From page 8 - 03/15/2024 (2:35 p.m.) In the MAR, Surveyor also observed the following 2 administrations of Resident 1's hydroxyzine: - 03/28/2024 (2:26 p.m.) - 03/29/2024 (2:49 p.m.) Surveyor reviewed Resident 1's current ISP, last signed as reviewed on 04/08/2024. Within the ISP, Surveyor observed a heading for "Psychotropic Medications" which included the following information: "Using psychotropic behaviors related to specific behaviors. See MAR for medications. Quetiapine 300 mg tab [prescriber name] [prescription number] start 2/9/23 Take One Tablet by Mouth Once Daily at Bedtime...Appropriate use of medications will be maintained. No adverse affects[sic] related to psychotropic medication use. Behaviors to be controlled as allowed by progression of disease process." Surveyor did not observe any information in Resident 1's ISP regarding his/her PRN lorazepam or hydroxyzine use. At approximately 2:45 p.m., Surveyor interviewed Manager A and Lead G. Manager A reported that staff typically called hospice prior to administering Resident 1 PRN lorazepam, and that this was because it was recommended but not necessarily required from his/her hospice team to do so. Manager A reported that sometimes on the weekends staff had to wait for call backs from an on call member of Resident 1's hospice organization regarding administering a PRN lorazepam when Resident 1 was exhibiting behaviors and so they were discussing a medication protocol with hospice for additional administration guidance.	N 408		

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{N 416}	Continued From page 9	{N 416}		
{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 2 of 3 non-licensed employees who administered injectable medications were delegated to do so by a registered nurse (RN). The provider did not ensure that Caregivers K and L, who administered insulin to Residents 1 and 3, were delegated by an RN to do so. This is a repeat deficiency. See Statement of Deficiency (SOD) YUJP11, dated 04/12/2023, and SOD YUJP12, dated 10/10/2023. Findings include: Example 1 - Caregiver K On 04/10/2024, while reviewing Resident 1's record, Surveyor observed the following injectable medications prescribed to him/her: - (Active from 12/19/2023 - 03/29/2024) Humalog KwikPen 100 units/mL with instructions to, "Inject 7 units subcutaneously three times daily before meals; give 5 units if [blood glucose] <100 prior to	{N 416}		

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{N 416}	Continued From page 10	{N 416}		

meal, +2 units for every 50 > 150 before meals..."
- (Active since 03/29/2024) Humalog KwikPen 100 units/mL with instructions to, "Inject 5 units subcutaneously three times daily before meals (subtract 2 units if [blood glucose] <100 prior to meal and add 2 units for every 50 > 150)"
- (Active since 02/12/2024) Humalog KwikPen 100 units/mL with instructions to, "And +2 units for every 50>200 at bedtime..." The phrasing for this order changed slightly with a new order on 03/28/2024: "Inject subcutaenously 2 units for every 50>200 at bedtime..."
- (Active from 02/01/2024 - 03/31/2024) Levemir FlexPen 100 units/mL with instructions to, "Inject 20 units subcutaneously nightly"

Surveyor reviewed Resident 1's medication administration records (MARs) from 03/01/2024 - 04/10/2024 and observed the following 9 occasions in which Caregiver K initialed off on administering Resident 1 his/her prescribed insulin:

- 03/02/2024 (5:00 p.m.): Humalog KwikPen
- 03/02/2024 (8:00 p.m.): Levemir FlexPen
- 03/03/2024 (5:00 p.m.): Humalog KwikPen
- 03/07/2024 (5:00 p.m.): Humalog KwikPen
- 03/11/2024 (12:00 p.m.): Humalog KwikPen
- 03/30/2024 (5:00 p.m.): Humalog KwikPen
- 03/30/2024 (8:00 p.m.): Levemir FlexPen
- 03/31/2024 (5:00 p.m.): Humalog KwikPen
- 04/10/2024 (8:00 a.m.): Humalog KwikPen

On 04/10/2024, while reviewing Resident 3's record, Surveyor observed the following injectable medications prescribed to him/her:

- (Active since 02/29/2024) Insulin lispro KwikPen 100 units/mL with instructions of, "Per [insulin to carb ratio] 1 unit: 20 [grams] carb meals/snacks +

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{N 416}	Continued From page 11	{N 416}		

correction starting at 2 units and going up by 1 unit for every 50 points > 150..151-200 = 2 units, 201-250 = 3 units, 251-300 = 4 units, 301-350 = 5 units, 351-400 = 6 units, >400 = 7 units..."
- (Active since 03/03/2024) Humalog sliding scale: "1 unit for every 50 points > 150 at 9pm Correction scale, <150 = 0, 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, >400 = 6 units..."
- (Active since 02/29/2024) Lantus SoloStar 100 unit/mL pen with instructions to, "Inject 7 units subcutaneously twice daily..."

Surveyor reviewed Resident 3's MARs from 03/01/2024 - 04/10/2024 and observed the following 9 occasions in which Caregiver K initialed off on administering Resident 3 his/her prescribed insulin:

- 03/02/2024 (5:00 p.m.): Insulin lispro
- 03/02/2024 (8:00 p.m.): Lantus SoloStar
- 03/03/2024 (5:00 p.m.): Insulin lispro
- 03/03/2024 (8:00 p.m.): Lantus SoloStar
- 03/07/2024 (5:00 p.m.): Insulin lispro
- 03/07/2024 (8:00 p.m.): Lantus SoloStar
- 03/11/2024 (12:00 p.m.): Insulin lispro
- 03/30/2024 (8:00 p.m.): Lantus SoloStar
- 03/31/2024 (5:00 p.m.): Insulin lispro

On 04/10/2024, at approximately 1:26 p.m., Surveyor requested from Licensee C the RN delegations for Caregiver K.

On 04/11/2024, Surveyor reviewed an e-mail sent by Licensee C on 04/10/2024 at approximately 9:33 p.m. In the e-mail, Licensee C reported that an RN delegation was not completed for Caregiver K due to being inadvertently missed with Caregiver K having been on leave during the initial delegation training. Licensee C reported

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(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 12 that his/her plan was to get Caregiver K trained by the end of the week. Example 2 - Caregiver L On 04/10/2024, while reviewing Resident 1's record, Surveyor observed the following injectable medications prescribed to him/her: - (Active from 12/19/2023 - 03/29/2024) Humalog KwikPen 100 units/mL with instructions to, "Inject 7 units subcutaneously three times daily before meals; give 5 units if [blood glucose] <100 prior to meal, +2 units for every 50 > 150 before meals..." - (Active since 03/29/2024) Humalog KwikPen 100 units/mL with instructions to, "Inject 5 units subcutaneously three times daily before meals (subtract 2 units if [blood glucose] <100 prior to meal and add 2 units for every 50 > 150)" - (Active since 02/12/2024) Humalog KwikPen 100 units/mL with instructions to, "And +2 units for every 50>200 at bedtime..." The phrasing for this order changed slightly with a new order on 03/28/2024: "Inject subcutaenously 2 units for every 50>200 at bedtime..." - (Active from 02/01/2024 - 03/31/2024) Levemir FlexPen 100 units/mL with instructions to, "Inject 20 units subcutaneously nightly" Surveyor reviewed Resident 1's medication administration records (MARs) from 03/01/2024 - 04/10/2024 and observed the following 5 occasions in which Caregiver L initialed off on administering Resident 1 his/her prescribed insulin: - 03/22/2024 (5:00 p.m.): Humalog KwikPen - 03/22/2024 (8:00 p.m.): Levemir FlexPen - 03/26/2024 (8:00 a.m.): Humalog KwikPen - 04/01/2024 (5:00 p.m.): Humalog KwikPen	{N 416}		

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{N 416}	Continued From page 13 - 04/03/2024 (5:00 p.m.): Humalog KwikPen On 04/10/2024, while reviewing Resident 3's record, Surveyor observed the following injectable medications prescribed to him/her: - (Active since 02/29/2024) Insulin lispro KwikPen 100 units/mL with instructions of, "Per [insulin to carb ratio] 1 unit: 20 [grams] carb meals/snacks + correction starting at 2 units and going up by 1 unit for every 50 points > 150..151-200 = 2 units, 201-250 = 3 units, 251-300 = 4 units, 301-350 = 5 units, 351-400 = 6 units, >400 = 7 units..." - (Active since 03/03/2024) Humalog sliding scale: "1 unit for every 50 points > 150 at 9pm Correction scale, <150 = 0, 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, >400 = 6 units..." - (Active since 02/29/2024) Lantus SoloStar 100 unit/mL pen with instructions to, "Inject 7 units subcutaneously twice daily..." Surveyor reviewed Resident 3's MARs from 03/01/2024 - 04/10/2024 and observed the following 2 occasions in which Caregiver L initialed off on administering Resident 3 his/her prescribed insulin: - 04/01/2024 (5:00 p.m.): Insulin lispro - 04/03/2024 (5:00 p.m.): Insulin lispro On 04/10/2024, at approximately 1:26 p.m., Surveyor requested from Licensee C the RN delegations for Caregiver L. On 04/11/2024, Surveyor reviewed an e-mail sent by Licensee C on 04/10/2024 at approximately 9:33 p.m. In the e-mail, Licensee C reported that an RN delegation was not completed for Caregiver L due to being inadvertently missed	{N 416}		

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{N 416}	Continued From page 14 with Caregiver L having been hired after the initial delegation training. Licensee C reported that his/her plan was to get Caregiver L trained by the end of the week.	{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 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 intoxication-related behaviors, including soiling him/herself and initiating verbal altercations with staff and other residents, were not being managed. Resident 4's behaviors, including interfering with other residents' belongings, responding negatively to or ignoring staff redirection, and initiating verbal altercations with other residents, were not being managed. This is a repeat deficiency. See Statement of Deficiency (SOD) YUJP12, dated 10/10/2023.	{N 433}		

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{N 433}	Continued From page 15 Findings include: The provider is licensed to serve up to 6 nonambulatory residents within the client groups of emotionally disturbed/mental illness, developmentally disabled, advanced aged, physically disabled, and traumatic brain injury. Example 1 - Resident 2 On 04/10/2024, 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 and anxiety. Resident 2 was documented as being his/her own legal representative. Surveyor reviewed Resident 2's observation notes from 03/01/2024 - 04/10/2024 and observed the following: - 03/02/2024 (4:45 p.m.): "...[s/he] left after lunch and came home intoxicated..." - 03/03/2024 (3:15 p.m.): "...had a good morning left the house for a bit and came back intoxicated..." - 03/05/2024 (10:15 a.m.): "...Swearing a lot, moaning and groaning...Smelt of beer." - 03/05/2024 (5:15 p.m.): "refused dinner [s/he] [sic] room smells like beer a[sic] pee [s/he] wont[sic] let staff clean it right now so i[sic] wil[sic] try again tomorrow." - 03/07/2024 (3:30 a.m.): "[s/he] is intoxicated and fell trying to get out of bed i[sic] called 911 for a lift assist. [s/he] is in [his/her] room yelling at staff saying this is bs and calling me all types of names."	{N 433}		

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{N 433}	Continued From page 16 - 03/07/2024 (6:45 a.m.): "finally went to bed at 4am after keeping [his/her] housemates up with [his/her] yelling and swearing and moaning and groaning." - 03/07/2024 (3:45 p.m.): "had an ok day, [s/he] left to go get a lighter and came home intoxicated." - 03/10/2024 (6:45 a.m.): "was up all night drinking being loud moaning and swear [s/he] pee'd[sic] all over the bathroom floor and hallway." - 03/17/2024 (2:45 p.m.): "Staff walked back and peeked into [his/her] room and was gonna[sic] ask if [s/he] was interested in a snack, and they noticed [s/he] was sleeping due to [him/her] getting drunk throughout the day, so they shut the door and left [him/her] alone. Not more than 5 minuets[sic] later staff heard [him/her] groaning in [his/her] room, and once staff opened [his/her] door they seen [him/her] laying on the floor yelling help me i[sic] got to pee...Due to [him/her] being intoxicated [s/he] will not be receiving [his/her] 4 pm narcotic." - 03/21/2024 (7:30 p.m.): "came back from the store and came back with 2 beers i[sic] asked [him/her] not to bring the beer in the house and [s/he] tried to argue with me and said i[sic] was on Bs. [S/he] is in[sic] intoxicated." - 03/21/2024 (7:45 p.m.): "the cops came here to check on [him/her] [s/he] got a call about [Resident 2] passed out on the bridge in the park [Resident 2] got a[sic] attitude with the cop cause[sic] he came to check on [him/her] was very verbal and rude to the officer."	{N 433}		

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{N 433}	Continued From page 17 - 03/29/2024 (6:45 p.m.): "asked a housemate to go to the store and buy beer for [him/her] since [his/her] electric scooter was not working right now." Surveyor reviewed Resident 2's current individualized service plan (ISP), most recently signed as reviewed on 03/13/2024, and observed the following: - 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 "Toileting" section: "Independent, no assistance required. Assistance is only required when resident has been drinking and [s/he] soils [him/herself]." Interventions included, "Staff to document when resident is incont[sic]. And what all assistance was needed. also if [s/he] refuses help. if [s/he] falls while trying to use the bathroom on [his/her] own call [local] non-emergency for assistance on lifting." - 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.	{N 433}		

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{N 433}	Continued From page 18 This has been addressed with [Resident 2] and [his/her] care team." Other documented interventions included: "Work with the care team to determine the best course of action for [Resident 2], as the option on the table is moving [him/her] to a homeless shelter, which is not preferred by [Resident 2] or Victory Vision. However, due to the excessive drinking, all other options have been exhausted at this time. Continue to work with [Resident 2] to encourage [him/her] to maintain [his/her] sobriety by keeping [him/her] as active as possible. Also engaging [him/her] in group discussions and outings if [s/he] chooses to participate. [S/he] does have a history of refusing to participate in outside activities." 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...The director has completed and been approved for [Resident 2] to be a part of a Residential Support program. This is a transitional program that will allow [Resident 2] to move into [his/her] own apartment in the near future. This is in coordination with [his/her] care team and Manage Care Organization..."	{N 433}		

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{N 433}	Continued From page 19 - Under the "Aggressive/Combative" section: "Requires supervision and monitoring to help manage/redirect aggressive/combative behaviors. Will become verbally aggressive with residents and staff when [s/he] has been drinking, when housemates come in [his/her] room or near [him/her] when drinking, will be disrespectful to staff and housemates, will be disrespectful to staff when given redirection." At approximately 11:27 a.m., Surveyor interviewed Caregiver K. Caregiver K that Resident 2 made fun of other residents, specifically Residents 1 and 3, and that it "happens very frequently." Caregiver K confirmed that this behavior only happened when Resident 2 was intoxicated, which s/he estimated occurred about 4 times weekly. Caregiver K clarified that Resident 2 made fun of them to their faces. Caregiver K reported that in response to being made fun of, Resident 1 would get upset, slam doors, and break his/her belongings in his/her room. When asked if Resident 2 making fun of other residents has happened in the last month, Caregiver K replied, "Oh yeah." Regarding staffs' management of Resident 2's intoxication-related behaviors, Caregiver K reported that staff verbally redirected him/her but that there was "not really anything else we can do." Caregiver K reported that verbally redirecting Resident 2 worked about "50/50" and depended on if s/he wanted to be nice that day. Caregiver K reported that Resident 2's intoxication-related behaviors, including soiling him/herself and his/her bed and falling, were a current problem. Caregiver K reported to Surveyor that Lead G had sent a message on 03/10/2024 in a staff group messaging thread describing an incident that day where Resident 2 was in the garage drunk and fell. In response,	{N 433}		

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{N 433}	Continued From page 20 Lead G texted that emergency medical services had to be called for lift assistance. Caregiver K reported the time of the text was 8:24 p.m. Caregiver K reported that when Resident 2 fell and was unable to get back up him/herself that staff were "not allowed" to assist him/her due to risk of injuring themselves or him/her. Caregiver K reported that staff were to call emergency medical services for assistance in lifting Resident 2. Caregiver K reported that when Resident 2 drinks s/he was known to swear at staff and stated, "[S/he] is very verbal to us. Any word just gets thrown at you." Caregiver K reported that Resident 2 was known to drink mostly outside the facility and return "wasted." Caregiver K reported that s/he thought Resident 2 still smoked in his/her room. At approximately 2:45 p.m., Surveyor interviewed Manager A and Lead G. Manager A reported that Resident 2 had been issued several involuntary discharge notices but nothing was done about him/her moving. Manager A reported that once when Resident 2 was hospitalized they tried to refuse him/her back since it was past the 30-day mark of his/her discharge, but hospital staff arranged for him/her to be transported back to the facility. Manager A reported staff had difficulties gaining traction with a plan because Resident 2's case manager frequently changed. Manager A reported that there recently was a meeting with his/her current case manager and that Resident 2 may try to participate in an outpatient wellness program. Regarding emergency medical services lift assistance, Manager A reported that emergency medical services had responded so many times to assist in lifting Resident 2 that they were now going to charge him/her every time they had to come out. Regarding Resident 2 drinking outside of the	{N 433}		

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home and returning intoxicated, Manager A reported that s/he believed staff knew of all his/her alcohol stashes throughout the community. Manager A reported that Resident 2 stashed alcohol by the dumpsters at the local grocery store, in the park, and in a cul-du-sac downtown. Manager A reported that staff "have tried literally everything" to manage Resident 2's behaviors. Manager A reported that Resident 2's drinking-related behaviors had improved recently due to his/her power wheelchair breaking and him/her not able to get out in the community as easily to obtain alcohol with his/her manual wheelchair. Regarding Resident 2's behaviors towards other residents, Manager A reported that Resident 2 making fun of his/her housemates has "calmed down" recently but that Resident 2 was known to yell at other residents when s/he was agitated. Manager A reported, "Anything can set [him/her] off." Manager A denied that Resident 2 was physical with staff or other residents but that s/he may attempt to swing at staff or kick them if they attempt to help him/her off the floor when s/he has fallen. Lead G reported that staff noticed different effects of his/her behavior dependent on the type of beer Resident 2 drinks. When asked about the frequency of Resident 2's intoxication-related behaviors, Lead G reported that s/he noticed a monthly cycle, with Resident 2 drinking more (and by extension, exhibiting his/her drinking related behaviors) towards the beginning of the month when money came to him/her. Lead G reported that s/he has heard Resident 5 complain of difficulties sleeping due to Resident 2 "being loud." Both Manager A and Lead G reported that they had heard staff recently, within the last month, complain about Resident 2's behaviors.

On 04/11/2024, at approximately 3:00 p.m.,

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{N 433}	Continued From page 22 Surveyor interviewed Case Manager M, who was Resident 2's case manager from his/her managed care organization. Case Manager M reported that s/he had been Resident 2's case manager since the end of January but had only seen him/her twice. Case Manager M reported that s/he had never seen Resident 2's drinking related behaviors but that "some of them have been shared with me." Case Manager M reported s/he had heard reports of Resident 2 not being able to take care of him/herself when intoxicated. Case Manager M reported that s/he knew Resident 2 had the tendency to "be a bully" to the other lower-functioning residents of the home when s/he was intoxicated. Case Manager M reported that Resident 2 did not think s/he has a drinking problem and thought that the provider will retain his/her residency no matter what s/he does. Regarding the interventions outlined in the provider's ISP for Resident 2, Case Manager M reported that s/he "never heard of anything like that" regarding the intervention to drop Resident 2 off at a homeless shelter if s/he continued to engage in excessive drinking. Case Manager M reported that s/he thought this was a misunderstood conversation with a past case manager. Case Manager M reported that s/he was unaware of any involuntary discharges provided to Resident 2 and denied that Resident 2 was currently under a discharge notice. Case Manager M reported that Resident 2 had outright refused any alcohol rehabilitation-type interventions, including support group participation, Alcohol and Other Drug Abuse (AODA) program participation, or inpatient rehabilitation care. Case Manager M reported that Resident 2 was responsive to the suggestion of clinical intervention to address mental health concerns being initiated, and that s/he was looking for someone in the county to provide this	{N 433}		

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type of service. Case Manager M reported that s/he didn't think the current CBRF was the best setting for Resident 2 and that staff, based on their training, were unequipped to meet Resident 2's AODA-related needs.

Example 2 - Resident 4

At approximately 10:56 a.m., Surveyor interviewed Caregiver K regarding residents, their care teams, and legal representatives. Caregiver K reported that Resident 4 was his/her own decision maker, had a case manager through his/her contracted managed care organization, and had a parole officer due to being on probation.

On 04/10/2024, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 04/10/2023 with diagnoses including autism, epsiodic mood disorder, and anxiety disorder. Surveyor reviewed Resident 4's observation notes from 03/01/2024 - 04/10/2024 and observed the following entries:

- 03/07/2024 (3:45 p.m.): "had a good day till[sic] about 4pm, [s/he] went in another residents[sic] [Resident 2]'s electric wheel chair[sic]. when asked to get out [s/he] ignored staff and refused. the resident who owns the chair is currently sleeping."

- 03/10/2024 (6:15 p.m.): "When staff arrived at East house [another community-based residential facility (CBRF) owed by the provider], [Resident 4] was visiting...[Resident 4] tried to joke and take [unidentified resident]'s cologne and hid it. The other staff from north called over to east when the east resident noticed [his/her] item missing that's when both staff caught [Resident 2] and that

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	0018367	A. BUILDING: _____ B. WING _____	R 04/16/2024

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
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[s/he] had took it and put it in [his/her] room. North staff removed and informed the resident of [his/her] belongings and let upper management aware."

- 03/11/2024 (1:45 p.m.): "Resident wanted to get loud with staff after [s/he] was asked to not put hands on residents to redirect them, [s/he] told staff to start doing their job and Then[sic] threatened staff they will get whats[sic] coming to them..."

- 03/27/2024 (10:30 a.m.): "keeps smoking [his/her] [tetrahydrocannabinol (THC), a cannabinoid molecule in cannabis] vape in the garage when staff asked [him/her] to stop smoking [his/her] vape in the garage [s/he] jst[sic] laughed and kept smoking."

- 03/27/2024 (10:45 a.m.): "Provoking housemate that's upset. when redirected [s/he] stated no this has been going on for a week. I redirected stated that housemate has no control of it and to back off and be cool, calm, and collective when interacting with that housemate. No positive interaction with housemates since 10:30 pm. Yelling at multiple housemates to do stuff. No redirection from staff is currently working...Continued to provoke housemate any time [s/he] was in the common area."

- 03/29/2024 (9:45 a.m.): "...very lippy and curing none[sic] stop. When staff were trying to talk to [him/her], [s/he] was ignoring staff."

- 03/29/2024 (6:45 p.m.): "went to the store and brought a housemate 2 4 packs of beer and was also riding around in housemate electric scooter."

- 04/02/2024 (1:45 p.m.): "...Got caught smoking

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in the garage with door open. When redirected stated i[sic] know i[sic] know. Cursing on and off all shift..."

- 04/04/2024 (5:45 p.m.): "been in a good mood was making fun of a housemate i redirected [him/her] and asked [him/her] to please leave [his/her] housemate alone and go for a walk or watch a movie and let [his/her] housemte[sic] do what [s/he] wants bes[sic] not hurting anyone."

Surveyor observed that the 03/29/2024 entry about Resident 4 riding in another resident's scooter was made by Lead G, who was on site during the survey. At approximately 1:59 p.m., Surveyor interviewed Lead G about the entry. Lead G confirmed that it was Resident 2's electric scooter that Resident 4 was riding in. Lead G reported that Resident 4 had done this without Resident 2's permission.

Surveyor reviewed Resident 4's current ISP, most recently signed as reviewed on 02/05/2024. Surveyor observed the following:

- Under the "Behavior Patterns" section: "It should be noted that it is believed that [Resident 4] is using THC Vapes when [s/he] is off the premises of the home...This has been discussed with [Resident 4] and it was reported to [his/her] care manager, probation officer...Street drugs and alcohol is not allowed on the premises, and this is also part of the House Guidelines that has been given to all residents and is posted...if you see [him/her] vaping in home remind [him/her] its[sic] not allowed in the home and [s/he] needs to vape outside..."

- Under the "Housemate Relationships" section: "[Resident 4] initially created friendly relationships

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with [his/her] housemates but has started to struggle...[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...Victory vision will continue to monitor [Resident 4] regarding marijuana habits."

- Under the "Relations" section: "[Resident 4] has [his/her] moments when [s/he] will pick on and make fun of [his/her] housemates that do not have the capability to speak up for themselves. [s/he] will also yell and make 'threatening statements' to staff and other residents. [s/he] has good days, where [s/he] is kind to everyone around [him/her] but it can also change in a moment. [Resident 4] struggles to take a breath and take 5 when [s/he] is upset...if [s/he] is picking on other residents please calmly remind [him/her] that what [s/he] is doing could hurt someones[sic] feelings and he wouldnt[sic] like that done to [him/her], offer [him/her] to go for a walk to help redirect [his/her] mind."

At approximately 2:45 p.m., Surveyor interviewed Manager A and Lead G. Surveyor reviewed the above entries with Manager A and Lead G, including those involving staff redirection of Resident 4 not working (such as on 03/27/2024) or being ignored (such as on 03/07/2024 and 03/27/2024). Lead G reported that when redirection doesn't work they prayed. Lead G reported that sometimes Resident 4 left the house or went to his/her room to leave the situation. Both Manager A and Lead G confirmed they had seen verbal redirection from staff not work when Resident 4 was engaged in behaviors. Both were unable to report any other methods staff utilized to manage Resident 4's behaviors when verbal redirection did not work or Resident

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{N 433}	Continued From page 27 4 did not leave the situation (either outside or retreat to his/her room).	{N 433}		