

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0019870</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/19/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>VICTORY VISION COMMUNITY CONNECTIONS DAY C</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>310 PORTLAND RD WATERLOO, WI 53594</b>
---	--

(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
E 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced onsite 2nd Initial and Additional Space survey was conducted on 12/17/2024 - 12/19/2024 at Victory Visions Community Connections Day Center, located in Waterloo, WI.</p> <p>Victory Visions was found to be out of compliance with Wisconsin Administrative Code DHS 105.14 regulations for Adult Day Care Centers.</p> <p>A total of two participant files were reviewed during this survey.</p> <p>6 citations are issued.</p> <p>Current Census on day of survey: 7</p> <p>Square footage of the facility original space = 883.02 feet the number of participants that can be served = 17</p> <p>Square footage with requested additional space = 2360.82 feet the number of participants that can be served = 47</p>	E 000		
E 181	<p><b>105.14(5)(b)4. ENROLLMENT: COMMUNICABLE DISEASE SCREEN</b></p> <p>Within 90 days before or 7 days after enrollment, a physician, physician assistant, clinical nurse practitioner, or a licensed registered nurse shall screen each participant for clinically apparent communicable diseases, including tuberculosis, and document the results of the screening. All screenings and immunizations shall be conducted in accordance with current standards of practice. The ADCC shall maintain the screening documentation in each participant's record.</p>	E 181		

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

TITLE

(X6) DATE

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0019870</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/19/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>VICTORY VISION COMMUNITY CONNECTIONS DAY C</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>310 PORTLAND RD WATERLOO, WI 53594</b>
---	--

(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
E 181	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to screen participants for communicable disease including Tuberculosis (TB) and document the results of the screening in 1 of 2 participant records reviewed (Participant 2).</p> <p>Findings Include:</p> <p>Review of Participant #2's record revealed no evidence any communicable disease screening including TB screening being completed in the participant's record.</p> <p>In an interview at exit conference on 12/17/2024 at 2:15 PM Manager A stated, "I will contact Owner B and send that to you by end of today." As of 12/19/2024 no further information on Participant #2 was received.</p>	E 181		
E 210	<p>105.14(7)(d)3.a-f. MEDICATIONS: CAREGIVER ADMINISTRATION REQS</p> <p>Caregiver administered medications shall be stored, obtained, and assembled for the participant. The caregiver is responsible for ensuring the correct medication, in the correct dose, at the correct time is administered to the correct participant. Medications administered by a caregiver shall meet all of the following conditions: a. A written order from the prescribing practitioner shall be in the participant's record. b. A listing of current medications with the dosage, frequency, and route of administration shall be in the participant's record. c. Over-the-counter and prescription medications shall remain in the original labeled containers and be stored in a locked, safe place. d. Non-licensed caregivers shall consult with the prescribing practitioner or</p>	E 210		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0019870</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/19/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>VICTORY VISION COMMUNITY CONNECTIONS DAY C</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>310 PORTLAND RD WATERLOO, WI 53594</b>
---	--

(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
E 210	<p>Continued From page 2</p> <p>pharmacist about each medication to be administered. e. Written information describing side effects and adverse reactions of each medication shall be kept in the participant's record. f. The administration of medications shall be documented in the participant's permanent record to include the name of the medication, dosage, method of administration, date and time administered, and name of the caregiver who administered the medication.</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to label over the counter medications with participants name, and failed to obtain information describing side effects and adverse reactions of each medication in 1 of 1 observation of facility medication storage.</p> <p>Findings Include:</p> <p>Review of Facility policy titled "Medication Management Protocol" dated 06/15/2023, revealed in part "Administration Process: Prepare medication by doing the following: Pull appropriate medication from the participants's medication container, check to ensure the correct medication has been pulled, by logging into ECP under the correct participant's name and finding the correct medication that needs to be administered at the correct time. Verify the name of participant, medication name, confirm order and administration time, dose, route and validate the prescription number."</p> <p>On 12/17/2024 at 1:00 PM during a observation of the facility with Manager A, the participants</p>	E 210		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0019870</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/19/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>VICTORY VISION COMMUNITY CONNECTIONS DAY C</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>310 PORTLAND RD WATERLOO, WI 53594</b>
---	--

(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
E 210	<p>Continued From page 3</p> <p>medication cabinet was observed to have medications for Participant #1 that were not labeled with the Participant #1's name on 9 containers of 1.5 cal Osmolite. Participant #1's medication record did not include information describing side effects and adverse reactions of each medication.</p> <p>On 12/17/2024 at 1:15 PM in an interview with Manager A, when asked where the information on Participant #1's medication side effects should be kept, Manager A stated, "It should be on the MAR or on the medication list in the ECP and I don't see one for Participant #1's medications."</p>	E 210		
E 226	<p>105.14(7)(f)4.b. NUTRITION: DOCUMENT EACH MEAL</p> <p>The ADCC shall document the food served at each meal and maintain the documentation on file for at least six months.</p> <p>This Rule is not met as evidenced by: Based on interview and record review the facility failed to document the food served at each meal for 2 participants (Participant #1 and #2) in a total of 2 participant records reviewed.</p> <p>Findings Include:</p> <p>Review of Participant #1 and #2 participant records revealed no evidence of what or how much the participants ate or if they received a snack.</p> <p>In an interview on 12/17/2024 at 10:32 AM with Manager A, when asked where it was</p>	E 226		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0019870</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/19/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>VICTORY VISION COMMUNITY CONNECTIONS DAY C</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>310 PORTLAND RD WATERLOO, WI 53594</b>
---	--

(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
E 226	Continued From page 4  documented what the participants were eating, Manager A stated, "participants bring their own meals, we supply a snack."	E 226		
E 229	105.14(7)(f)5.b. SANITATION: FOOD HANDLERS HAND WASHING/DRYING  The ADCC shall provide hand-washing facilities in the kitchen for use by food handlers. Use of a common towel is prohibited.  This Rule is not met as evidenced by: Based on observation and interview the facility failed to provide hand-washing facilities in the kitchen in 1 of 1 kitchens areas observed.  Findings Include:  On 12/17/2024 at 10:56 AM during a observation of the kitchen it was observed that there was no sink or hand-washing facility for the food handlers. The closest hand-washing sink is located in the bathroom which is approximately 10 feet away from the kitchen area.  In an interview with Manager A on 12/17/2024 at 10:56 AM with Manager A, when asked where the food handlers wash their hands, Manager A stated, "in the bathroom."	E 229		
E 233	105.14(7)(f)6.e. FOOD SAFETY: STORAGE CLEAN, DRY, OFF FLOOR  Whether food is prepared at the ADCC or off-site, the ADCC shall store, prepare, distribute, and serve food in accordance with professional standards for food service safety. The ADCC shall do all of the following:	E 233		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0019870</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/19/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>VICTORY VISION COMMUNITY CONNECTIONS DAY C</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>310 PORTLAND RD WATERLOO, WI 53594</b>
---	--

(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
E 233	<p>Continued From page 5</p> <p>e. Keep food storage areas clean and dry and store food at least six inches off the floor.</p> <p>This Rule is not met as evidenced by: Based on observation and interview the facility failed to label and store food in accordance with professional standards of food service safety in 2 of 2 food storage areas observed.</p> <p>Findings include:</p> <p>During a observation of the facility on 12/17/2024 at 10:38 AM with Manager A, observed the large refrigerator in the kitchen area was filled with undated and unlabeled food including 5 bottles of dressings/condiments, 1 bag of tortillas, 1 bottle of juice, and string cheese. The upper freezer was filled with packages of unlabeled, undated food, the stand alone small freezer was filled with unlabeled, undated food.</p> <p>On 12/17/2024 at 10:45 AM in an interview with Manager A, when asked how do you know if food is not expired if there is no date, Manager A stated "I didn't realize it should be dated when we open it." Manager A stated we have no policy on food handling/storage.</p>	E 233		
E 240	<p>105.14(8)(a)7. ENVIRONMENT: CLEAN, COMFORTABLE, GOOD REPAIR</p> <p>The premises shall be clean, comfortable, and in good repair.</p> <p>This Rule is not met as evidenced by: Based on observation and interview the facility</p>	E 240		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0019870</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/19/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>VICTORY VISION COMMUNITY CONNECTIONS DAY C</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>310 PORTLAND RD WATERLOO, WI 53594</b>
---	--

(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
E 240	<p>Continued From page 6</p> <p>failed to maintain the premises in good repair.</p> <p>Findings:</p> <p>On 12/17/2024 at 10:56 AM during a tour with Manager A, observed the new additional space that will be used as an activity room to have the following:                      Floor had rough uneven concrete surfaces with large cracks present.                      Walls had cracked, peeling and chipping paint, gaps in the sheet rock and in the base along the floor boards with exposed wood molding.                      The emergency exit ramp was the same color as the floor and was not identified to indicate it was an uneven surface.</p> <p>On 12/17/2024 at 10:56 AM in an interview with Manager A, Manager A said the new space will be used for more physical activities.</p>	E 240		
Z 001	<p>Initial Comments</p> <p>An unannounced 2nd Initial survey was conducted on 12/17/2024 - 12/19/2025 at Victory Visions Community Connections in Waterloo, WI.</p> <p>Victory Visions Community Connections was found to be in compliance with the Wisconsin Administrative Codes: DHS 12 and 13 Caregiver Regulations.</p> <p>A total of 2 personnel files were reviewed.</p>	Z 001		