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	410107	A. BUILDING: _____ B. WING _____	C 02/27/2024

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N 000	Initial Comments On 02/07/2024, 02/12/2024, and 02/16/2024 Surveyor conducted 4 complaint investigations and a standard survey at Homme Residential Wittenberg. Additional information was gathered through 02/27/2024. All 4 complaints were unsubstantiated. As a result of the survey 12 deficient practices were identified. Census: 53	N 000		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on observation, record review, and interview the provider did not ensure residents were living in a safe environment. Multiple concerns were identified regarding the safety of the facility's physical plant including an active gas leak, emergency evacuation, public access to the facility, areas in need of repair, smoke separation, and fire detection and suppression systems. The facility is licensed to serve up to 75 residents who may be physically disabled, of advance age, emotionally disturbed/ mental illness, and /or irreversible dementia/ Alzheimer's disease.	N 358		

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

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N 358	Continued From page 1 Findings Include: Facility Layout The Community Based Residential Facility (CBRF) is built into a hill resulting in half of the basement being ground level for exit and half of the basement requiring ascension to the first floor to exit at ground level. Additionally, the first floor was half at ground level for exit and half required descension to the basement to exit at ground level. The second floor had resident bedrooms and common space that was added in 2020. The second floor contained interconnected smoke detection in the resident rooms and common areas. The second floor was directly above the former Skilled Nursing Facility (SNF) space on the first floor and was directly accessible from the SNF space. The CBRF is attached to a SNF that closed in 2022. The SNF space is still open and accessible (open hallway with no doors or other separation) internally to the residents, visitors, and staff, however the SNF is not staffed, is dark and no longer in use, besides some common areas used for activities. The SNF space contained the main CBRF kitchen, storage, staff areas, and was openly connected to the CBRF on the first and 2nd floors. The first floor had 4 resident bedroom wings, including a memory care wing, and common space. The basement was located below the main CBRF and the nursing home space. The basement contained rooms with CBRF building systems including the boiler, generator, electrical, air compressors, ventilation, laundry, garbage, and rooms for general storage including resident	N 358		

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personal storage, maintenance storage, and building services storage. The basement included areas rented by private businesses such as physical therapy services, a salon, and a thrift store. On 12/12/2024 at approximately 12:30 PM, Administrator A stated the privately rented spaces were patroned by both residents and the public and acknowledged the general public had access directly into the CBRF. The basement additionally contained a connected hallway to an apartment complex and a wing for resident inpatient therapy that was no longer in use.

General Findings

On 02/07/2024 at approximately 11:40 AM - 2:30 PM, Surveyor toured the facility accompanied by Administrator A and at times Maintenance Manager E. Surveyor interviewed Administrator A and Maintenance Manager E during the tour. Surveyor observed over 50 habitable rooms in the basement that were not equipped with smoke detection and/ or heat detection. At approximately 12:00 PM, Maintenance Manager E confirmed there were rooms that did not contain smoke detection and/ or heat detection and stated it was his/her belief the rooms had been "grandfathered in" and did not require it. Administrator A entered each room with Surveyor and acknowledged each of the 50 plus rooms did not have smoke and/ or heat detection present.

At approximately 1:00 PM, Surveyor toured the first and 2nd floors of the facility and identified at least 1 room and 3 corridor areas with lintels that exceeded greater that 8 inches that did not have smoke and/ or heat detection. Administrator A acknowledged the 4 areas identified did not have the required smoke and/ or heat detection.

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N 358	Continued From page 3 Surveyor observed the basement and parts of the first floor did not have emergency egress lighting and had fire rated smoke separation doors removed or replaced with nondescript doors. Surveyor observed multiple delay egress doors that were not approved by the department or inspected through the Office of Plan Review and Inspection and exit paths with more than one delay and/or obstructed access. During the tour, Surveyor identified the areas of concern to Administrator A and when present, Maintenance Manager E. Administrator A and Maintenance Manger E acknowledged the lack of emergency egress lighting, removal of required fire rated doors, obstructed exit paths, exit paths with more than one delay and the egressed doors present without department approval. Surveyor observed the basement and first floor had multiple rooms and corridors where the walls and ceiling had cracks, leaks, holes, open areas from previous works, and areas where piping and/or electrical cords were not securely sealed with fire rated putty. In the main boiler room Surveyors observed duct work coming off of a blower system with two caved in tube vents, an oscillating fan set up to keep a small motor cool that was running an aluminum boiler system, and running equipment held into place with makeshift construction such a s a plastic bucket to hold equipment in place. A storage room in the basement had open electrical wires running from the ceiling that had an active water leak dripping down from the wires. The drips were being collected in a bucket that appeared to have overflowed. The floor appeared to have hard water deposits in a formation of a dried puddles of water beneath the leak. During the tour Surveyor identified the areas of concern to Administrator A and, at times when present,	N 358		

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Maintenance Manager E. Administrator A and Maintenance Manger E acknowledged the areas in need of repair.

On 02/12/2024 at approximately 9:15 AM- 1:00 PM, Surveyor toured the facility accompanied by Administrator A and at times Maintenance Manager E. Surveyor interviewed Administrator A and Maintenance Manager E during the tour. Surveyor observed a second fire suppression system located within the rented thrift store space. The sprinkler room was only accessible through the thrift store. The room containing the suppression system was open and accessible to anyone passing by as the door had been removed. The sprinkler room was located within the thrift store common space allowing free access for anyone inside the store to tamper with the sprinkler system. The system did not have a chain to secure the emergency shut off valve, so the valve could be turned off by anyone, preventing it from spraying in an emergency situation. The suppression system was openly accessible to the public where anyone would have the ability to turn the system off.

Administrator A stated the thrift store, therapy services, and salon were privately rented spaces that were all located in the facility basement and were open to the public. Surveyor observed the rented areas had direct internal access to the CBRF including residential areas and areas where resident private property is stored. During the tour, Surveyor identified the areas of concern to Administrator A and when present, Maintenance Manager E. Administrator A and Maintenance Manger E acknowledged the suppression system was not secured against unauthorized access and that the public had access to the CBRF including areas where

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residents reside and store personal belongings.

On 12/16/2024 at approximately 10:00 AM, Surveyor toured the facility accompanied by Administrator A and Board Member C. Board Member C was shown all the areas and systems identified in the previous tours that needed to be addressed. Both Administrator A and Board Member C acknowledged all the areas of concern and the potential risk of resident safety.

Surveyor conducted an exit interview with Board Member C and Administrator A on 12/16/2024 at approximately 2:30 PM. Both Administrator A and Board Member C stated their concern for the residents' safety and commitment to take immediate steps to resolve the areas that were identified during the survey.

Gas leak and Evacuation:

https://www.wisconsinpublicservice.com/services/outages (retrieval date 02/27/2024)
According to WI Public Service, for "Natural gas leaks and emergencies ...Call ... from another location. Leave immediately - do not turn on light switches or use phone."

During the tour on 12/12/2024 at 10:00 AM, Surveyor observed a former boiler room in the basement that was being used for storage of items including paints and various chemicals. (Photos 81, 82, 83, and 85). Upon opening the door to the room, Surveyor and Administrator A were able to smell what appeared to be natural gas. The room was observed to be uncomfortably warm by both Surveyor and Administrator A. Administrator A pointed out hot water pipes within

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the room. Surveyor was unable to touch the pipes for more than 5 seconds due to the pipe's extreme heat. Surveyor observed the chemicals and paints were being stored in close proximity to the heated pipes. Neither Maintenance Manager E nor Administrator A took immediate steps once Surveyor voiced concern related to smelling natural gas. Surveyor informed Administrator A smelling natural gas was an emergent situation and that s/he should follow the provider's emergency plan. Administrator A was unsure if the provider had a plan in place for a natural gas leak. As the situation was an actual emergency, Surveyor advised Administrator A to call the gas professionals and follow their gas company's directives.

At 10:17 AM, Maintenance Manager E returned to the room and stated the gas company advised the facility to be immediately evacuated. The gas company would come to the facility to assess the leak and determine when and/ or if people may reenter the premises.

At 10:22 AM, Surveyors observed Administrator A, Coordinator B, and other staff exiting the main office. No residents had been evacuated yet. Administrator A repeated the building had to be evacuated to staff and began to have staff take steps (22 minutes after initially noticing the gas smell.)

At 10:32 AM, Surveyor observed staff moving residents from the 2nd floor CBRF down to the first floor via the elevator. Residents were observed trying to go back up to their rooms on the 2nd floor to retrieve personal items. A resident is overheard saying, "They said to get your coat!" Caregiver H was overheard stating s/he would go back upstairs to grab the resident's coat.

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N 358	Continued From page 7 At 10:34 AM, a cart of blankets was wheeled into the main lobby where some residents were gathered. The staff were congregating the resident in the main lobby of the building to wait for busses. The residents appeared to be unaware of the emergency of the situation. Resident 5 was overheard stating, "I don't want to go!" A resident asked Surveyor, "Is this a drill?" A visitor asked Surveyor if the evacuation was "planned." The alarm was not activated, no overhead announcement was made, and it appeared only the staff were informed the evacuation was not a drill. At 10:37 AM, a school bus arrived to transport ambulatory residents from the facility to an alternate location. A second smaller bus arrived but could only transport 3 residents with limited mobility at a time. At 10:43 AM, 3/53 residents were evacuated away from the facility while the other residents were brought by the staff to congregate in the lobby, still within the building. (Photo 2). The gas company arrived at the facility. At 10:46 AM, Gas Professional F located 4 natural gas leaks in the old boiler room with a 2.6% gas reading. (Photos 80, 83, and 84). Additionally, it was noted two old gas pipes were capped off using fire rated caulk to plug the holes instead of an actual cap with a secure seal. Gas Professional F worked with Maintenance Manager E to locate a valve to turn the gas off and access for repairs. At 11:15 AM, Surveyors observed residents were still congregated in the lobby area of the facility waiting for transportation to an alternate location	N 358		

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instead of emergently exiting the facility. Administrator A stated to the Surveyors the local police arrived after they overheard the call for the busses to evacuate the residents. Administrator A stated to his/her knowledge no one from the facility had called to alert the police or fire department. The staff continued to use the elevators. Administrator A stated s/he was unsure how they would evacuate the residents from the 2nd floor if they did not use the elevator. Administrator A stated, "I'd have to look to see if there is a way to use the stairs."

At 11:57 AM, Gas Professional F notified it was safe to call off the evacuation and have people return to the facility. Surveyors observed there were still 8 residents and staff present in the lobby that had not evacuated the facility during the 100 minutes the evacuation was in effect. The provider did not follow the gas professional's instructions to immediately have all persons evacuate the building.

On 12/16/2024, Surveyor reviewed the providers "Emergency Preparedness Manual." The manual had the phone number for the gas company listed on the front cover but did not have a plan specific to a gas leak. The provider had a general "Evacuation Procedure":

" ...The following employees/individuals are responsible for ordering a full or partial evacuation of the building under the direction of Shawano County Emergency Management and are responsible for defining which areas of the building will be evacuated: Administrator, Maintenance Manager, Clinical leadership/designee. This shall be done in consultation with Fire Department, Law Enforcement and Emergency Management

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N 358	Continued From page 9 personnel... Announcement When an evacuation has been ordered an announcement will be made to evacuate the necessary areas of the facility. All employees that can safely leave his/her duties shall report to the announced location to assist in the evacuation. Resident families will be notified of evacuation via telephone by nursing and social service staff. In the event of an evacuation off duty personnel will be called to assist in the evacuation process ... Order of Evacuation Move residents that are closest to the disaster area first starting with the ambulatory residents (panic is less likely to be caused by moving ambulatory residents) group residents together and lead them to a safe area or designated area of rescue. A staff person must remain with the residents at all times. Move semi-ambulatory residents. Next those that require wheelchairs. In the event that the 2nd floor must be evacuated in a fire situation stairwells must be used and ambulatory residents will go down stairwell first. Non-ambulatory residents will be evacuated by stretchers, a 2- person carry method, mattresses or blanket drag... ... medications and treatments will be evacuated and brought to the designated triage area ... the care staff on each unit is responsible for bringing the resident mar paper backups ... During evacuation medications, medication records, resident charts, and portable oxygen tanks will be evacuated with the resident... Ambulance and fire services from the local and surrounding areas, along with area medical	N 358		

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N 358	Continued From page 10 transport vans, bus, and work van companies will be utilized for transporting residents ..." The provider's own evacuation procedure was not adhered to. No local police or fire authorities were notified, no announcement for the evacuation was made, the residents appeared to be unaware of the emergency, resident's legal decision makers were not contacted, residents were not immediately moved out of the building to a safe location, and the staff continued to use phones and the elevator for transportation. The providers evacuation procedure did not address specifics for a gas emergency and their plan included time-consuming delays in exiting the facility such as gathering resident charts and medications. Surveyor interviewed Administrator A and Coordinator B at approximately 2:00 PM. Administrator A stated the resident were informed they needed to be evacuated but had not alerted them or their legal decision makers to the situation being an emergency. Administrator A stated the provider had not notified the police or fire emergency services. When discussing the nature of a gas leak and the directive from the gas professional to evacuate the facility, Administrator A stated s/he didn't realize the resident should have been moved outside immediately. In a subsequent interview on 12/16/1014 at approximately 2:00 PM, Administrator A stated after review of the incident s/he would in the future "bundle the residents up with the available blankets and get them outside immediately." Administrator A stated s/he would be reviewing and revising the evacuation procedures. Cross Reference N0393 DHS 83.35(5)(a) Initial Evaluation Of	N 358		

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N 358	Continued From page 11 Evacuation Limitations N0491 DHS 83.44(2)(c) Interior Floors, Walls And Ceilings N0507 DHS 83.46(1)(f) Combustibles. N0525 DHS 83.47(2)(d) Fire Drills. N0527 DHE 83.47(2)(f) Horizontal Evacuation N0546 DHS 83.48(4)(f) Smoke Detectors In Non-Resident Living Areas N0554 DHS 83.48(6)(e) Integrated Heat Detector In Laundry Room N0649 DHS 83.59(4)(a) Delayed Egress: Only One device Permitted N0637 DHS 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways N0666 DHS 83.59(7)(a) Emergency Egress Lighting Provided N0700 DHS 83.64(5) Smoke Compartments Formed By Smoke Barriers	N 358		
N 393	83.35(5)(a) Initial evaluation of evacuation limitations. Initial evaluation. The CBRF shall evaluate each resident within 3 days of the resident ' s admission to determine whether the resident is able to evacuate the CBRF within 2 minutes in an unsprinklered CBRF and 4 minutes in a sprinklered CBRF without any help or verbal or physical prompting, and what type of limitations that resident may have that prevent the resident from evacuating the CBRF within the applicable period of time. A form provided by the department shall be used for the evaluation. The resident ' s evaluation shall be retained in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview the	N 393		

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provider did not ensure residents were evaluated to determine whether the resident is able to evacuate the CBRF within 4 minutes without any help or verbal or physical prompting. The provider did not ensure department approved forms were implemented.

The facility is licensed to serve up to 75 residents who may be physically disabled, of advance age, emotionally disturbed/ mental illness, and /or irreversible dementia/ Alzheimer's disease.

Findings include:

On 02/12/2024, Surveyor reviewed Resident 1, 2, 3, and 4's records. Four out of four resident records did not contain an evacuation evaluation on the department approved form. Four out of four resident records did not contain an individualized evaluation of the resident evacuation time but instead had a goal time assigned. The residents all had sections in their Individual Service plan (ISP) titled "Evacuation and Emergency Preparedness" and each was given the same goal of 4 minutes to evacuate instead of the required individual evaluation:

Resident 1 (dated 02/06/2024): "Will evacuate to area of designated safety in 4 min [sic] or less once alarm sounds. Will follow staff cueing to keep in safe area. Reviewed. One assist using EZ- stand to transfer into W/C. Hearing impaired deaf in right ear and HOH in left), may need cueing to engage in evacuation."

Resident 2 (dated 08/08/2023): "Will evacuate to area of designated safety in 4 min [sic] or less once alarm sounds."

Resident 3 (dated 08/16/2023): "Will evacuate to

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area of designated safety in 4 min [sic] or less once alarm sounds."

Resident 4 (dated 11/20/2023): "Will evacuate to area of designated safety in 4 min [sic] or less once alarm sounds. Will follow staff cueing to keep in safe area. Reviewed and agreed. Up ad lib using walker. Requires cueing to go to safe place."

Resident 1 and Resident 4 were evaluated to need increased assistance including the use of lifts and/ or cueing but did not reflect if the additional assistance would increase the time it would take for them to evacuate. The provider maintained a goal of evacuation within 4 minutes for both residents instead of the time being based on an accurate evaluation or assessment after an increased need was noted.

On 02/12/2024 at approximately 3:00 PM, Surveyor interviewed Coordinator B with Administrator A present. Coordinator B stated the provider had not been using the Department approved forms and requested review of the associated code. Coordinator B and Administrator a reviewed the applicable code and acknowledged they had not been utilizing the department approved form as was required. After discussion about the emergency evacuation that occurred earlier in the day Administrator A and Coordinator B acknowledged the need for individual evacuation evaluation to be completed and accurately reflect the resident's individual evacuation time and expectations for each resident during an emergency.

Cross Reference
N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment

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	410107	A. BUILDING: _____ B. WING _____	C 02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMME RESIDENTIAL - WITTENBERG	604 WEBB ST WITTENBERG, WI 54499

(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 393	Continued From page 14 N0525 DHS 83.47(2)(d) Fire Drills. N0527 DHE 83.47(2)(f) Horizontal Evacuation N0637 DHS 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways N0649 DHS 83.59(4)(a) Delayed Egress: Only One device Permitted	N 393		
N 491	83.44(2)(c) Interior floors, walls and ceilings. Every interior floor, wall and ceiling shall be clean and in good repair. This Rule is not met as evidenced by: Based on observation and interview the provider did not maintain all floors, walls, and ceiling in good repair. More than 10 areas throughout the basement and first floor of the facility had rooms and corridors where the walls and ceiling had cracks, leaks, holes, open areas from previous works, and areas where piping and/or electrical cords were not securely sealed with fire rated putty. The facility is licensed to serve up to 75 residents who may be physically disabled, of advance age, emotionally disturbed/ mental illness, and /or irreversible dementia/ Alzheimer's disease. Findings include: On 02/07/2024 at approximately 11:40 AM, Surveyor toured the facility accompanied by Administrator A and at times Maintenance Manager E. Surveyor interviewed Administrator A and Maintenance Manager E during the tour. The basement and first floor had over 10 rooms and corridors where the walls and ceiling had cracks, leaks, holes, open areas from previous works, and areas where piping and/or electrical cords	N 491		

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N 491	Continued From page 15	N 491		

were not securely sealed with fire rated putty. (Photos; Electrical: 5, 8, 9, 12, 14,17, 22, 24, 27, 28, 29, 30, 48, 52, 56, 61, 62, 63, 64, 68, 73, 75, 77, 123, 163, 164, 165, and 177; Ceiling 1, 17, 40, 41, 45, 46, 96, 98, 121, 136, 164, 165, 177; walls and floors: 6, 7, 32, 33, 44, 87, 110, 115, 163, 182, 183; leaks: 19, 20 ,21, 40, 47, 51, 52, 54, 55, 58, 59, 60, 62, 63, 70, 74, 79, 87, 89, 92, 102, 121, 135, 163, 164, 165, 174, 181, and 183). The areas of concerns were brought to Administrator A and Maintenance Manager E's attention during the tour. Administrator A acknowledged the areas on the walls, ceilings, and floors that were in need of repair and the areas where the required fire rated putty sealant was required.

On 02/16/2024 at approximately 11:00 AM, Surveyor toured the facility with Administrator A and Board Member C present. Administrator A and Board Member C both acknowledged the walls, ceiling, and floors in need of repair throughout the basement and areas of the first floor.

02/16/2024 at approximately 1:00 PM Surveyor interviewed Administrator A with Board Member C present. Both acknowledged the safety concerns related to the walls, ceiling and floors not being maintained including areas where the fire rated sealant was not applied.

On 02/27/2024 Surveyor received an e-mail at 8:37 AM from Administrator A noting repair on some of the identified areas had begun:

" ... repaired the leak that was found in the resident storage area and are now in the process of repairing the wall that we opened up to make repairs on Homestead.

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N 491	Continued From page 16 The cracks in the concrete walls down in the Terrace level have all been sealed up. The cracks in the ceiling drywall in laundry have been sealed up. Sealed up hole in storage area ceiling with fire caulk. Removed old nursing kiosks in A floor hallway and breakroom, and repaired holes in the wall ..." Cross Reference N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment N0507 DHS 83.46(1)(f) Combustibles. N0527 DHE 83.47(2)(f) Horizontal Evacuation N0546 DHS 83.48(4)(f) Smoke Detectors In Non-Resident Living Areas N0554 DHS 83.48(6)(e) Integrated Heat Detector In Laundry Room N0637 DHS 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways N0700 DHS 83.64(5) Smoke Compartments Formed By Smoke Barriers	N 491		
N 507	83.46(1)(f) Combustibles. Combustible materials shall not be placed within 3 feet of any furnace, boiler, water heater, fireplace or other similar equipment. This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure all combustible materials were at least 3 ft away from a heating source or related equipment. Three areas throughout the basement and first floor of the facility had areas with heating/ electrical equipment that contained combustible material within 3ft. The facility is licensed to serve up to 75 residents	N 507		

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N 507	Continued From page 17 who may be physically disabled, of advance age, emotionally disturbed/ mental illness, and /or irreversible dementia/ Alzheimer's disease. Findings include: On 02/07/2024 at approximately 11:40 AM, Surveyor toured the facility accompanied by Administrator A and at times Maintenance Manager E. Surveyor interviewed Administrator A and Maintenance Manager E during the tour. At approximately 12:45 PM, Surveyors observed a maintenance room that lead to the main boiler room. The ancillary maintenance room contained various chemicals and combustible materials that were haphazardly stored within 3 feet of electrical equipment. The room did not contain smoke detection. The main boiler room was observed to have combustible materials stored within 3 feet of equipment. (Photo 48, 49, 50, 58, 60, 61, and 64). The room contained a gas storage tank that was propped on a diagonal near the boiler. (Photo 53) The room was observed not to have heat or smoke detection. Other sources of combustible materials within 3 feet of heating or other electrical equipment were observed in the maintenance receiving room and air compressor/ ventilation room. On 02/16/2024 at approximately 11:00 AM, Surveyor toured the facility with Administrator A and Board Member C present. Administrator A and Board Member C both acknowledged the combustible materials being stored near heating or electrical equipment throughout the maintenance and building systems areas of the facility.	N 507		

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N 507	Continued From page 18 On 02/16/2024 at approximately 1:00 PM, Surveyor interviewed Administrator A with Board Member C present. Both acknowledged the safety concerns related to combustible storage. Cross Reference N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment N0491 DHS 83.44(2)(c) Interior Floors, Walls And Ceilings N0546 DHS 83.48(4)(f) Smoke Detectors In Non-Resident Living Areas N0554 DHS 83.48(6)(e) Integrated Heat Detector In Laundry Room	N 507		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours.	N 525		

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N 525	Continued From page 19 This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure fire drills were completed as required. The fire drills did not involve the evacuation of the entire facility or participation of each resident and staff member present. The fire drills did not identify residents with evacuations times greater than 4 minutes as the drills conducted were not evacuating the residents. The facility is licensed to serve up to 75 residents who may be physically disabled, of advance age, emotionally disturbed/ mental illness, and /or irreversible dementia/ Alzheimer's disease. Findings include: On 02/12/2024 at approximately 3:00 PM, Surveyor reviewed the providers records including fire drill documentation. Coordinator B gave Surveyor the records that indicated fire drills were performed on 02/02/2023 with an evacuation time of 3.5 minutes, 05/23/2023 with an evacuation time of 7 minutes, 08/22/2023 with an evacuation time of 6 minutes, and 11/27/2023 with an evacuation time of 4 minutes. Coordinator B stated when a fire drill is performed it is not performed for the whole facility but instead a wing of the facility will be selected once annually. Coordinator B gave an example stating an alarm will sound throughout the facility and the staff will wait to hear another staff announce where the fire is located over the speaker system. Coordinator B stated when the alarm initially sounds caregivers on the 2nd floor of the CBRF are expected to go to the fire panel, visualize where the fire alarm was set off in the facility, go to the facility wide speaker system and alert the staff as to where the fire is located. Only the staff in the area that the fire is located for that particular drill	N 525		

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N 525	Continued From page 20 are then expected to relocate only the residents within that section of the facility to a horizontal area of refuge. Coordinator B stated the staff within the wing that is announced are timed on how quickly they can get only the residents of the wing where the fire is detected to the area of refuge. At approximately 3:10 PM, after review of the code requirements, Coordinator B and Administrator A acknowledged the fire drills had not been conducted as required. Both administrators acknowledged the safety risks of not including the entire staff, residents, and facility in each quarterly fire drill, training staff to wait after hearing a fire alarm for an announcement of where the fire is, relying on a caregiver on the second floor to announce the area of fire before evacuation efforts begin, implementing horizontal evacuation that has not been approved by the department, and the existing physical plant deficiencies including the removal of the smoke compartment/ fire rated doors that would allow for a horizontal evacuation. Cross Reference N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment N0393 DHS 83.35(5)(a) Initial Evaluation Of Evacuation Limitations N0527 DHE 83.47(2)(f) Horizontal Evacuation N0700 DHS 83.64(5) Smoke Compartments Formed By Smoke Barriers	N 525		
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	N 527		

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N 527	Continued From page 21	N 527		

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 provide 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, and the smoke/ fire compartments required to implement horizontal evacuation were not maintained.

Findings include:
On 02/07/2024 at approximately 11:40 AM, Surveyor toured the facility accompanied by Administrator A and at times Maintenance Manager E. Surveyor interviewed Administrator A and Maintenance Manager E during the tour. The basement and first floor had multiple hallways that Surveyor observed were listed as exit passageways on the facility emergency exit maps. Surveyor observed at least 2 areas in the basement (located in the main hallway) and at least 4 areas on the first floor (between the main office and the SNF, within the North, South, and end of the memory care hall) where fire rated solid core doors were not present in the corridors. (Photos 2, 3, 4, 35, 101,121, 124, 136, and137). Surveyor observed the fire rated solid core doors required to maintain a smoke compartment had been removed or replaced with hollow core and or vented doors through the basement and areas of the first floor. (Photos 118, 125, 127, 133, 189, and 199). Throughout the tour the removed and/ or replaced doors were brought to Administrator A's attention. Administrator A acknowledged all the passageways and stairwells that required a smoke compartment were not equipped with the

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N 527	Continued From page 22 required doors. On 02/12/2024 at approximately 3:00 PM, Surveyor reviewed the providers records including fire drill documentation and exit diagrams. Surveyor interviewed Coordinator B with Administrator A present. Coordinator B described the facility fire evacuation plan detailing the use of horizontal evacuation in different wings of the facility. Surveyor noted the exit diagrams did not identify internal horizontal exits. Surveyor reviewed a copy of the provider's emergency horizontal evacuation plan. Coordinator B and Administrator A were both unaware the horizontal evacuation required department approval and the approval had not been granted. Both administrators acknowledged the fire rated smoke compartment that would allow for safe horizontal evacuation had been removed and acknowledged the risk to the residents' safety by using unapproved horizontal evacuation as their primary evacuation plan. On 02/16/2024 at approximately 11:00 AM, Surveyor toured the facility with Administrator A and Board Member C present. Administrator A and Board Member C both acknowledged the removal and or replacement of the required doors throughout the basement and areas of the first floor. 02/16/2024 at approximately 1:00 PM, Surveyor interviewed Administrator A with Board Member C present. Both acknowledged the safety concerns related to the lack of smoke compartments due to the removal or replacement of required doors. Both acknowledged they would need to consult with a professional to review the smoke compartment requirements, incorporate the internal horizontal exits into the diagrams, and	N 527		

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N 527	Continued From page 23 seek department approval before implementing horizontal evacuation as part of their emergency plan. Cross Reference N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment N0393 DHS 83.35(5)(a) Initial Evaluation Of Evacuation Limitations N0525 DHS 83.47(2)(d) Fire Drills. N0649 DHS 83.59(4)(a) Delayed Egress: Only One device Permitted N0700 DHS 83.64(5) Smoke Compartments Formed By Smoke Barriers	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 smoke detectors were installed in each habitable room and space where lintels exceed 8 inches throughout the facility. Over 50 rooms in the basement were observed to not have interconnected smoke detectors along with more than 20 other areas in the facility. The facility is licensed to serve up to 75 residents who may be physically disabled, of advance age, emotionally disturbed/ mental illness, and /or irreversible dementia/ Alzheimer's disease.	N 546		

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N 546	Continued From page 24 Findings Include: On 02/07/2024 at approximately 11:40 AM, Surveyor toured the facility accompanied by Administrator A and at times Maintenance Manager E. Surveyor interviewed Administrator A and Maintenance Manager E during the tour. The Community Based Residential Facility (CBRF) is built into a hill resulting in half of the basement being ground level for exit and half of the basement requiring ascension to the first floor to exit at ground level. Additionally, the first floor is half at ground level for exit and half requires descension to the basement to exit at ground level. The second floor has resident bedrooms and common space that was added in 2020. The second floor contained interconnected smoke detection in the resident rooms and common areas. The second floor was directly above the former Skilled Nursing Facility (SNF) space on the first floor and was directly accessible from the SNF space. The CBRF is attached to a SNF that closed in 2022. The SNF space is still open and accessible internally to the residents, visitors, and staff, however the SNF is not staffed, is dark, and no longer in use by residents. The SNF space contained the main kitchen, storage, staff areas, and was openly connected to the CBRF on the first and 2nd floors. The first floor had multiple resident bedroom wings, including a memory care wing, and common space. The basement was located below the main CBRF and the nursing home space. The basement contained rooms with building systems including	N 546		

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the boiler, generator, electrical, air compressors, ventilation, laundry, garbage, and rooms for general storage including resident personal storage, maintenance storage, and building services storage. The basement included areas rented by private businesses such as physical therapy services, a salon, and a thrift store. On 12/12/2024 at approximately 12:30 PM, Administrator A stated the privately rented spaces were patroned by both residents and the public and acknowledged the public had access directly into the CBRF. The basement additionally contained a connected hallway to an apartment complex and a wing for resident inpatient therapy that was no longer in use. (Photo 149).

Surveyor observed over 50 habitable rooms in the basement that were not equipped with smoke detection. (Photos 12, 13, 14, 21, 22, 26, 29, 30, 31, 34, 37, 38, 39, 42, 43, 45, 52, 57, 65, 68, 72, 74, 75, 76, 77, 80, 82, 84, 88, 90, 93, 94, 95, 96, 97, 99, 100, 102, 103, 110, 111, 112, 114, 117, 119, 120, 121, 122, 123, 124, 127, 128, 129, 130, 131, 132, 133, 136, 137, 162, 163, 166, 170, 171, 172, 173, 176, 177, 180, 181, 185, 186, and 189).

At approximately 12:00 PM, Maintenance Manager E confirmed there were rooms that did not contain smoke detection and stated it was his/her belief the rooms had been "grandfathered in" and did not require it. Administrator A entered each room with Surveyor and acknowledged each of the 50 plus rooms did not have smoke detection present.

At approximately 1:00 PM, Surveyor toured the first and 2nd floors of the facility and identified rooms and corridor areas with lintels that exceeded greater that 8 inches that did not have smoke detection. (Photos 201, 203, 204, 206,

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N 546	Continued From page 26 207, 208, 209, 298, and 299). Surveyor observed enclosed stairwells that did not have smoke detection. (Photos 212, 213, 214, 215, and 217). Surveyor observed a room where oxygen tanks were stored and refilled that did not have smoke detection. (Photos 210 and 211). Administrator A acknowledged the multiple areas identified did not have the required smoke detection. On 02/16/2024 at approximately 11:00 AM, Surveyor toured the facility with Administrator A and Board Member C present. Administrator A and Board Member C both acknowledged the multiple rooms and corridors with lintels that exceeded 8 inches, and enclosed stairwells throughout the facility that did not contain smoke detection. On 02/16/2024 at approximately 2:30 PM, Surveyor conducted an exit interview with Administrator A and Board Member C present. Administrator A and Board Member C acknowledged the facility required smoke detection in each habitable room and space with lintels exceeding 8 inches, and enclosed stairwells, and did not have the detection in place for numerous required rooms and spaces. Both administrators acknowledged they would need to consult with a professional to receive exact specifications for the locations of all the smoke detectors that are required throughout the facility. Cross Reference N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment N0491 DHS 83.44(2)(c) Interior Floors, Walls And Ceilings N0507 DHS 83.46(1)(f) Combustibles. N0525 DHS 83.47(2)(d) Fire Drills. N0527 DHE 83.47(2)(f) Horizontal Evacuation	N 546		

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N 546	Continued From page 27 N0554 DHS 83.48(6)(e) Integrated Heat Detector In Laundry Room N0700 DHS 83.64(5) Smoke Compartments Formed By Smoke Barriers	N 546		
N 554	83.48(6)(e) Integrated heat detector in laundry room. CBRFs shall have at least one heat detector integrated with the smoke detection system at all of the following locations or in accordance with the heat detector manufacturer ' s specifications: Laundry room. This Rule is not met as evidenced by: Based on observation, record review, and interview the provider did not ensure heat detectors were installed in each required space in the facility. Three rooms were observed to not have heat detection. The facility is licensed to serve up to 75 residents who may be physically disabled, of advance age, emotionally disturbed/ mental illness, and /or irreversible dementia/ Alzheimer's disease. Findings Include: On 02/07/2024 at approximately 11:40 AM, Surveyor toured the facility accompanied by Administrator A and at times Maintenance Manager E. Surveyor interviewed Administrator A and Maintenance Manager E during the tour. At approximately 12:00 PM, Surveyor entered an attached garage "receiving room" in the basement that had a large garage style door. Surveyor observed no heat detector was present in the room. (Photos 69, 71, 174, and 175). Maintenance Manager E and Administrator A	N 554		

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N 554	Continued From page 28	N 554		

acknowledged heat detection was required in all kitchens, attached garages, enclosed compartments of the attic, furnace rooms, and laundry rooms. Maintenance Manager A confirmed there were rooms that did not contain heat detection and stated it was his/her belief the rooms had been "grandfathered in" and did not require it. At approximately 12:10 PM, Surveyor observed 2 laundry rooms that were not equipped with heat detection. (Photos 46 and 47). Administrator A entered each room with Surveyor and acknowledged both of the laundry rooms did not have heat detection present.

On 02/16/2024 at approximately 11:00 AM, Surveyor toured the facility with Administrator A and Board Member C present. Administrator A and Board Member C both acknowledged the rooms within the facility that did not contain heat detection.

On 02/16/2024 at approximately 2:30 PM, Surveyor conducted an exit interview with Administrator A and Board Member C present. Administrator A and Board Member C acknowledged the facility required heat detection in each kitchen, attached garage, enclosed compartments of the attic, furnace room, and laundry room and did not have the detection in place for numerous required rooms and spaces. Both administrators acknowledged they would need to consult with a professional to receive exact specifications for the locations of all the heat detectors that are required throughout the facility.

Cross Reference
N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment
N0491 DHS 83.44(2)(c) Interior Floors, Walls And

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N 554	Continued From page 29 Ceilings N0507 DHS 83.46(1)(f) Combustibles. N0525 DHS 83.47(2)(d) Fire Drills. N0527 DHE 83.47(2)(f) Horizontal Evacuation N0546 DHS 83.48(4)(f) Smoke Detectors In Non-Resident Living Areas N0700 DHS 83.64(5) Smoke Compartments Formed By Smoke Barriers	N 554		
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 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 all exits were maintained clear and	N 637		

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N 637	Continued From page 30	N 637		

unobstructed at all times. Surveyor observed 4 exits that were obstructed by the force required to open the door, had debris in the pathway, and /or had cement that had shifted creating a bump that would be difficult for residents with limited mobility to negotiate.

The facility is licensed to serve up to 75 residents who may be physically disabled, of advance age, emotionally disturbed/ mental illness, and /or irreversible dementia/ Alzheimer's disease. Findings Include:

On 02/07/2024 at approximately 11:40 AM, Surveyor toured the facility accompanied by Administrator A and at times Maintenance Manager E. Surveyor interviewed Administrator A and Maintenance Manager E during the tour. Administrator A stated there were areas in the basement of the building that resident frequent including therapy services, the salon, and a thrift store. Administrator A acknowledged all exits in the facility had the potential for residents who had limited strength and/ or difficulty with ambulation to utilize in an emergency.

During the tour surveyor observed 4 exist that were not maintained clear and unobstructed:

-Surveyor observed a first-floor exit within a stairwell leading from the 2nd floor to the former nursing home and out to the NW side ground level. Surveyor observed the door had multiple cobwebs by the exit push bar and appeared to be rusted. (Photo 142). When Surveyor attempted to open the exit, it initially appeared to be locked. Administrator A stated the door was not supposed to be locked. Great force had to be applied to the door to get it to open. Administrator A acknowledged the force required to open the door

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would be difficult for residents with limited strength to negotiate.

-Surveyor observed an exit door in the basement leading out to the North side facility dumpsters that had to have great force applied before it would open. (Photo160). Administrator A acknowledged the force required to open the door would be difficult for residents with limited strength to negotiate.

-Surveyor observed a basement exit door within a stairwell leading to the first floor on the E side of the building near Maintenance Manager E's office. The door led outside to a slab of cement that had an approximate 2-inch bump. (Photos 168 and 169). Administrator A acknowledged the bump would be difficult for residents with limited mobility to negotiate.

-Surveyor observed an exit leading from the first floor café area. The exit had debris on the exterior passageway. (Photo 200). Administrator A acknowledged the path needed to be cleared of debris.

On 02/07/2024 at approximately 3:00 PM, Surveyor interviewed Administrator A. Administrator A acknowledged the safety concerns related to not maintaining clear and unobstructed exits.

Cross Reference
N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment
N0393 DHS 83.35(5)(a) Initial Evaluation Of Evacuation Limitations
N0491 DHS 83.44(2)(c) Interior Floors, Walls And Ceilings
N0649 DHS 83.59(4)(a) Delayed Egress: Only

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N 637	Continued From page 32 One device Permitted N0666 DHS 83.59(7)(a) Emergency Egress Lighting Provided	N 637		
N 649	83.59(4)(a) Delayed egress: only one device permitted Delayed egress door locks are permitted with department approval only in facilities with a supervised automatic fire sprinkler system and a supervised interconnected automatic fire detection system and shall comply with all of the following: No more than one device shall be present in a means of egress. This Rule is not met as evidenced by: Based on observation, record review, and interview the provider did not ensure egressed doors were approved by the Department prior to installation, did not ensure there was no more than 1 device present in means of egress, and did not ensure each was equipped with a sign indicating how the door can be unlocked. The facility is licensed to serve up to 75 residents who may be physically disabled, of advance age, emotionally disturbed/ mental illness, and /or irreversible dementia/ Alzheimer's disease. Findings Include: Surveyor reviewed the provider's records and noted the provider reached out to obtain approval for delayed egress doors in 2010 and again on 07/19/2021. The provider received preliminary	N 649		

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approval from the North Eastern Regional Office. The provider was then required to submit their plan to the Office of Plan Review and Instruction (OPRI) for final approval. The record did not contain documentation of submission to OPRI or documentation of final approval.

On 02/07/2024 at approximately 11:40 AM, Surveyor toured the facility accompanied by Administrator A and at times Maintenance Manager E. Surveyor interviewed Administrator A and Maintenance Manager E during the tour. The Community Based Residential Facility (CBRF) is built into a hill resulting in half of the basement being ground level for exit and half of the basement requiring ascension to the first floor to exit at ground level. Additionally, the first floor is half at ground level for exit and half requires descension to the basement to exit at ground level.

The second floor of the CBRF, located above the former SNF, has resident bedrooms and common space that was added in 2020 and had exit doors equipped with delayed egress. The second floor was directly above the former Skilled Nursing Facility (SNF) space on the first floor and was directly accessible from the SNF space.

The CBRF is attached to the SNF that closed in 2022. The SNF space is still open and accessible internally to the residents, visitors, and staff, however the SNF is not staffed, is dark and no longer in use by residents. The SNF space contained the main CBRF kitchen, storage, staff areas, and was openly connected to the CBRF on the first and 2nd floors.

The first floor of the CBRF had 4 resident bedroom wings, including a memory care wing,

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and common space. The first floor had exit doors equipped with delayed egress that lead from one area of the CBRF into another area.

The basement was located below the main CBRF and the nursing home space. The basement contained rooms with building systems utilized by the CBRF including the boiler, generator, electrical, air compressors, ventilation, laundry, garbage, and rooms for general storage including resident personal storage, maintenance storage, and building services storage. The basement included areas rented by private businesses such as physical therapy services, a salon, and a thrift store. On 12/12/2024 at approximately 12:30 PM, Administrator A stated the privately rented spaces were patroned by both residents and the public and acknowledged the public had access directly into the CBRF. The basement additionally contained a connected hallway to an apartment complex and a wing for resident inpatient therapy that was no longer in use. One of the emergency egress paths leads into a common space with laundry facilities that is not locked and is used by the apartment renters. The basement had some exit doors that were equipped with delayed egress. Surveyor observed all delayed egress exit doors were listed as exits on the provider's emergency exit maps.

At approximately 11:50 AM Surveyor engaged a delayed egress door in the main common space on the second floor. The door led to an internal stairwell. The stairwell led down to the first floor where there was a locked door that was only accessible by pressing a release button approximately 5 ft high. (Photo 146). Surveyor continued down the exit path of the stairwell to the basement floor. The immediate exit signs led to an internal lighted exit door equipped with a

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2nd delay egress. (Photo 148). The door led to an apartment complex hallway and final lighted exit door to the outside ground level. (Photo 150). Administrator A acknowledged there were 2 delay egress doors in the direct exit path.

At approximately 11:55 AM, Surveyor was in the basement main hall and observed exit signs leading to a lighted external exit that was located within the human resources office. (Photos 238 and 152). The office was equipped with a door that could be locked so the lighted exit door to the outside was inaccessible. Administrator A acknowledged if the office door was locked the exit would be inaccessible.

At approximately 12:30 PM, Surveyor observed a door within the memory care common room that led directly to the main CBRF common space was blocked by a table and chair. Administrator A stated the door is frequently blocked by the chair. Surveyor observed the lighted exit main entrance to the memory care unit was a locked door that required a staff badge to open. (Photos 133 and 189). Once opened, the exit path led to a common space dining area and a secondary facility entrance that were both equipped with delayed egress doors causing a 2nd delay in the exit path. Administrator A acknowledged exiting the secured internal memory care door, or chair blocked door, followed by either of the delayed egress doors caused a second delay in exiting the facility.

At approximately 12:33 PM, Surveyor toured the memory care wing and observed a delayed egress door leading from the memory care sunroom to a set of concrete steps outside. (Photos 191,198, 196, and 195). The instructions for door operations were not present. (Photo

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N 649	Continued From page 36 197). Administrator A acknowledged the sign indicating how to access the egressed door was not present. On 02/16/2024 at approximately 11:00 AM, Surveyor toured the facility with Administrator A and Board Member C present. Administrator A and Board Member C both acknowledged the multiple delayed egress exits throughout the facility that caused secondary delays in the path to exit the facility. On 02/16/2024 at approximately 1:00 PM, Surveyor interviewed Administrator A with Board Member C present. Both acknowledged the safety concerns related to the exit paths with delayed egress doors and secondary delays. Administrator A and Board Member C were both unaware the egressed doors had not been approved by the Department. Both acknowledged they would need to consult with a professional to review the delayed egress and exit plans and submit for department approval. Cross Reference N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment N0393 DHS 83.35(5)(a) Initial Evaluation Of Evacuation Limitations N0525 DHS 83.47(2)(d) Fire Drills. N0527 DHE 83.47(2)(f) Horizontal Evacuation N0637 DHS 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways	N 649		
N 666	83.59(7)(a) Emergency egress lighting provided All exit passageways and stairways shall be provided with emergency egress lighting with a stand-by power source.	N 666		

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N 666	Continued From page 37 This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure emergency egress lighting with a stand-by power source was present in all exit passageways and stairwells. All hallways and stairwells used for exit in the basement and first floor level were not equipped with emergency lighting. The facility is licensed to serve up to 75 residents who may be physically disabled, of advance age, emotionally disturbed/ mental illness, and /or irreversible dementia/ Alzheimer's disease. Findings Include: On 02/07/2024 at approximately 11:40 AM, Surveyor toured the facility accompanied by Administrator A and at times Maintenance Manager E. Surveyor interviewed Administrator A and Maintenance Manager E during the tour. The facility is built into a hill resulting in half of the basement being ground level for exit and half of the basement requiring ascension to the first floor to exit at ground level. Additionally, the first floor is half at ground level for exit and half requires descension to the basement to exit at ground level. The second floor has resident bedrooms and common space that had been renovated in 2020. The second floor was directly below the former nursing home space on the first floor and was directly accessible from the nursing home space. The first floor had 4 resident bedroom wings, including a memory care wing, and common space. The first floor also had a nursing home space that was no longer in use by residents but was openly connected to the CBRF on the first and 2nd floors. The basement was located below the main CBRF and the nursing home space. The basement included areas	N 666		

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rented by private businesses, contained a connected hallway to an apartment complex, and a wing for resident inpatient therapy that was no longer in use.

The basement and first floor had multiple hallways that Surveyor observed were listed as exit passageways on the facility emergency exit maps. (Photos 36, 187, and 190). Surveyor observed no emergency exit lighting was present in the basement corridors and stairwells used for exit. (Photos 154, 156, 158, 204, 208, 212, and 299). Surveyor observed multiple areas on the first floor where emergency lighting was not present in the exit corridors and exits. Throughout the tour the lack of emergency lighting was brought to Administrator A's attention. Administrator A acknowledged the passageways and stairwells were not equipped with the require emergency lighting.

On 02/16/2024 at approximately 11:00 AM, Surveyor toured the facility with Administrator A and Board Member C present. Administrator A and Board Member C both acknowledged the lack of emergency lighting throughout the basement and areas of the first floor.

On 02/16/2024 at approximately 1:00 PM Surveyor interviewed Administrator A with Board Member C present. Both acknowledged the safety concerns related to the lack of emergency lighting. Both acknowledged they would need to consult with a professional to review the emergency lighting and exit plans.

Cross Reference
N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment
N0525 DHS 83.47(2)(d) Fire Drills.

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N 666	Continued From page 39 N0527 DHE 83.47(2)(f) Horizontal Evacuation N0546 DHS 83.48(4)(f) Smoke Detectors In Non-Resident Living Areas N0554 DHS 83.48(6)(e) Integrated Heat Detector In Laundry Room N0637 DHS 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways N0649 DHS 83.59(4)(a) Delayed Egress: Only One device Permitted	N 666		
N 700	83.64(5) Smoke compartments formed by smoke barriers All CBRF with a license capacity of 9 or more residents shall have smoke compartments formed by smoke barriers in accordance with s. Comm 61. This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure the facility was equipped with smoke compartments maintained by required smoke barriers. Fire rated solid core doors between compartments were removed or replaced with nondescript hollow core and/ or vented doors. Findings include: On 02/07/2024 at approximately 11:40 AM, Surveyor toured the facility accompanied by Administrator A and at times Maintenance Manager E. Surveyor interviewed Administrator A and Maintenance Manager E during the tour. The Community Based Residential Facility (CBRF) is built into a hill resulting in half of the basement being ground level for exit and half of the basement requiring ascension to the first floor to	N 700		

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HOMME RESIDENTIAL - WITTENBERG	604 WEBB ST WITTENBERG, WI 54499

(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 700	Continued From page 40	N 700		

exit at ground level. Additionally, the first floor is half at ground level for exit and half requires descension to the basement to exit at ground level.

The second floor has resident bedrooms and common space that was added in 2020. The second floor contained interconnected smoke detection in the resident rooms and common areas. The second floor was directly above the former Skilled Nursing Facility (SNF) space on the first floor and was directly accessible from the SNF space.

The CBRF is attached to a SNF that closed in 2022. The SNF space is still open and accessible internally to the residents, visitors, and staff, however the SNF is not staffed, is dark, and no longer in use by residents. The SNF space contained the main CBRF kitchen, storage, staff areas, and was openly connected to the CBRF on the first and 2nd floors.

The first floor had 4 resident bedroom wings, including a memory care wing, and common space in the CBRF.

The basement was located below the main CBRF and the nursing home space. The basement contained rooms with building systems including the boiler, generator, electrical, air compressors, ventilation, laundry, garbage, and rooms for general storage including resident personal storage, maintenance storage, and building services storage. The basement included areas rented by private businesses such as physical therapy services, a salon, and a thrift store. The basement additionally contained a connected hallway to an apartment complex and a wing for resident inpatient therapy that was no longer in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410107	A. BUILDING: _____ B. WING _____	C 02/27/2024

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N 700	Continued From page 41 use. The basement and first floor had multiple hallways that Surveyor observed were listed as exit passageways on the facility emergency exit maps. Surveyor observed at least 2 areas in the basement (located in the main hallway) and at least 4 areas on the first floor (between the main office and the SNF, within the North, South, and end of the memory care hall) where fire rated solid core doors were not present in the corridors. (Photos 2, 3, 4, 35, 101,121, 124, 136, and137). Surveyor observed the fire rated solid core doors required to maintain a smoke compartment had been removed or replaced with nondescript hollow core and/or vented doors through the basement and areas of the first floor. (Photos 118, 125, 127, 133, 189, and 199). Areas that were once established as Point of Rescue platforms in the facility were no longer fire rated and had doors to the rest of the facility either removed or were hollow with vent panels. Throughout the tour the removed and or replaced doors were brought to Administrator A's attention. Administrator A acknowledged all the passageways and stairwells that required a smoke compartment were not equipped with the required doors. On 02/16/2024 at approximately 11:00 AM, Surveyor toured the facility with Administrator A and Board Member C present. Administrator A and Board Member C both acknowledged the removal and/or replacement of the required doors throughout the basement and areas of the first floor. 02/16/2024 at approximately 1:00 PM, Surveyor interviewed Administrator A with Board Member C present. Both acknowledged the safety concerns	N 700		

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N 700	Continued From page 42 related to the lack of smoke compartments due to the removal or replacement of required doors. Both acknowledged they would need to consult with a professional to review the smoke compartment requirements. Cross Reference N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment N0491 DHS 83.44(2)(c) Interior Floors, Walls And Ceilings N0507 DHS 83.46(1)(f) Combustibles. N0525 DHS 83.47(2)(d) Fire Drills. N0527 DHE 83.47(2)(f) Horizontal Evacuation N0546 DHS 83.48(4)(f) Smoke Detectors In Non-Resident Living Areas N0554 DHS 83.48(6)(e) Integrated Heat Detector In Laundry Room N0637 DHS 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways N0649 DHS 83.59(4)(a) Delayed Egress: Only One device Permitted	N 700		