

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013853	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/02/2025
NAME OF PROVIDER OR SUPPLIER HOMETOWN ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2 HERITAGE LANE BELLEVILLE, WI 53508		
(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 10/02/2025, Surveyor conducted a complaint investigation at Hometown Assisted Living Inc, a CBRF in Belleville. One deficiency was identified. The complaint was substantiated. Census: 1	N 000		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure the facility and its operation complied with all laws governing the CBRF. Findings include: On 10/02/2025, Surveyor conducted a complaint investigation concerning resident safety with the upcoming closure of the CBRF. On 10/02/2025 at 7:00 a.m., Surveyor reviewed the DHS Resident Relocation Manual, which states the following: - The provider must continue to provide adequate care and treatment until each resident has relocated to a suitable alternate setting within statutory timeframes. - The provider must continue ongoing	N 196		

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: 0013853	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/02/2025
NAME OF PROVIDER OR SUPPLIER HOMETOWN ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2 HERITAGE LANE BELLEVILLE, WI 53508		
(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 196	Continued From page 1 assessments of each residents' care needs. - The provider must maintain the physical plant. During the complaint investigation, Surveyor identified the following concerns: Example 1 - Environment: On 10/02/2025 at approximately 8:30 a.m., Surveyor toured the provider's facility. Surveyor observed carpeting had been torn out in common areas and unoccupied resident rooms, a wall in the common area had been removed exposing the ceiling, smoke detectors and sprinklers were covered with plastic wrap, wires were exposed at outlets and hanging from the ceiling, furnishings were piled up and carpentry tools and supplies were scattered throughout the facility. On 10/02/2025 at 8:40 a.m., Surveyor interviewed Resident 1. Resident 1 stated the construction work in the common areas was disruptive to him/her and s/he didn't feel it was safe to walk in the common area any longer. Resident 1 stated s/he was contacting his/her physician that day to beg for an upcoming appointment to be moved up so s/he could move out of the facility sooner than the following week. On 10/02/20225 at 9:00 a.m., Surveyor interviewed Licensee A. Licensee A acknowledged the facility was under significant construction. Licensee A stated initially s/he and Caregiver C had just ripped up carpet in the common areas and started small repairs in unoccupied resident rooms. Licensee A stated larger repairs, including the removal of a wall and exposing wires, started on 09/30/2025 because s/he thought all residents would be moved out on that date. Licensee A explained the scenario as a	N 196			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013853	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/02/2025
NAME OF PROVIDER OR SUPPLIER HOMETOWN ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2 HERITAGE LANE BELLEVILLE, WI 53508		
(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 196	Continued From page 2 "whirlwind" and that the work the contractors had completed that week was a surprise to Licensee A. Licensee A stated s/he believed s/he continued to take good care of Resident 1 and that the construction was acceptable because Resident 1 liked to stay in his/her room. Surveyor questioned if exposed wires, covered up sprinklers, smoke detectors and construction noise provided a safe and comfortable environment. Licensee A stated s/he thought the construction was fine because Resident 1 liked to stay in his/her room, but stated perhaps his/her interpretation was "too farm." Personnel and Resident Care: On 10/02/2025 at 7:30 a.m., Surveyor interviewed Caregiver B. Caregiver B stated on 10/01/2025, Caregiver C made a comment that Resident 1 should be financially contributing to his/her continued stay at the facility. Caregiver B stated s/he wasn't sure what was said between Resident 1 and Caregiver C, but that Resident 1 was observed in tears. Caregiver B stated Caregiver C had a history of making rude comments. On 10/02/2025 at 8:40 a.m., Surveyor interviewed Resident 1. Resident 1 stated Caregiver C was very volatile, and that Resident 1 never knew what Caregiver C was going to say. Resident 1 stated the day prior Caregiver C had made comments to former caregivers that Resident 1 should be contributing to the cost of his/her care now that the managed care organization contract termed on 09/30/2025. Resident 1 stated s/he confronted Caregiver C, who later apologized. Resident 1 stated Licensee A also followed up with Resident 1 regarding the incident. Resident 1 stated s/he had a severe anxiety disorder and would get upset over little things. Resident 1	N 196		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013853	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/02/2025
NAME OF PROVIDER OR SUPPLIER HOMETOWN ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2 HERITAGE LANE BELLEVILLE, WI 53508		
(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 196	Continued From page 3 stated s/he didn't feel safe at the facility when only Caregiver C was working. Resident 1 stated, "You never know what is going to [expletive] [him/her] off." Resident 1 stated months ago Caregiver C got in a screaming match with Resident 1 over undercooked meat and Caregiver C once stated Resident 1 didn't need to use a scale because Resident 1 wasn't going to lose weight just sitting around. On 10/02/2025 at 8:50 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 08/30/2024 with diagnosis including anxiety. Resident 1's record did not include any progress notes, incident reports or assessments after 07/17/2025. The record did not include documentation of the 10/01/2025 incident or monitoring of Resident 1's health during the relocation process. On 10/02/2025 at 9:00 a.m., Surveyor interviewed Licensee A and asked about Caregiver C's interactions with residents and particularly Resident 1. Licensee A stated Caregiver C had no filter and was rough around the edges but was a really good caregiver. Surveyor asked if Caregiver C upset Resident 1 the day prior regarding finances. Licensee A replied, "Yes. And I told [him/her] that was none of [his/her] business." Surveyor asked if there was any investigation or documentation regarding his/her follow up with Resident 1. Licensee A replied, "No." Surveyor asked Licensee A if s/he was aware Caregiver C's actions were fearful to Resident 1. Licensee A replied, "No," and asked what s/he was to do because s/he and Caregiver C were the only staff available to work at the facility until Resident 1 moved and the facility closed.	N 196		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013853	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/02/2025
NAME OF PROVIDER OR SUPPLIER HOMETOWN ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2 HERITAGE LANE BELLEVILLE, WI 53508		
(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 196	Continued From page 4 On 10/02/2025 at 9:40 a.m., Surveyor reviewed concerns that Licensee A did not maintain a safe physical environment or assess resident's needs through the relocation process. Licensee A replied, "I can't believe I screwed up again." Licensee A stated s/he thought giving residents 60 days' notice of closure was adequate and that all residents would have been discharged on 09/30/2025, allowing for all former staff besides him/her and Caregiver C to be termed effective 09/30/2025 and to allow for heavy construction to begin.	N 196		