

Wisconsin Department of Health Services

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0018367</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>09/18/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>VICTORY VISION COMMUNITY LIVING NORTH</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>734 NORTH MONROE STREET</b><br><b>WATERLOO, WI 53594</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| {N 000}                                                                          | <p>Initial Comments</p> <p>On 09/18/2024, 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.</p> <p>As a result of the survey, 0 deficiencies were identified.</p> <p>The previous deficiencies from Statement of Deficiency (SOD) YUJP13, dated 04/16/2024, were corrected.</p> <p>Under statutory provisions of Wis. Stat. Chapter 50, a \$200 revisit fee is being assessed.</p> <p>Census: 4</p> | {N 000}                                                                                              |                                                                                                                          |                                                                    |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE