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 _____	R-C 04/15/2026

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 04/08/2026, Surveyor conducted a complaint investigation and verification visit at Bethany Home Inc. Additional information was gathered through 04/15/2026. The complaint was substantiated, and 6 deficient practices were identified, including 4 repeat deficient practices. Under statutory provisions, a $200 revisit fee is being assessed for the follow-up licensing visit. Census: 26	{N 000}		
N 362	83.33(1)(d) Grievance procedure: written summary The CBRF shall provide a written summary of the grievance, the findings and the conclusions and any action taken to the resident or the resident ' s legal representative and the resident ' s case manager. The CBRF shall maintain a copy of the investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written summary of findings and the conclusions or any actions taken was provided to Resident 3's chosen representative (Rep F) after being notified of a grievance. Findings include: On 04/08/2026 at 12:30 PM, Surveyor interviewed Licensee D with Administrator E present at times. Licensee D stated s/he recalled an incident that occurred between	N 362		

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

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N 362	Continued From page 1 12/04/2025-12/06/2025 when Resident 3 was found lying on the floor of his/her room at approximately 1:30 AM after an unwitnessed fall. Licensee D stated at the time s/he was not the licensee but recalled having knowledge of the incident as there was a reported concern that Resident 3 (who required 2 hour checks) alleged s/he was on the floor from approximately 9:00-10:00 PM until being found at 1:30 AM while Administrator A (who was working the floor and responsible for completing the 2 hour-checks) stated the resident had been checked on every 2 hours prior to finding him/her on the floor at 1:30 AM. Licensee D stated at the time of the event, Licensee C and Administrator A were the responsible parties for the facility and it would have been Licensee C's responsibility to conduct an investigation and respond to any grievances. Licensee D stated s/he was aware there was a meeting between Rep F and Licensee C in December of 2025, but s/he did not know when or what was discussed. Licensee D stated when s/he took over the role of Licensee, no documentation regarding the incident including any documentation of an investigation or grievance response was given to him/her. Licensee D looked through his/her computer and files and stated s/he could not find any record of the incident or proof an investigation was conducted to review. On 04/15/2026 at 8:49 AM, Surveyor interviewed Rep F. Rep F stated on approximately 12/15/2025 s/he had a meeting with Licensee C to discuss transferring Resident 3 from the facility to the skilled nursing facility. Rep F stated s/he discussed his/her and Resident 3's grievance with Licensee C related to the fall that occurred when	N 362		

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N 362	Continued From page 2 Resident 3 was found on the floor at 1:30 AM (between 12/04/2025-12/06/2025) and the discrepancy in the timeline. Rep F stated Licensee C stated s/he would "look into it." Rep F stated after notifying Licensee C of his/her grievance, no written statement with a summary of findings, actions taken, or any conclusion was received by him/her or Resident 3. Cross Reference N0431 DHS 83.38(1)(g) Health Monitoring	N 362		
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 other health care providers, and shall record any changes in the resident ' s health or mental health	N 431		

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N 431	Continued From page 3 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 Resident 3's health was monitored by documenting all changes in his/her condition in his/her medical record. Resident 3 was not discovered on the floor for at least 2 hours after having a fall. The provider was aware the incident occurred but did not document it in Resident 3's record to allow for continued health monitoring. Findings include: On 01/09/2026, the Department received a complaint alleging an incident occurred with a resident that was not documented or reported by the provider. On 04/08/2026 at 12:30 PM, Surveyor reviewed Resident 3's record. Resident 3 was admitted on 02/12/2024 with diagnoses including Parkinson's disease, abnormality of gait and mobility and a history of falls which required 2-hours checks by staff for supervision and health monitoring. On 04/08/2026 at 12:30 PM, Surveyor interviewed Licensee D with Administrator E present at times. Licensee D stated s/he recalled an incident that occurred between 12/04/2025-12/06/2025 when Resident 3 was found lying on the floor of his/her room at approximately 1:30 AM after an unwitnessed fall. Licensee D stated at the time s/he was not the licensee but recalled having knowledge of the incident as there was a reported concern that Resident 3 (who required 2 hour checks) alleged	N 431		

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N 431	Continued From page 4 s/he was on the floor from approximately 9:00-10:00 PM until being found at 1:30 AM while Administrator A (who was working the floor and responsible for completing the 2 hour-checks) stated the resident had been checked on every 2 hours prior to finding him/her on the floor at 1:30 AM. Licensee D and Administrator E stated it is their expectation any incident is documented in the resident record, including completing an incident report. Licensee D stated it is critical to document all incidents including unwitnessed falls so that staff can be notified to increase supervision and health monitoring such as performing regular neurological checks after an unwitnessed fall. Surveyor requested to review all documentation regarding the incident. Both Licensee D and Administrator E searched for records to review and found no documentation of the event. Resident 3 had a subsequent fall on 12/07/2025 that was documented as it required a visit to the emergency department. No documentation reflecting the circumstances described in the fall event that reportedly occurred between 12/04/2026-12/06/2025 or efforts to increase health monitoring were discovered. Cross Reference N0362 DHS 83.33(1)(d) Grievance Procedure: Written Summary	N 431		
{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	{N 527}		

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{N 527}	Continued From page 5 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. This is a repeat deficient practice. See Statement of Deficiency (SOD) 72NJ11, dated 12/03/2025. 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 04/08/2026 at 11:00 AM, Surveyor interviewed Licensee D with Administrator E present at times. Licensee D stated s/he was new to the role of Licensee/ Director of Health Services as of mid-February 2026 and Administrator D had been in his/her position for approximately 2 weeks. Licensee D stated s/he reviewed SOD 72NJ11 (dated 12/03/2025) which was issued to the provider on 02/04/2026. Licensee D confirmed no changes to the physical plant of the facility, plan for horizontal evacuation, or fire emergency plan related to the deficient practices identified in SOD 72NJ11 were made. Licensee D stated the provider did not meet the deadline to request an extension and was aware not completing the corrections would result in a repeat deficient practice. Licensee D presented Surveyor with the current emergency response plan and horizontal evacuation map for review. Surveyor reviewed	{N 527}		

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{N 527}	Continued From page 6 the provider's records and found no Department approval for the use of a horizontal evacuation plan. Physical Plant On 04/08/2026 at 1:00 PM, Surveyor conducted a tour of the facility accompanied by Licensee D. Surveyor observed no corrections to the physical plant were made since the previous survey. 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. Surveyor observed the general hallways and areas that the horizontal evacuation map noted would be used as a smoke and fire barrier corridor during a fire. The corridors were separated by different doors made of different materials, some that were not fire rated. Emergency Response Plan Surveyor reviewed the provider's "Fire Emergency Response Plan" and noted no modifications were made to the areas that were identified during SOD 72NJ11 as in need of review and modification. The plan continued to include a general evacuation plan based on Rescue, Alarm and Activate, Contain, Evacuate (RACE.) Appendix B was for the CBRF and still noted: "11. 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	{N 527}		

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{N 527}	Continued From page 7 wait to hear back from the fire department before beginning to evacuate the residents: "13. If determined necessary by the Fire Department, follow Evacuation Policy and Procedure." After review of the emergency plan, Licensee D acknowledged the areas that needed to be reviewed and modified and stated s/he would ensure it was completed. Horizontal Evacuation 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 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. On 04/08/2026, Licensee D gave Surveyor a map as evidence of a plan for horizontal evacuation. Surveyor reviewed the map was the same map that was identified in SOD 72NJ11 as requiring professional review and modification, as well as the Department's approval, prior to utilizing horizontal evacuation. Licensee D stated s/he was unaware the map was the same that had been reviewed during DSOD 72NJ11 and stated upon assuming the role of Licensee s/he spoke	{N 527}		

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{N 527}	Continued From page 8 with Maintenance Director B about a plan of correction for SOD 72NJ11 and that was the map s/he had been given. Licensee D stated s/he questioned the evacuation plan after Maintenance Director B described the evacuation plan as moving residents internally in the building from one smoke/ fire corridor to another depending on where the fire was determined to be located. After a review of the requirements prior to utilizing horizontal evacuation, Licensee D acknowledged no professional review or modifications had been made to the map and horizontal evacuation plan and no Department approval was received. Licensee D stated the provider would no longer be utilizing horizontal evacuation until it was professionally reviewed, including review of the smoke compartment requirements, incorporation of the internal horizontal exits into the diagrams and corrections of the life safety plans to match the physical layout of the building, and the plan was submitted and approved by the Department. Cross Reference N0546 DHS 83.48(4)(f) Smoke Detectors In Non-Resident Living Areas	{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	{N 546}		

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{N 546}	Continued From page 9	{N 546}		

interview, the provider did not ensure interconnected smoke detection was installed in at least 58 non-resident living areas.

This is a repeat deficient practice. See Statement of Deficiency (SOD) 72NJ11, dated 12/03/2025.

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.

SOD 72NJ1, dated 12/03/2025: "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 required interconnected smoke detection ..."

On 04/08/2026 at 1:00 PM, Surveyor conducted a tour of the facility accompanied by Licensee D. Surveyor observed no corrections to the physical plant were made since the previous survey (SOD 72NJ11, dated 12/03/2025.) Surveyor and Licensee D observed interconnected smoke detection was not installed in at least 58 non-resident living areas.

On 04/08/2026 at 11:00 AM, Surveyor interviewed

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{N 546}	Continued From page 10 Licensee D with Administrator E present at times. Licensee D stated s/he was new to the role of Licensee/ Director of Health Services as of mid-February 2026 and Administrator D had been in his/her position for approximately 2 weeks. Licensee D stated s/he reviewed SOD 72NJ11 (dated 12/03/2025) which was issued to the provider on 02/04/2026. Licensee D confirmed no changes to the physical plant of the facility, including interconnected smoke detection, related to the deficient practices identified in SOD 72NJ11 were made. Licensee D stated the provider did not meet the deadline to request an extension and was aware not completing the corrections would result in a repeat deficient practice. Licensee D stated the provider did not hire or consult with a professional to install interconnected smoke detection and was instead choosing to install permanent shelving into the rooms identified in SOD 72NJ11 as in need of interconnected smoke detection. Licensee D stated the shelves were not installed yet. Licensee D stated the only record to review was the map from the previous survey which was not updated. Licensee D and Surveyor reviewed the facility map record. Licensee D reviewed 58 rooms that were identified during the previous survey (SOD 72NJ11 dated 12/03/2025) as not having an interconnected smoke detector as required. Licensee D 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 D acknowledged if the provider chose to correct the deficient practice by adding interconnected smoke detection then they would be required to submit plans for modifications of the smoke detection system to the Office of Plan Review and Inspection and the	{N 546}		

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{N 546}	Continued From page 11 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: 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. Additionally, smoke detectors present throughout the facility were mounted on the walls greater than 8 inches below the ceiling. This is a repeat deficient practice. See Statement of Deficiency (SOD) 72NJ11, dated 12/03/2025. 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 547}		

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{N 547}	Continued From page 12 SOD 72NJ1, dated 12/03/2025: "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 ... 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 04/08/2026 at 1:00 PM, Surveyor conducted a tour of the facility accompanied by Licensee D. Surveyor observed no corrections to the physical plant were made since the previous survey (SOD 72NJ11, dated 12/03/2025.) Surveyor and Licensee D observed interconnected smoke detection was not installed in at least 9 areas and compartments on the ceiling where lintels exceeded 8 inches and smoke detectors present throughout the facility were mounted on the walls greater than 8 inches below the ceiling. On 04/08/2026 at 11:00 AM, Surveyor interviewed Licensee D with Administrator E present at times. Licensee D stated s/he was new to the role of Licensee/ Director of Health Services as of mid-February 2026 and Administrator D had been in his/her position for approximately 2 weeks. Licensee D stated s/he reviewed SOD 72NJ11 (dated 12/03/2025) which was issued to the provider on 02/04/2026. Licensee D confirmed no changes to the physical plant of the facility,	{N 547}		

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{N 547}	Continued From page 13 including ensuring there was interconnected smoke detection in areas with lintels exceeding 8 inches, related to the deficient practices identified in SOD 72NJ11 were made. Licensee D stated the provider did not meet the deadline to request an extension and was aware not completing the corrections would result in a repeat deficient practice. Licensee D stated the provider did not hire or consult with a professional to install interconnected smoke detection where lintels exceed 8 inches or verify the rating of the smoke detectors mounted 8 inches below the ceiling. Licensee D stated the only record to review was the map from the previous survey which was not updated. Licensee D reviewed the map including 9 areas where lintels exceeded 8 inches that were identified as not having interconnected smoke detection as required. Licensee D reviewed areas where installed smoke detectors were lower than 8 inches from the ceiling. Licensee D 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 D 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 D 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 D 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.	{N 547}		

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 _____	R-C 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{N 547}	Continued From page 14 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 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. This is a repeat deficient practice. See Statement of Deficiency (SOD) 72NJ11, dated 12/03/2025. 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. SOD 72NJ1, dated 12/03/2025: "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	N 555		

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N 555	Continued From page 15	N 555		

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 04/08/2026 at 1:00 PM, Surveyor conducted a tour of the facility accompanied by Licensee D. Surveyor observed no corrections to the physical plant were made since the previous survey (SOD 72NJ11, dated 12/03/2025.) Surveyor and Licensee D observed resident rooms and common spaces were not updated with interconnected smoke detectors equipped with horn and strobe to meet the needs of the population served.

On 04/08/2026 at 11:00 AM, Surveyor interviewed Licensee D with Administrator E present at times. Licensee D and Administrator E 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.

Licensee D stated s/he was new to the role of Licensee/ Director of Health Services as of mid-February 2026 and Administrator D had been in his/her position for approximately 2 weeks. Licensee D stated s/he reviewed SOD 72NJ11 (dated 12/03/2025) which was issued to the provider on 02/04/2026. Licensee D confirmed no changes to the physical plant of the facility, including ensuring interconnected smoke detectors in resident rooms were equipped with horn and strobes for residents who may be visually or hearing impaired, related to the deficient practices identified in SOD 72NJ11 were made. Licensee D stated the provider did not

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N 555	Continued From page 16 meet the deadline to request an extension and was aware not completing the corrections would result in a repeat deficient practice. Licensee D stated the provider did not hire or consult with a professional to install horn and strobes on the interconnected smoke detection within resident rooms and commons spaces or verify the decibel level of the installed smoke detectors in use. Licensee D stated the only record to review was the map from the previous survey which was not updated. Licensee D reviewed the map including resident rooms and common spaces. Licensee D 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. Licensee D reviewed Maintenance Director B stated during the previous survey that the horns located in the facility halls were at a decibel level of 75 but still 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 D 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 N0547 DHS 83.48(4)(g) Smoke Detectors Where lintels Exceed 8 Inches	N 555		