STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018368	A. BUILDING: _____ B. WING _____	R 11/08/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 11/07/2024, with information obtained through 11/08/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit and standard licensing survey at Victory Vision Community Living East, a community-based residential facility (CBRF) located in Waterloo, WI. As a result of the survey, 12 deficiencies were identified. Five deficiencies are repeat deficiencies from Statement of Deficiency (SOD) N7X612, dated 05/16/2024, SOD N7X611, dated 10/27/2023, and SOD F1EK11, dated 02/22/2023. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 5	N 000		
N 283	83.26(1) Documentation of required employee training The CBRF shall maintain documentation of all employee training under s. DHS 83.21 and task specific training under s. DHS 83.22 and shall include the name of the employee, the name of the instructor, the dates of training, a description of the course content, and the length of the training. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that documentation of employee training completed by 1 of 2 caregivers reviewed was maintained.	N 283		

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 283	Continued From page 1 There were no records indicating that Caregiver M was trained in any of the required all employee training subjects, task specific training subjects, or orientation training subjects. Findings include: On 11/07/2024, Surveyor conducted a review of 2 employees to verify compliance with all employee, task-specific, and orientation training requirements. At approximately 1:27 p.m., Surveyor requested from Caregiver Coordinator C all training records for Resident Care Coordinator I and Caregiver M since their hire. Caregiver Coordinator C reported s/he would relay the request to Manager G, who had access to the training records and would provide them to Surveyor. On 11/08/2024, at approximately 8:31 a.m., Surveyor e-mailed Manager G to report that Caregiver M's training records since hire were still needed and would be due at 12:00 p.m. that day. On 11/08/2024, Surveyor reviewed training records sent electronically from Manager G. The records included the following: - "Assessment for Nasal Glucagon Medication Administration" - Skill check-off records showing competencies for various medication administration-related tasks At approximately 2:31 p.m., Surveyor e-mailed Manager G and asked if there were any training records which showed training in cares or all employee training requirements. Surveyor asked Manager G to provide any additional training records for Caregiver M since his/her hire.	N 283		

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N 283	Continued From page 2 Manager G replied to Surveyor's e-mail with the same training records that were previously provided. At approximately 2:51 p.m., Surveyor e-mailed Manager G confirming that the same training records were received. Surveyor asked if there were other training records for cares, orientation, and all employee training topics. Manager G replied with an attachment and reported that the attachment contained a list of orientation training topics for all employees. Manager G reported that Caregiver M was trained in all "the required topics" during his/her orientation but that it wasn't in the provider's training record system yet because Caregiver M did not have access to a computer or internet at that time. Surveyor reviewed the attachment, which was a screenshot of an online training course list and the course hours that each course took. There was nothing in the screenshot verifying the training was completed by Caregiver M, who conducted the training, or the dates s/he completed each orientation, task-specific, and all employee training topic. At approximately 3:38 p.m., Surveyor e-mailed Manager G and asking if there was evidence that Caregiver M was trained in the topics from the course list s/he had provided earlier. Nothing further was provided.	N 283		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s	N 387		

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N 387	Continued From page 3 legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 7's legal representative signed his/her individual service plan (ISP), acknowledging his/her involvement in, understanding of, and agreement with the plan. Findings include: On 11/07/2024, Surveyor reviewed Resident 7's record. Resident 7 was admitted to the provider on 09/16/2024 with diagnoses including dementia with agitation. Resident 7 was documented as having a legal guardian. Surveyor reviewed Resident 7's ISP, which was not dated as reviewed. There were no signatures in the ISP indicating that it was reviewed by his/her legal guardian. At approximately 4:02 p.m., Surveyor interviewed Caregiver Coordinator C. Caregiver Coordinator C reported s/he was unable to find any evidence in Resident 7's record that Resident 7's ISP was reviewed and signed by his/her guardian.	N 387		

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N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 7's individual service plan (ISP) was implemented and followed as written. Resident 7's ISP directed for staff to monitor and document his/her bowel movements. From 09/24/2024 - 11/07/2024, staff documented about Resident 7's bowel movements on 7 occasions across 6 days. This is a repeat deficiency. See Statement of Deficiency (SOD) N7X611, dated 10/27/2023. Findings include: On 11/07/2024, Surveyor reviewed Resident 7's record. Resident 7 was admitted to the provider on 09/16/2024 with diagnoses including dementia with agitation and irritable bowel syndrome. Resident 7 was documented as having a legal guardian. Resident 7's prescriptions included the following as needed (PRN) medications related to bowel movements, all active since 09/23/2024: - Bisacodyl 10 mg suppository with instructions to, "Unwrap and insert 1 suppository rectally every 3 days as needed for constipation" - Docusate 100 mg capsule with instructions to, "Take 1 capsule by mouth every 12 hours as needed for constipation" - Loperamide 2 mg capsule with instructions to, "Take 1 capsule by mouth every 8 hours as	N 388		

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N 388	Continued From page 5	N 388		

needed for loose stools"
- Milk of magnesia 400 mg / 5 mL oral solution with instructions to, "Take 30 mL by mouth once daily as needed for constipation"
- Polyethylene glycol 3350 powder with instructions to, "Mix 17 grams (fill cap to line) in 4-8 oz liquid, stir well and drink once daily as needed for constipation. Call [medical doctor] if no bowel movement within 72 hours."
- Senna 8.6 mg tablet with instructions to, "Take 2 tablets by mouth every 12 hours as needed for constipation."

Surveyor reviewed Resident 7's ISP, which was not dated as reviewed. Under the "Toileting" section of the ISP, the following was documented: "Staff to assist in toileting. Staff to monitor and document bowel movements."

Surveyor reviewed Resident 7's observation notes from 09/24/2024 (the day they began) - 11/07/2024, where staff on occasion appeared to document about Resident 7's bowel movements. This included:

- 09/27/2024 (3:45 a.m.): "...[s/he] had bowel movement(twice) [sic]..."
- 10/01/2024 (3:30 p.m.): "...[s/he] went to bed after having bowel movement..."
- 10/09/2024 (7:45 a.m.): "...resident had no bowel movements..."
- 10/21/2024 (4:45 p.m.): "...Resident had a shower at 3pm due to having an X-Large [bowel movement]..."
- 10/29/2024 (7:45 a.m.): "...no bowel movements."
- 11/01/2024 (7:30 a.m.): "...no bowel movements..."
- 11/01/2024 (7:30 p.m.): "...no bowel movements..."

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N 388	Continued From page 6 At approximately 3:35 p.m., Surveyor requested bowel movement monitoring documentation from Caregiver Coordinator C to account for the remainder of the days between 09/24/2024 - 11/07/2024. After several minutes, Caregiver Coordinator C reported s/he was unable to find any bowel movement documentation for Resident 7. Caregiver Coordinator C reported that typically bowel movement monitoring was listed as a daily task in the provider's electronic record system, where staff were then expected to document residents' bowel movements, but s/he wasn't sure why entries were missing for Resident 7. Caregiver Coordinator C reported s/he would have to follow up to have this addressed.	N 388		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential benefits and side effects of the medication. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 1 of 1 residents reviewed who was prescribed scheduled psychotropic medications was reassessed by a	N 407		

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N 407	Continued From page 7	N 407		

pharmacist, practitioner, or registered nurse at least quarterly for the desired responses and side effects of the medications.

Resident 1, who was prescribed scheduled alprazolam since 11/04/2022, buspirone since 01/21/2021, citalopram since 04/05/2023, and olanzapine since 08/31/2023, did not have a reassessment for any psychotropic medication use since 03/30/2023.

This is a repeat deficiency. See Statement of Deficiency (SOD) F1EK11, dated 02/22/2023.

Findings include:

On 11/07/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 12/16/2020 with diagnoses including profound intellectual disabilities, generalized anxiety disorder, and oppositional defiant disorder. Resident 1's prescriptions included the following 4 psychotropic medications:

- Alprazolam 0.5 mg tablet with instructions to, "Take 1 tablet by mouth three times daily."
- Buspirone 10 mg tablet with instructions to, "Take 2 tablets (20 mg) by mouth twice daily for anxiety."
- Citalopram 20 mg tablet with instructions to, "Take 1 tablet by mouth once daily for unspecified mood (affective) disorder."
- Olanzapine 5 mg tablet with instructions to, "Take 1 tablet by mouth once daily in the morning for mood disorder /T/ self harm behaviors."

An after-visit summary from a visit Resident 1 had with his/her medical provider, dated 02/24/2023, included a list of Resident 1's prescriptions at that time, which showed his/her

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N 407	Continued From page 8	N 407		

alprazolam and buspirone as active.

An after-visit summary from a visit Resident 1 had with his/her medical provider, dated 05/23/2023 included a list of Resident 1's prescriptions at that time, which showed his/her alprazolam, buspirone, and citalopram as active.

An after-visit summary from a visit Resident 1 had with his/her medical provider, dated 03/01/2024, included a list of Resident 1's prescriptions at that time, which showed his/her alprazolam, buspirone, citalopram, and olanzapine as being active.

At approximately 4:07 p.m., Surveyor interviewed Caregiver Coordinator C and Resident Care Coordinator I. Surveyor requested information showing the original start dates of Resident 1's above scheduled psychotropic medications. Caregiver Coordinator C reported that Resident 1's alprazolam was active since 11/04/2022, his/her buspirone was active since 01/21/2021, his/her citalopram was active since 04/05/2023, and his/her olanzapine was active since 08/31/2023. Surveyor requested Resident 1's psychotropic medication reviews for 2023 - 2024. Caregiver Coordinator C reported s/he relayed the request to Manager G and Manager G would get the records to Surveyor.

On 11/08/2024, at approximately 8:31 a.m., Surveyor e-mailed Manager G and again requested Resident 1's psychotropic reviews, due at 12:00 p.m. that day.

On 11/08/2024, Surveyor reviewed records sent electronically by Manager G, which included 1 psychotropic medication review for Resident 1 dated 03/30/2023 and signed by his/her medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018368	A. BUILDING: _____ B. WING _____	R 11/08/2024

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N 407	Continued From page 9 provider on 04/17/2023. No other psychotropic medication reviews were provided. On 11/08/2024, at approximately 2:51 p.m., Surveyor interviewed Manager G via e-mail to confirm that only 1 psychotropic medication review was received and ask if any others were completed in 2023 - 2024. At approximately 3:23 p.m., Manager G e-mailed Surveyor back and reported that the review sent was all the provider had. Manager G also reported, "We have also sent over the required paperwork to have it reviewed to [his/her] physician today."	N 407		
N 431	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and	N 431		

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 431	Continued From page 10 other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 7's health was monitored in relation to his/her blood sugar levels. From 09/25/2024 - 11/07/2024, Resident 7's blood sugar level was not recorded on 26 of 37 days. This is a repeat deficiency. See Statement of Deficiency (SOD) N7X611, dated 10/27/2023. Findings include: On 11/07/2024, at approximately 9:40 a.m., Surveyor interviewed Resident Care Coordinator I about residents' functioning. Regarding Resident 7's needs, Resident Care Coordinator I reported that Resident 7 requires staff to check his/her blood sugars but s/he was not prescribed insulin. At approximately 11:45 a.m., Surveyor observed the medication cart with Resident Care Coordinator I. Surveyor observed a blood sugar testing kit identified as belonging to Resident 7. Resident Care Coordinator I reported that staff check Resident 7's blood sugars once daily.	N 431		

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N 431	Continued From page 11 On 11/07/2024, Surveyor reviewed Resident 7's record. Resident 7 was admitted to the provider on 09/16/2024 with diagnoses including dementia with agitation and type II diabetes mellitus with diabetic peripheral angiopathy. Resident 7's medical provider orders included orders for lancets, Presto test strips, and a Presto system kit (all used for testing blood sugar levels), all with the instructions to, "Use as directed every morning." Resident 7 was also prescribed a glucose gel and glucagon 1 mg injection with instructions to take as needed for hypoglycemia. Surveyor reviewed Resident 7's individual service plan (ISP), which was not dated as reviewed. There was a heading for "Diabetes Management" but the text within the heading documented, "Not Applicable." Surveyor reviewed Resident 7's medication administration records (MARs) from 09/25/2024 through 11/07/2024, where entries for Resident 7's blood sugar testing supplies indicated that his/her daily checks were scheduled to be completed by staff at 8:00 a.m. Surveyor also observed Resident 7's observation notes for the same date range, where staff on occasion appeared to document Resident 7's blood sugars. Of the 44 dates in that range, Resident 7 was documented as refusing blood sugar checks 7 of the days. Of the remaining 37 days, his/her blood sugar was not documented on 26 days, including 09/25/2024, 09/27/2024 through 09/30/2024, 10/03/2024 through 10/06/2024, 10/08/2024 through 10/13/2024, 10/15/2024 through 10/17/2024, 10/19/2024, 10/20/2024, 10/22/2024 through 10/24/2024, 10/26/2024, 10/27/2024, and 10/31/2024.	N 431		

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 431	Continued From page 12 At approximately 4:07 p.m., Surveyor interviewed Caregiver Coordinator C and Resident Care Coordinator I. Resident Care Coordinator I reported s/he had noticed there wasn't any entry for staff to record Resident 7's blood sugars in his/her MAR and so s/he started recording them in the annotations (accounted for in the above tally). Resident Care Coordinator I reported that the MAR template was now changed so that staff would be prompted to record Resident 7's blood sugar values in the future.	N 431		
N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not provide medication administration services appropriate to Resident 1's eye drop needs. As of 11/07/2024 (day of the survey), Resident 1's medication list identified an active prescription for Systane eye drops, active since 11/24/2023, which directed for administration of 1 drop in each eye 5 times daily. Despite this, staff administered	N 432		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018368	A. BUILDING: _____ B. WING _____	R 11/08/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 432	Continued From page 13	N 432		

or attempted to administer it on only approximately 22 doses across 6 days from 09/06/2024 - 09/11/2024 and had entered an end date of 09/11/2024 in Resident 1's medication administration record (MAR) without any evidence of a discontinuation order of the drops from his/her medical provider. In MARs reviewed from 09/01/2024 - 11/07/2024, another entry for Resident 1's Systane eye drops was observed in the as needed (PRN) section despite containing the same scheduled administration directions above. Staff report revealed the perception that this was a PRN medication, however, there was no evidence of a PRN order having been initiated and pharmacy staff interview confirmed that the drops were active on a scheduled, not PRN, basis. The same nearly-full bottle of Resident 1's Systane eye drops, dispensed on 11/23/2023, that Surveyor observed from the last survey on 05/15/2024 was observed in the medication cart, containing approximately the same amount of solution on 11/07/2024 as was observed then (6 months prior).

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

Findings include:

On 11/07/2024, at approximately 11:47 a.m., while observing the medication cart with Resident Care Coordinator I, Surveyor observed a baggie containing 1 bottle of Systane ophthalmic solution eye drops prescribed to Resident 1. The pharmacy label for the medication identified that the bottle was dispensed on 11/23/2023 and the instructions documented were: "Instill one drop in both eyes 5 times daily..." The bottle appeared to be nearly completely full (Photos 13 and 14).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018368	A. BUILDING: _____ B. WING _____	R 11/08/2024

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

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N 432	Continued From page 14 Surveyor asked Resident Care Coordinator I about Resident 1's eye drops, to which Resident Care Coordinator I replied that s/he believed they were administered on a PRN basis. On 110/07/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 12/16/2020 with diagnoses including profound intellectual disabilities. Resident 1's prescriptions included the following: - Systane 0.3/0.4% ophthalmic solution with instructions to, "Instill one drop in both eyes 5 times daily..." Within Resident 1's active orders list, the eye drops were documented as having a start date of 11/24/2023 (1 day after they were dispensed according to the pharmacy label). The eye drops were an active medication in his/her medication list since that date. Surveyor reviewed Resident 1's MARs from 09/01/2024 - 11/07/2024, and observed the following: - Entries for the drops were placed on the MAR template from 4:00 p.m. on 09/06/2024 through 8:00 a.m. on 09/11/2024, with administration times of 8:00 a.m., 12:00 p.m., 4:00 p.m., 8:00 p.m., and 10:00 p.m. Of 24 possible administrations in this date range, 19 administrations were initialed as occurring, 2 entries were blank, 2 refusals were documented, and 1 entry indicated an activity outing (without clarification as to whether Resident 1 received his/her drops that administration). An end date in the MAR of the eye drops was written as 09/11/2024. - No other entries for the eye drops after 8:00 a.m. on 09/11/2024 or prior to 4:00 p.m. on	N 432		

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 432	Continued From page 15 09/06/2024 - Throughout the entire date range, a separate entry for the eye drops, with the same scheduled prescription instructions as in the active order, showed in the PRN section, with no evidence that staff administered the drops. Surveyor noted that nowhere in the medication direction did it indicate the drops were to be administered on a PRN basis. Surveyor reviewed Resident 1's observation notes from 09/01/2024 - 11/07/2024, and observed an entry on 10/01/2024 that documented, "...Clinic called back confirming the eye drop of discontinued..." Surveyor observed no clarification of the eye drop name from the note and noted that from previous SOD N7X612, Resident 1 had another type of eye drops, polymyxin eye drops, that were active on 05/16/2024 but at some point were discontinued as evidenced by not being on his/her active prescription list. There were no other notes about eye drops, or specifically identifying Resident 1's Systane eye drops. Surveyor reviewed medical records for Resident 1. There were no notes indicating changes to his/her Systane eye drop prescription directions (such as from a scheduled to PRN medication) or a discontinuation of the medication. At approximately 4:07 p.m., Surveyor interviewed Caregiver Coordinator C and Resident Care Coordinator I and requested evidence of Resident 1's scheduled Systane eye drops having been discontinued. Caregiver Coordinator C was observed to look in Resident 1's binder and electronic record, and after several minutes, confirmed s/he was not able to find anything.	N 432		

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	0018368	A. BUILDING: _____ B. WING _____	R 11/08/2024

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N 432	Continued From page 16 Caregiver Coordinator C confirmed that in the provider's electronic record platform, the order showed as an active order but under the "PRN" section. Caregiver Coordinator C reported understanding of Surveyor's concern that the prescription instructions did not identify the eye drops as PRN medication. Caregiver Coordinator C reported s/he would follow up with Manager G regarding an order. On 11/08/2024, at approximately 8:30 a.m., Surveyor e-mailed Manager G, requesting a discontinuation order for Resident 1's Systane eye drops. Nothing further was received. At approximately 4:04 p.m., Surveyor e-mailed Manager G again to confirm that a discontinuation order was not received. Manager G replied to Surveyor's e-mail reporting that s/he was unable to find any additional information. On 11/08/2024, at approximately 4:09 p.m., Surveyor interviewed Pharmacy Technician L, from the pharmacy that dispensed Resident 1's medications. Pharmacy Technician L confirmed that Resident 1's Systane eye drops were an active medication and that no discontinuation order had ever been received by the pharmacy. Pharmacy Technician L confirmed that the prescription directions called for scheduled dosing of the drops, not PRN dosing. Pharmacy Technician L reported the pharmacy did not have any sort of evidence of a separate PRN order for Resident 1's Systane eye drops. Pharmacy Technician L confirmed the Systane eye drops had not been refilled since they were initially filled on 11/23/2023 (same date as observed by Surveyor the previous day on the pharmacy label). Of note, Surveyor again reviewed SOD N7X612,	N 432		

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	0018368	A. BUILDING: _____ B. WING _____	R 11/08/2024

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

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N 432	Continued From page 17 dated 05/16/2024, in which pharmacy staff identified through interview that Resident 1's Systane eye drop bottle contained an approximate 30-day supply when used as prescribed for him/her. When comparing photos from SOD N7X612 of Resident 1's Systane eye drop remaining amount with Photo 6 (identified above), Surveyor observed the bottle containing a similar amount on 11/07/2024 as it did during the previous survey.	N 432		
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 clean and homelike. This is a repeat deficiency. See Statement of Deficiency (SOD) F1EK11, dated 02/22/2023. Findings include: On 11/07/2024, Surveyor conducted a tour of the home with Caregiver Coordinator C and observed the following: - At approximately 10:48 a.m., while viewing Resident 10's bedroom, a hole in the wall was observed near where his/her television cable	N 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018368	A. BUILDING: _____ B. WING _____	R 11/08/2024

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

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N 481	Continued From page 18 connected behind the drywall level with no cover (Photo 6). - At approximately 10:53 a.m., while viewing the home's exits, the back deck patio door was observed. The patio door handle was loose within the door and was able to be pulled out by Surveyor (Photos 7 and 8). Caregiver Coordinator C confirmed Surveyor's observations and reported s/he would have to have it addressed by maintenance. At approximately 2:30 p.m., after Resident 7 had finished lunch, s/he and a guest were observed on the back deck visiting. - At approximately 11:09 a.m., Resident 9's bedroom was observed. The area of wall behind his/her door had a quarter-sized hole through the drywall, consistent in appearance and area with damage from his/her doorknob hitting the wall (Photo 9). Caregiver Coordinator C acknowledged Surveyor's concern and reported s/he would have the area addressed. On 11/07/2024, at approximately 11:20 a.m., the kitchen was observed with Resident Care Coordinator I. The oven door appeared to be heavily stained, and the interior base of the oven appeared with covered with charred/burnt bits of food debris (Photos 10, 11, and 12). Resident Care Coordinator I reported that cleaning the oven was on his/her "to-do" list.	N 481		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually.	N 526		

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	0018368	A. BUILDING: _____ B. WING _____	R 11/08/2024

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

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N 526	Continued From page 19 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 1 of 2 semi-annual emergency or disaster evacuation drills was completed in 2023. Findings include: On 11/07/2024, Surveyor conducted a review of evacuation drills to verify compliance with semi-annual evacuation drill requirements. Surveyor requested semi-annual emergency or disaster evacuation drills from Caregiver Coordinator C for 2023. The records provided contained evidence of a tornado drill conducted on 04/06/2023. There was no other evidence of a semi-annual emergency or disaster evacuation drill having been completed in 2023. At approximately 11:45 a.m., Surveyor interviewed Caregiver Coordinator C. Caregiver Coordinator C confirmed s/he did not have any other evidence of other semi-annual emergency or evacuation drills completed in 2023. On 11/08/2024, at approximately 10:39 a.m., Surveyor interviewed Manager G. Manager G acknowledged Surveyor's above concern but said nothing further.	N 526		
N 532	83.47(4)(b) Fire extinguishers: locations. A fire extinguisher shall be mounted on a wall or a post or in an unlocked wall cabinet used exclusively for that purpose. Fire extinguishers shall be clearly visible. The route to the fire extinguisher shall be unobstructed and the top of	N 532		

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	0018368	A. BUILDING: _____ B. WING _____	R 11/08/2024

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

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N 532	Continued From page 20 the fire extinguisher shall not be over 5 feet high. The extinguisher shall not be tied down, locked in a cabinet or placed in a closet or on the floor. Fire extinguishers on upper floors shall be located at the top of each stairway. Extinguishers shall be located so the travel distance between extinguishers does not exceed 75 feet. The extinguisher on the kitchen floor level shall be mounted in or near the kitchen. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that 1 fire extinguisher was mounted on the wall or in an unlocked wall cabinet. Findings include: On 11/07/2024, at approximately 10:41 a.m., while touring the environment with Caregiver Coordinator C, Surveyor observed a fire extinguisher located on the floor of the area identified by Caregiver Coordinator C as the "man cave" (Photo 1). The tag on the extinguisher identified that it was last serviced in December of 2023. Surveyor observed a television and couch in the area, and Caregiver Coordinator C reported that in this area residents, including Resident 1, were known to watch television or hang out. Caregiver Coordinator C reported s/he was not sure why the extinguisher wasn't mounted on the wall.	N 532		
N 612	83.55(3) Bath and toilet areas: hand drying. Hand drying. All sink areas shall have dispensers for single use paper towels, cloth towel dispensing units that are enclosed for protection against being soiled or electric hand dryers. This	N 612		

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	0018368	A. BUILDING: _____ B. WING _____	R 11/08/2024

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

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N 612	Continued From page 21	N 612		

requirement does not apply to sink areas located in toilet rooms accessed directly from a resident bedroom.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure that 1 of 2 resident restrooms had dispensers with single use paper towels, cloth dispensing units, or electric hand dryers.

Findings include:

On 11/05/2024, at approximately 11:05 a.m., while touring the environment, Surveyor observed 1 of 2 resident bathrooms, which was located near the office. An empty paper towel dispenser was observed on the wall at the sink (Photo 2). No other means of hand drying were observed within the bathroom.

At approximately 11:20 a.m., Surveyor interviewed Resident Care Coordinator I. Resident Care Coordinator reported I reported s/he thought that paper towels had been ordered and the provider was waiting on their delivery.

At approximately 2:30 p.m., Surveyor observed Resident 7 walk into the bathroom near the office door and close the door. Resident Care Coordinator I reported Resident 7 was likely using the bathroom, which s/he sometimes was able to do on his/her own.

At approximately 5:05 p.m., Surveyor again observed the resident bathroom near the office. The paper towel dispenser was still empty and there was no other means of hand drying observed in the bathroom. At that time Surveyor interviewed Caregiver Coordinator C and Resident Care Coordinator I about the lack of

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	0018368	A. BUILDING: _____ B. WING _____	R 11/08/2024

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

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N 612	Continued From page 22 paper towels. Resident Care Coordinator I again reported that s/he believed paper towels had been ordered. On 11/08/2024, at approximately 12:43 p.m., Surveyor received an e-mail from Manager G. Manager G reported that it was brought to his/her attention that paper towels were not available in the home. Manager G reported that paper towels had been on site, delivered back in August, which were located in the staff office. Manager G reported that the paper towel dispenser had been re-stocked and that the staff who was responsible for not stocking the supplies was going to be reprimanded.	N 612		
N 637	83.59(1)(g) Proper exit locations, sidewalks, driveways. All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Exits, sidewalks and driveways used for exiting shall be kept free of ice, snow, and obstructions. For facilities serving only ambulatory residents, the CBRF shall maintain a cleared pathway from all exterior doors to be used in an emergency to a public way or safe distance away from the building. For facilities serving semi-ambulatory and non-ambulatory residents, a CBRF shall maintain a cleared, hard surface, barrier-free walkway to a public way or safe distance away from the building for at least 2 primary exits from the building. All other required exits shall have at least a cleared pathway maintained to a public way or safe distance from the building. An exit door or walkway to a cleared	N 637		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018368	A. BUILDING: _____ B. WING _____	R 11/08/2024

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

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N 637	Continued From page 23 driveway leading away from the CBRF also meets this requirement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that 1 of 2 identified emergency exits was clear of obstructions. Findings include: The provider is licensed to serve up to 6 nonambulatory individuals in the client groups of advanced aged, developmentally disabled, physically disabled, emotionally disturbed/mental illness, and traumatic brain injury. On 11/07/2024, at approximately 9:40 a.m., Surveyor interviewed Resident Care Coordinator I regarding residents' functioning. Resident Care Coordinator I identified that 1 resident, Resident 8, utilized a manual wheelchair that s/he was able to self-propel for all ambulation, and 1 resident, Resident 7, utilized a walker for ambulation. On 11/07/2024, at approximately 10:41 a.m., Surveyor observed the home's exits with Caregiver Coordinator C. The side exit, located off of the area Caregiver Coordinator C identified as the "man cave", consisted of an interior solid-core door and an exterior screen/storm door. A black tie, consistent in appearance with a shoelace, was tied around the inner and outer handle of the screen door at one end and was secured to the interior door's hinges on the other (Photos 3 and 4) - preventing the screen door from being opened. While the screen door was observed to be missing its interior portion, the frame was still intact, providing an approximate 2.5" tall frame border at the base of the door.	N 637		

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	0018368	A. BUILDING: _____ B. WING _____	R 11/08/2024

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

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N 637	Continued From page 24 Surveyor observed that this bottom section of screen door frame prevented an even grade for egress from the interior to the exterior ramp of the home. On 11/07/2024, Surveyor observed the home's emergency evacuation diagram. The diagram identified the front door and side door (observed earlier by Surveyor above) as the 2 emergency exits from the home. At this same time, Surveyor interviewed Caregiver Coordinator C and Resident Care Coordinator I regarding the obstructed side door exit. Caregiver Coordinator C reported s/he thought maybe the exterior screen door was broke. Both reported being unsure why a tie was maintaining the screen door closed, but reported understanding of Surveyor's concern that the tie prevented use of the screen door.	N 637		
N 640	83.59(2)(b) Solid core wood doors or equivalent A solid core wood door or an equivalent fire resistive door shall be provided at any interior stair between the basement and the first floor. The door shall have a positive latch and an automatic closing device and normally shall be kept closed. Enclosed furnace and laundry areas with self-closing doors in a split level home may substitute for the self-closing door between the first and second levels. Enclosed furnace and laundry areas shall have self-closing solid core wood doors or an equivalent fire resistive door when located on a common level with resident bedrooms. This Rule is not met as evidenced by: Based on observation and interview, the provider	N 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018368	A. BUILDING: _____ B. WING _____	R 11/08/2024

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

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N 640	Continued From page 25 did not ensure that the door at the interior stair between the basement and first floor was able to close and latch automatically. Findings include: On 11/07/2024, at approximately 11:16 a.m., while touring the environment with Caregiver Coordinator C, Surveyor observed the door on the first floor that separated the first floor from the stairs leading to the basement. An automatic closing device was observed on the door. Upon testing the door from the fully opened position, Surveyor observed that the door did not fully close and latch (Photo 5). At this same time, Surveyor interviewed Caregiver Coordinator C. Caregiver Coordinator C reported understanding of Surveyor's concern and reported s/he would have the door followed up on.	N 640		