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	0015232	A. BUILDING: _____ B. WING _____	R-C 03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY VISION BUSINESS VENTURES	6220 N 89TH STREET MILWAUKEE, WI 53225

(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
{M 000}	INITIAL COMMENTS On 03/10/2026, Surveyor concluded a standard survey, complaint investigation and a verification visit at Victory Vision Business Ventures. Ten deficiencies were identified. Two of 10 deficiencies are repeat violations. See statement of deficiency (SOD)769G12, dated 10/12/2021. Two of 10 deficiencies are being cited for the third time. See statement of deficiency SOD 769G11, dated 09/08/2020, (SOD)769G12, dated 10/12/2021 and SOD 769G13, dated 06/13/2024. Complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 3	{M 000}		
M 216	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the home and its operation complied with this chapter. During the survey, verification visit and complaint investigation, 10 deficiencies were identified. Findings include:	M 216		

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

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M 216	Continued From page 1 Victory Vision Business Solutions was licensed 10/27/2014 to serve up to 4 residents within the client groups: advanced aged, public funding, developmentally disabled, physically disabled, and emotionally disturbed/mental illness. On 03/10/2026, Surveyor concluded a standard survey, verification visit and complaint investigation. Ten violations, including this violation, were identified during the time of the survey. Two deficiencies were repeat violations. Two deficiencies are being cited for a third time. One complaint was substantiated. 88.04(2) Responsibilities 88.04(2)(g) Health Screening for Staff (3rd time being cited) 88.04(2)(h) Comply with OSHA (3rd time being cited) 88.04(5)(a) Training - 15 Hours Within 6 Months (repeat) 88.05(2)(a) Difficulty Walking 88.05(3)(a) Homelike Environment (repeat) 88.05(4)(a) Fire Safety: Fire Extinguishers 88.05(4)(b)1 Fire Safety Smoke Detectors 88.06(3)(d)1Description Of Services 88.10(3)(l) Safe Physical Environment On 03/10/2026 at 11:15 p.m., Surveyor interviewed Director A, who stated, "We are working on correcting many of the things we found during survey already."	M 216		
M 232	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee	M 232		

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M 232	Continued From page 2	M 232		

and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not obtain documentation indicating staff had been screened for illness detrimental to residents, including tuberculosis (TB), by a physician, a registered nurse or a physician's assistant, within 90 days before the start of providing service for 1 of 4 staff reviewed (Caregiver L).

This deficiency is being cited for a third time. See Statement of Deficiency SOD 769G11, dated 09/08/2020 and (SOD) 769G12, dated 10/12/2021.

Findings include:

On 03/04/2026 at 10:20 a.m., Surveyor received employee roster from Director A. Surveyor observed Caregiver L's start date was 08/15/2025.

On 03/04/2026 at 12:00 p.m., Surveyor reviewed Caregiver L's records and identified the following: Caregiver L was hired on 08/15/2025. Caregiver L started working with the residents in the home on 08/20/2025. Caregiver L's record did not contain a TB skin test within 90 days before the start of

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M 232	Continued From page 3 providing service. On 03/04/2026 at 9:00 a.m., Surveyor interviewed Caregiver L, who stated s/he worked at the facility previously and left. Caregiver L stated s/he returned to work in August of 2025. On 03/04/2026 at 1:30 p.m., Surveyor interviewed Director A, who stated s/he had the TB skin test documentation for Caregiver L in another location. Surveyor gave Director A until March 6th at 8:00 a.m. to provide the documentation. On 03/05/2026 at 7:34 p.m., Surveyor received Caregiver L's TB skin test dated 05/05/2024. The provider did not obtain documentation indicating Caregiver L had a TB screen, by a physician, a registered nurse or a physician's assistant, within 90 days before the start of providing service. On 03/10/2026 at 1:30 p.m., Surveyor interviewed Director A, who stated Caregiver L worked at another location before s/he came to the Milwaukee location. The TB test was when Caregiver L worked at the previous facility.	M 232		
{M 235}	88.04(2)(h) COMPLY WITH OSHA The licensee and all service providers involved in the operation of the adult family home shall comply with the universal precautions contained in the U.S. Occupational Safety and Health Administration Standard 29 CFR 1910.1030 for the control of blood-borne pathogens.	{M 235}		

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{M 235}	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 caregivers (Caregiver O and Caregiver N) reviewed received training in standard precautions as required in the U.S. Occupational Safety and Health Administration (OSHA) Standard 29 CFR 1910.1030 for the control of blood-borne pathogens, prior to providing care to residents and annually. The OSHA standard requires the employer train each employee with occupational exposure, "At the time of initial assignment to tasks where occupational exposure may take place" per 1910.1030(g) (2)(ii)(A); and "At least annually thereafter," per 1910.1030(g)(2)(ii) (B). This deficiency is being cited for a third time. See Statement of Deficiency (SOD) 769G12, dated 10/12/2021 and SOD 769G13, dated 06/13/2024. Findings include: On 03/04/2026 at 11:30 a.m., Surveyor reviewed staff records and identified the following: Caregiver O was hired 05/21/2023. Caregiver O's record did not include evidence of standard precautions training in 2024 and 2025. Caregiver N was hired 02/18/2024. Caregiver N's record did not include evidence of standard precautions training in 2025. On 03/04/2026 at 1:30 p.m., Surveyor interviewed Director A, who stated s/he had given surveyor all the training s/he had for Caregiver O and Caregiver N. Director A stated, "I am looking for a new training program." Director A confirmed	{M 235}		

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{M 235}	Continued From page 5 caregivers provided activities of daily living (ADLs) for residents, which could include coming into contact with bloodborne pathogens.	{M 235}		
M 244	88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS The licensee and each service provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 staff (Caregiver L) received the required training related to resident rights and fire safety prior to or within 6 months after starting to provide care. This is a repeat deficiency. See Statement of Deficiency 769G11, dated 09/08/2020. Findings include: On 03/04/2026 at 11:30 a.m., Surveyor reviewed staff records and identified the following: Caregiver L was hired on 08/15/2025. Caregiver L's record did not contain evidence s/he completed resident rights and fire safety training prior to or within 6 months after starting to provide	M 244		

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M 244	Continued From page 6 care on 8/20/2025. On 03/04/2026 at 9:30 a.m., Surveyor interviewed Caregiver L, who stated that when s/he was hired, all s/he had to do was provide his/her community based residential facility (CBRF) training which was in medications, first-aid, and standard precautions. Caregiver L stated s/he had not had any training since s/he started in August 2025. On 03/04/2026 at 1:30 p.m., Surveyor interviewed Director A, who confirmed s/he checked the caregivers' CBRF and CNA training before s/he had service providers start working on the floor. Director A confirmed Caregiver L did not have training in resident rights and fire safety prior to or within 6 months after starting to provide care on 8/20/2025 in his/her file. Director A stated s/he was currently consulting with new training companies to hire to stay in compliance.	M 244		
M 262	88.05(2)(a) DIFFICULTY WALKING If a resident is not able to walk at all or able to walk only with difficulty, or only with the assistance of crutches, a cane, or walker or is unable to easily negotiate stairs without assistance: 1. The exits from the home shall be ramped to grade with a hard surfaced pathway with handrails. 2. All entrance and exit doors and interior doors serving all common living areas and all bathrooms and bedrooms used by a resident not able to walk at all shall have a clear opening of at least 32 inches.	M 262		

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M 262	Continued From page 7 3. Toilet and bathing facilities used by a resident not able to walk at all shall have enough space to provide a turning radius for the resident's wheelchair and provide accessibility appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure there were two ramped to grade exits from the facility for 1 of 3 residents who utilized a rollator/walker for mobility. The front, south-side exit door had three steps leading into the facility. It was not ramped to grade. The back exit door led out to a patio with a ramp. The ramp did not lead to a hard surfaced pathway and did not have handrails. Surveyor observed Residents 2 self-propel with his/her rollator/walker for mobility. Findings include: Victory Vision Business Solutions was licensed 10/27/2014 to serve up to 4 non-ambulatory residents within the client groups: advanced aged, public funding, developmentally disabled, physically disabled, and emotionally disturbed/mental illness. On 03/04/2026, between 9:00 a.m. and 3:30 p.m., Surveyor toured the facility and observed the following: - The front, south-side exit door had three steps into the facility. It was not ramped to grade. - The back exit door led out to a patio with a ramp. The ramp did not have handrails and	M 262		

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M 262	Continued From page 8 ended onto the grass in the backyard. The exit did not lead to a hard surfaced pathway. - The posted exit plan identified three emergency exits; one was at the back door of the facility, and another was the front, south-side exit door. - Surveyor observed Resident 2 ambulate with his/her rollator/walker for mobility. On 03/04/2026 at 2:35 p.m., Surveyor interviewed Director A, who confirmed the back door was listed as an emergency exit. Director A acknowledged the two exit doors were not ramped to grade.	M 262		
{M 276}	88.05(3)(a) Homelike Environment An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the adult family home was safe, clean, well-maintained, and provided a homelike environment for 3 of 3 residents. This is a repeat deficiency. See Statement of Deficiency SOD 769G13, dated 06/13/2024. Findings include:	{M 276}		

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{M 276}	Continued From page 9 On 03/04/2026, between 9:00 a.m. and 3:30 p.m., Surveyor toured the facility and observed the following: Resident bathroom: -The ceiling above the bathtub had portions of the drywall peeling and hanging down. -The bathtub appeared dirty, and the caulk sealant was peeling in many spots and had an orangish appearance. -The bathroom did not have a hand drying dispenser or any paper towels to dry hands with. Resident bedrooms: -Bedroom 2's ceiling fan was covered in a thick layer of dust. Common areas: -In a small sitting area near the back of the home, observed two of 3 curtain rods bent. - Grey, leather, like couch, wore through on arm rests and on head rest of furniture. - Wood paneling on wall, painted dark grey, behind couch, contained chips, gauges and was peeling, exposing white underneath. -An interior wall, leading down to the basement, had approximately 14 pea sized holes in the drywall. Basement: -The space between the wall and dryer was filled with lint dust. Surveyor observed dryer tubing connection coming loose. Kitchen: -The metal cover, behind the stove was covered in a thick layer of a sticky substance. -Black kitchen cabinets contained greasy, dripping substance down the cabinets, around the stove.	{M 276}		

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{M 276}	Continued From page 10 On 03/10/2026, at 11:32 AM, Surveyor conducted an exit conference and shared findings with Director A. Director A stated they tried to clean up the home. Director A stated s/he must have missed some of the items on the list.	{M 276}		
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS Fire extinguishers. Every adult family home shall be equipped with one or more fire extinguishers on each floor. Each required fire extinguisher shall have a minimum 2A, 10-B-C rating. All required fire extinguishers shall be mounted. A fire extinguisher is required at the head of each stairway and in or near the kitchen except that a single fire extinguisher located in close proximity to the kitchen and the head of a stairway may be used to meet the requirement for an extinguisher at each location. Each required fire extinguisher shall be maintained in readily usable condition and shall be inspected annually by the authorized dealer or the local fire department and have an attached tag showing the date of the last dealer or fire department inspection. This Rule is not met as evidenced by: Based on observation and interview, the licensee did not ensure 2 of 2 fire extinguishers were inspected annually by an authorized dealer or the local fire department. The fire extinguisher in the	M 332		

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M 332	Continued From page 11 basement and the kitchen had not been serviced since December 2023. The facility did not have fire extinguishers that were inspected in 2024 and 2025. Findings include: On 03/04/2026, at approximately 9:30 a.m., Surveyor toured the facility's physical environment. On 03/04/2026, at approximately 9:40 a.m., Surveyor observed the kitchen fire extinguisher service tag was dated 12/2023. At approximately 9:55 a.m., Surveyor observed the basement fire extinguisher service tag was dated 12/2023. On 03/04/2026, at approximately 9:42 a.m., Caregiver L observed the fire extinguisher service tag and told Surveyor, "It looks like the last time it was done was December 2023." The fire extinguishers were due for inspection by December of 2024 and December 2025. The fire extinguisher in the basement and the kitchen was overdue for 2 years. On 03/04/2026 at 12:40 p.m., Surveyor shared findings with Director A about the kitchen fire extinguisher tag date. Director A stated, "I didn't even realize I missed that. I'll get those taken care of right away."	M 332		
M 334	88.05(4)(b)1 FIRE SAFETY-SMOKE DETECTORS Every adult family home shall be equipped with one or more single station battery operated, electrically	M 334		

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M 334	Continued From page 12 interconnected or radio signal emitting smoke detectors on each floor level. Required smoke detectors shall be located in each habitable room except the kitchen and bathroom and specifically in the following locations: at the head of each open stairway, at the door leading to every enclosed stairway, on the ceiling of the living room or family room, on the ceiling of each sleeping room and in the basement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure there was a smoke detector in all required places. The smoke detector in the office area was mounted on the wall. The head of the open stairway down to the basement did not contain a smoke detector. Findings include: On 03/04/2026, at approximately 9:30 a.m., Surveyor toured the home and observed the following: - The head of the open stairway leading down to the basement did not contain a smoke detector. - The smoke detector in the office area was mounted on the wall. Surveyor observed a smoke detector bracket on the ceiling. On 03/04/2026, at approximately 4:25 p.m., Surveyor interviewed Director A, who reported s/he was unaware of the missing smoke detector at the head of the basement stairwell. Director A stated s/he would get them fixed right away.	M 334		

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M 412	88.06(3)(d)1 DESCRIPTION OF SERVICES A description of services the licensee will provide to meet the assessed need. This Rule is not met as evidenced by: Based on record review and interviews, the provider did not have a description of the services in the individual service plan (ISP) where the licensee would provide and meet the assessed needs of 1 of 1 resident (Resident 6). Resident 6's ISP did not include information regarding how staff would support Resident 6's complex medical diagnoses. Resident 6 needed kidney dialysis three times a week. Resident 6 had type 1 diabetes and required assistance with regulating carbohydrate intake. Resident 6's ISP did not address Resident 6's need for assistance with diabetic compliance, regulation of carbohydrate intake or kidney dialysis three times a week. Findings include: On 03/04/2026, Surveyor reviewed Resident 6's record and identified the following: Resident 6 was admitted on 08/20/2025 with diagnoses including, type 1 diabetes with complication, diabetic ketoacidosis, acute-chronic anemia, and kidney dialysis. Resident 6 had a move in date of 08/20/2025 and a move out date of 11/15/2025. Resident 6 had an activated health care power of attorney (AHCPOA). Resident 6 was enrolled in services with a managed care	M 412		

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organization (MCO) and was assigned case managers. Resident 6's individual service plan (ISP), dated 08/20/2025, did not include information on how to support Resident 6 after kidney dialysis or how staff would manage Resident 6's diabetic meal plan. Resident 6 did not have a behavioral support plan (BSP). Resident 6 did not have a physician's order for a diabetic diet in his/her file.

Resident 6's initial assessment, dated 08/06/2025, stated the following, "Eating: Requires no assistance with eating. Resident's goals & outcome: To maintain independent eating habits. Service provider responsibilities: N/A ... Snack monitoring: Do they require monitoring of food intake between of their scheduled mealtimes?" This area was left blank. "Special dietary needs: Do they require assistance with special dietary needs? If yes, document individual needs and scheduling." This area was left blank. "Diabetes Management. Diabetes Status ... Not a diabetic. Has normal blood sugars."

Resident 6's ISP, dated 08/20/2025, stated the following, under eating: "Requires no assistance with eating." Under appointments, it read, "Dialysis three times per week- Tuesdays, Thursdays, and Saturdays." The ISP did not indicate resident needs/preferences, resident goals and outcomes or service provider responsibilities. Under, Diabetes Management, it read, "Not a diabetic. Has normal blood sugar levels."

On 03/10/2026, at 12:55 p.m., Surveyor reviewed Resident 6's facility observation notes. The following was identified:

- On 08/29/2025 at 1:30 p.m., Caregiver L wrote,

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"When I arrived [sic] [Resident 6] was still in bed. Went in there to check on [sic] s/he was still sleeping. Around 8:00 am [sic] went to get [Resident 6] up for breakfast but s/he was in pain all over his/her body. Ended [sic] up throwing up 4 times today [sic] vomit was brown liquid. Didn't want to take his/her morning meds [sic] because [sic] how s/he was feeling but had to remind him/her that s/he has too. Didn't [Sic] want to go to the doctor today had [sic] to tell him/her that its [sic] important for him/her that s/he does because of how much pain s/he was in. Helped him/her get dressed for his/her appointment and assisted him/her with his/her boot as well. S/He was able to get up and walk so s/he can [sic] go to his/her appointment. Meds were given and [Resident 6] was able to make it to his/her appointment."

- On 09/08/2025 at 11:00 a.m., Caregiver L wrote, "Upon arrival, [Resident 6] was asleep. When [sic] awakened, s/he refused his/her scheduled morning insulin, stating s/he did not want to eat. I offered him/her food so insulin could be administered safely, but s/he declined, saying s/he was not hungry. I explained that insulin could not be given without food for safety reasons."

- On 09/22/2025 at 12:45 p.m., Manager U wrote, [Resident 6] refuses to eat, i [sic] made mashed potatoes, mixed vegetables and fish today s/he wanted to eat popcorn and drink a soda instead of the food i [sic] made."

On 03/10/2026, at 1:45 p.m., Surveyor reviewed Resident 6's MCO case notes. The following was identified:

- On 09/08/2025, Care Manager (CM) S documented that Director A informed MCO that Resident 6 refused dialysis and was not following

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diabetic diet.

- On 09/11/2025 CM S documented, "Hospital Social Worker stated s/he does not think [Resident 6] will be compliant and there needs to be some planning with the home to see what we can do. Informed him/her s/he is still able to make his/her own choices with food and what not [sic] so unfortunately Nurse thinks this will continue to happen until s/he is ready to change his/her lifestyle. Contacted [Director A]."

- On 09/11/2025 CM S documented, "[Resident 6] agreed to go to dialysis." Director A informed CM S of Resident 6's purchased maraschino cherries and crispy crème donuts.

On 03/04/2026, at 10:45 a.m., Surveyor interviewed Caregiver L who stated that staff had to count Resident 6's carbohydrates due to his/her diabetes. Caregiver L stated Resident 6 would order food from local restaurants and have it delivered to the facility. Caregivers could not take the food away. It was next to impossible to count Resident 6's carbohydrates when s/he ordered food from outside restaurants. Resident 6 would often refuse the meal the facility would provide. Resident 6 was often non-compliant with his/her diabetic diet. Surveyor asked Caregiver L where all that information was written for reference. Caregiver L stated, "We were just trained on it."

On 03/04/2026, at 1:45 p.m., Surveyor interviewed Director A who confirmed Resident 6 was ordered dialysis three times a week. Director A stated when s/he assessed him/her, Resident 6 had a sweet demeanor. However, when s/he moved in Resident 6 immediately became non-compliant with his/her diabetic diet, which

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M 412	Continued From page 17 caused multiple hospitalizations. Director A confirmed Resident 6 was a type 1 diabetic as well. Director A stated, "S/He would order Krispy Krème donuts and a case of soda. Resident 6 was in the hospital more than s/he was here in the facility." On 03/04/2026, at 2:40 p.m., Director A reviewed Resident 6's ISP with Surveyor. Director A confirmed that s/he conducted assessments and assisted with writing resident ISPs. Surveyor asked where both diabetes and dialysis management information was for service provider was located. Director A stated, "It's not in there? We certainly knew s/he was diabetic." Surveyor asked Director A how staff knew how to care for Resident 6's complex health needs if the information was not in the ISP. Director A stated, "We had a separate binder for training staff on his/her needs." Director A was unable to locate binder during survey.	M 412		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability.	M 570		

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M 570	Continued From page 18 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a safe physical environment for 3 of 3 residents residing in the home. The hot water temperature in the resident bathroom was 160° Fahrenheit (F). Residents had independent access to bathroom sink. Findings include: Victory Vision Business Solutions was licensed 10/27/2014 to serve up to 4 non-ambulatory residents within the client groups: advanced aged, public funding, developmentally disabled, physically disabled, and emotionally disturbed/mental illness. On 03/04/2026, at 9:45 a.m., Surveyor toured the physical environment. Surveyor measured the resident's bathroom sink's hot water. The temperature was 160° F. Residents were observed to freely ambulate throughout the facility. "Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding, e.g. second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability." (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017)	M 570		

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M 570	Continued From page 19 On 03/04/2026, at 9:46 a.m., Surveyor interviewed Caregiver L regarding the hot water temperatures. Caregiver L confirmed the residents could use the bathroom on their own and had the ability to turn the water on. Caregiver L confirmed the temperature in the resident bathroom sink measured at 160° F. When s/he felt the water s/he stated, "Whoa! That's hot." On 03/04/2026, at approximately 4:30 p.m., Surveyor shared findings with Director A, who stated when s/he had work done on the furnace, someone must have messed with the water temperature. S/He stated s/he would take care of it immediately.	M 570		