STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016965	A. BUILDING: _____ B. WING _____	C 12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME INC	1226 BERLIN ST WAUPACA, WI 54981

(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 11/10/2025, Surveyor conducted a complaint investigation and a standard survey at Bethany Home Inc. Additional information was gathered through 12/03/2025. The complaint was unsubstantiated and as a result of the survey, 6 deficient practices were identified. Census: 26	N 000		
N 356	83.32(3)(l) Rights of Residents: Least restrictive env In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Least restrictive environment. Have the least restrictive conditions necessary to achieve the purposes of the resident ' s admission. The CBRF may not impose a curfew, rule or other restriction on a resident ' s freedom of choice. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure resident's rights to be in the least restrictive environment. The provider did not allow residents to freely access all the licensed common areas of the facility. The residents were secured in an area of the facility that did not have adequate common space to meet the requirments for the number of residents they are licensed to serve. The residents were restricted to enter the main common area by double-sided magnetic locking doors that were not approved by the Department. Findings include:	N 356		

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

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N 356	Continued From page 1 The provider is licensed to serve up to 49 residents who may have diagnoses including advanced age, physical disability, irreversible dementia/ Alzheimer's disease, and/or terminally ill. On 11/10/2025 at 9:30 AM, Surveyor interviewed Administrator A. Administrator A stated some of the residents had memory care needs and activated Power of Attorneys for healthcare, while other residents remained their own persons. Administrator A stated they did not currently have any residents who had a tendency to exit seek or elope. On 11/10/2025 at 10:00 AM, Surveyor conducted a tour of the facility accompanied by Maintenance Director B and at times Administrator A. The Community Based Residential Facility (CBRF) had a connected Residential Care Apartment Complex and a Skilled Nursing Facility. Within the licensed CBRF space, corridors D, E, F and G101 (located in the back half of the facility,) was where residents' rooms and some common space was located. Corridor C was a wing that no longer housed residents and was being used for storage at the time of the survey. Corridors A, G100/W, and H contained the front half of the licensed space with the majority of the common room space, including two dining rooms, a chapel, a front lobby gathering area, the library, a bar, a game room, and the main offices. Surveyor observed internal doors fitted with two-way magnetic keypad access locks separated the residents from the front main common spaces of the facility. There were magnetic locks stopping residents from entering C wing, at the end of D wing leading to A wing, at the end of F wing leading to H wing, an at the end of G101 wing leading to G100/W wing. The back half of the	N 356		

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N 356	Continued From page 2	N 356		

building where the residents were secured did not contain enough common area space to ensure up to 49 residents had adequate space. Additionally, Surveyor observed in the back half of the facility there were external doors leading outside that were equipped with wander gaurd systems.

During the tour at 11:00 AM, Surveyor interviewed Administrator A. Administrator A stated residents were allowed to go into the front of the facility common space, but that they had to ask a staff member to unlock the door for them to ensure no other residents left the secured space. Per Administrator A's interview at 9:30 AM, many of the residents were their own person and none were identified as frequently exit seeking. All of the residents had the right to freely access the common areas of the facility with the expectation that the provider would provide enough supervision to meet the residents' needs. Administrator A commented that if the provider was expected to leave the doors open to the main common areas of the facility, they would have to "double" their staff to meet the residents' supervision needs.

On 11/24/2025 at 10:30 AM, Surveyor interviewed Administrator A, Maintenance Director B, and Licensee C during an exit conference while reviewing the facility map. Licensee C reviewed and acknowledged the area the residents had free access to during the survey did not meet the common space requirements for the total capacity of 49 residents. Licensee C acknowledged the resident's right to freely access all the licensed common space in the facility and the provider's responsibility to provide enough supervision for the residents to maintain their safety. Licensee C acknowledged use of two-way magnetically locked internal doors is not

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N 356	Continued From page 3 permitted under Chapter 83 and any delayed egress doors would require Office of Plan Review and Inspection and Department approval prior to making any changes to the buildings systems.	N 356		
N 394	83.35(5)(b) Annual evaluation of evacuation limits Evaluation update. The CBRF shall evaluate each resident ' s mental or physical capability to respond to a fire alarm at least annually or when there is a change in the resident ' s mental or physical capability to respond to a fire alarm. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all residents had an annual evacuation evaluation completed. Resident 1 did not have an evacuation evaluation for 2024, and Resident 2 had an evacuation evaluation dated for 2025, but not completed. Findings include: The provider is licensed to serve up to 49 residents who may have diagnoses including advanced age, physical disability, irreversible dementia/ Alzheimer's disease, and/or terminally ill. On 11/12/2024 at 1:00 PM, Surveyor reviewed resident records while interviewing Administrator A. Surveyor requested to review the evacuation evaluation documentation for Residents 1 and 2. Administrator A showed Surveyor the most recent records the provider had for the residents. Surveyor reviewed Resident 1's most recent evacuation evaluation was dated 06/28/2023. Administrator A confirmed an evacuation	N 394		

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N 394	Continued From page 4 evaluation for 2024 was not completed. Surveyor reviewed Resident 2 had an evacuation evaluation that was dated 05/14/2025 but was not filled out completely. The document had no evacuation time notes or signatures present. Administrator A confirmed the document was not completed. Cross Reference N0527 DHE 83.47(2)(f) Horizontal Evacuation N0555 DHS 83.48(7)(a) Equipment For Hearing Or Vision Impaired	N 394		
N 527	83.47(2)(f) Horizontal evacuation. Horizontal evacuation. The CBRF shall have approval from the department before including horizontal evacuation in the emergency and disaster plan. CBRFs using horizontal evacuation shall document the total evacuation time of the fire zone evacuated. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure they received Department approval prior to implementing horizontal evacuation in their emergency plan. The provider utilized horizontal evacuation while it was unapproved. Findings include: The provider is licensed to serve up to 49 residents who may have diagnoses including advanced age, physical disability, irreversible dementia/ Alzheimer's disease, and/or terminally ill.	N 527		

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N 527	Continued From page 5 On 11/10/2025 at 10:00 AM, Surveyor conducted a tour of the facility accompanied by Maintenance Director B and at times Administrator A. Surveyor interviewed Maintenance Director B during the tour. Surveyor observed the facility had doors made of various materials used to separate hallways including metal, wood and glass, and wood composite. Surveyor observed some of the wooden doors, and all of the wood composite doors, did not have a fire rating present. During the tour, Maintenance Director B pointed out general hallways and areas that s/he stated would be used as a smoke and fire barrier corridor during a fire. The corridors Maintenance Director B pointed out were separated by different doors made of different materials, some that were not fire rated. Maintenance Director B described the provider's evacuation plan as moving residents internally in the building from one smoke/ fire corridor to another depending on where the fire was determined located. Maintenance Director B did not recognize the provider's plan as horizontal evacuation required Department approved prior to its use. Surveyor reviewed the provider's records and found no Department approval for the use of a horizontal evacuation plan. On 11/10/2025, Maintenance Director B gave Surveyor a highlighted facility map that was intended to note where the smoke/fire compartments were located based on identifying the smoke/fire walls that separated the compartments. The map was not consistent with the current facility layout and Surveyor noted the wood and wooden composite doors without a smoke and/ or fire rating were being utilized as a fire/ smoke barrier. On 12/02/2025 Licensee C sent Surveyor the facility architectural plans which	N 527		

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N 527	Continued From page 6 were noted to contain inaccuracies in the physical layout of the facility. The architectural maps, including the life safety plans, also used the non-fire/ smoke rated doors as the fire barrier between corridors. Surveyor reviewed the provider's "Fire Emergency Response Plan." The place included a general evacuation plan based on Rescue, Alarm and Activate, Contain, Evacuate (RACE.) Appendix B was for the CBRF and noted: "13. If needed, exit the affected smoke compartment by bringing all residents to the next smoke compartment." The plan did not include identification of the various smoke compartments. Additionally, the plan had conflicting messaging that staff were to wait to hear back from the fire department before beginning to evacuate the residents: "14. If determined necessary by the Fire Department, follow Evacuation Policy and Procedure." On 11/24/2025 at 10:30 AM, Surveyor interviewed Administrator A, Maintenance Director B, and Licensee C during an exit conference. Licensee C acknowledged the provider would need to consult with a professional to review the smoke compartment requirements, incorporate the internal horizontal exits into the diagrams, and seek Department approval before implementing horizontal evacuation as part of their emergency plan. Cross Reference N0394 DHS 83.35(5)(b) Annual Evaluation Of Evacuation Limits	N 527		

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N 527	Continued From page 7 N0555 DHS 83.48(7)(a) Equipment For Hearing Or Vision Impaired	N 527		
N 546	83.48(4)(f) Smoke detector in non-resident living areas Pursuant to s. 50.035(2)(b), Stats., all facilities shall have at least one smoke detector located at each of the following locations: In all non-resident living areas, except the furnace, bathroom, kitchen and laundry room. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure interconnected smoke detection was installed in at least 58 non-resident living areas. Findings include: The provider is licensed to serve up to 49 residents who may have diagnoses including advanced age, physical disability, irreversible dementia/ Alzheimer's disease, and/or terminally ill. On 11/10/2025 at 10:00 AM, Surveyor conducted a tour of the facility accompanied by Maintenance Director B and at times Administrator A. Surveyor observed the facility had resident rooms that were equipped with one or more walk-in closets within the room and/or preceding the room entrance. The walk-in closets did not contain interconnected smoke detectors. Surveyor observed multipurpose rooms and offices that did not contain interconnected smoke detection. Surveyor observed at least 58 rooms throughout the facility that were not equipped with the	N 546		

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N 546	Continued From page 8 required interconnected smoke detection. Maintenance Director B entered each room with Surveyor and acknowledged each room identified throughout the facility that did not contain required smoke detection. On 11/24/2025 at 10:30 AM, Surveyor interviewed Administrator A, Maintenance Director B, and Licensee C during an exit conference while reviewing facility records, including the facility map. The providers reviewed the 58 rooms that were identified as not having an interconnected smoke detector as required. The providers acknowledged as the facility is large and their map was found to have some inaccuracies, all areas in need of interconnected smoke detection may not be identified during the survey process. Licensee C acknowledged the provider is required to submit plans for modifications to the facility smoke detection system to the Office of Plan Review and Inspection and the Department for approval prior to making any changes. Cross Reference N0547 DHS 83.48(4)(g) Smoke Detectors Where lintels Exceed 8 Inches N0555 DHS 83.48(7)(a) Equipment For Hearing Or Vision Impaired	N 546		
N 547	83.48(4)(g) Smoke detector where lintels exceed 8 inches Pursuant to s. 50.035(2)(b), Stats., all facilities shall have at least one smoke detector located at each of the following locations: Additional smoke detectors shall be located where wall projections from the ceiling or lintels exceed 8 inches. This Rule is not met as evidenced by:	N 547		

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N 547	Continued From page 9 Based on observation, record review, and interview, the provider did not ensure interconnected smoke detection was installed in at least 9 areas and compartments on the ceiling where lintels exceeded 8 inches. Findings include: The provider is licensed to serve up to 49 residents who may have diagnoses including advanced age, physical disability, irreversible dementia/ Alzheimer's disease, and/or terminally ill. On 11/10/2025 at 10:00 AM, Surveyor conducted a tour of the facility accompanied by Maintenance Director B and at times Administrator A. Surveyor observed areas throughout the facility where lintels exceeded 8 inches. Surveyor observed at least 9 spaces where lintels exceeded 8 inches throughout the facility that were not equipped with interconnected smoke detectors. Maintenance Director B observed each space identified with Surveyor and acknowledged each space with lintels greater than 8 inches identified throughout the facility that did not contain required interconnected smoke detection. Surveyor observed smoke detectors present throughout the facility were mounted on the walls greater than 8 inches below the ceiling. On 11/10/2025, Surveyor reviewed the facility records and noted the provider did not have a waiver or variance from the Department for the placement of the smoke detectors below 8 inches from the ceiling. On 11/24/2025 at 10:30 AM, Surveyor interviewed Administrator A, Maintenance Director B, and Licensee C during an exit conference while	N 547		

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N 547	Continued From page 10 reviewing facility records, including the facility map. The provider reviewed the 9 areas where lintels exceeded 8 inches that were identified as not having interconnected smoke detection as required. The provider reviewed areas where installed smoke detectors were lower than 8 inches from the ceiling. The providers acknowledged as the facility is large and their map was found to have some inaccuracies, all areas in need of interconnected smoke detection may not be identified during the survey process. Licensee C acknowledged the provider did not have a waiver or variance approval from the Department for the smoke detectors installed below 8 inches from the ceiling. Licensee C acknowledged if a professional can provide verification the installed smoke detectors are an appropriate rating to be deemed acceptable to be installed below 8 inches from the ceiling, a variance approval would be required from the Department. Licensee C acknowledged the provider is required to submit plans for modifications to the facility smoke detection system to the Office of Plan Review and Inspection and the Department for approval prior to making any changes to the building's systems. Cross Reference N0546 DHS 83.48(4)(f) Smoke Detectors In Non-Resident Living Areas N0555 DHS 83.48(7)(a) Equipment For Hearing Or Vision Impaired	N 547		
N 555	83.48(7)(a) Equipment for hearing or vision impaired Notification. If any resident with impaired hearing or vision is unable to detect or respond to a fire emergency, the licensee shall ensure the	N 555		

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N 555	Continued From page 11	N 555		

appropriate audio, visual or vibrating notification alarms are installed in the resident ' s bedroom, in or near a living room in an apartment, and in each common area used by the resident.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure interconnected smoke detectors in resident rooms were equipped with horn and strobes for residents who may be visually or hearing impaired.

Findings include:

The provider is licensed to serve up to 49 residents who may have diagnoses including advanced age, physical disability, irreversible dementia/ Alzheimer's disease, and/or terminally ill.

On 11/10/2025 at 9:30 AM, Surveyor interviewed Administrator A. Administrator A reviewed the client groups the provider is licensed to admit and confirmed hearing and/ or visual impairment was a common characteristic of the residents served.

On 11/10/2025 at 10:00 AM, Surveyor conducted a tour of the facility accompanied by Maintenance Director B and at times Administrator A. Surveyor observed the required interconnected smoke detectors that were in resident bedrooms were not equipped with the required features needed to assist the population served. The detectors did not have capability to produce sound (horn) or flash a light (strobe) for those residents who may be visually or hearing impaired.

On 11/24/2025 at 10:30 AM, Surveyor interviewed Administrator A, Maintenance Director B, and Licensee C during an exit conference. Licensee C

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N 555	Continued From page 12 acknowledged the resident rooms did not have interconnected smoked detectors that were equipped with horn or strobe for residents who may be visually or hearing impaired, which is a common characteristic of the population served. Maintenance Director B stated the horns located in the facility halls were at a decibel level of 75 but did not have a waiver, variance, or any documentation of a professional review to verify the horns located in the halls were determined to meet the required decibel levels throughout the facility, including resident rooms when the doors are closed. Licensee C acknowledged the provider is required to submit plans for modifications to the facility smoke detection system to the Office of Plan Review and Inspection and the Department for approval prior to making any changes to the building's systems. Cross Reference N0394 DHS 83.35(5)(b) Annual Evaluation Of Evacuation Limits N0546 DHS 83.48(4)(f) Smoke Detectors In Non-Resident Living Areas N0547 DHS 83.48(4)(g) Smoke Detectors Where lintels Exceed 8 Inches	N 555		