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 _____	R-C 03/04/2025

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 000}	Initial Comments On 02/11/2025 and 02/19/2025, Surveyor conducted a verification visit and 2 complaint investigations at Homme Residential Wittenberg. Additional information was collected through 03/04/2025. One complaint was substantiated and resulted in 1 identified deficient practice. As a result of the verification visit, 8 additional deficient practices were identified. The survey resulted in the identification of 9 deficient practices total; 5 of 9 were repeat violations. Under statutory provisions, a $200 revisit fee is being assessed for the follow-up licensing visit. Census: 38	{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 licensee did not ensure all the Community Based Residential Facility (CBRF) and its operation complied with all laws governing the CBRF. 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. At the time of the Survey on 02/11/2025 - 03/04/2025, the census was 38. Findings include:	N 196		

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

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N 196	Continued From page 1	N 196		

Surveyor reviewed the providers history noting the CBRF is overseen by a community board. The board selected the Board President (Licensee M) to be the licensee on 03/20/2024. On 05/01/2024 the provider received the Statement of Deficiency (SOD) Y5HZ11 (dated 02/27/2024) and enforcement orders:

"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:

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
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
N0666 DHS 83.59(7)(a) Emergency Egress Lighting Provided
N0700 DHS 83.64(5) Smoke Compartments Formed By Smoke Barriers."

"ORDER TO COMPLY WITH REQUIREMENTS

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N 196	Continued From page 2 1. Pursuant to Wis. Stat. § 50.03(5g)(b)3., effective immediately, the licensee shall comply with the requirements specified by Wis. Stat. ch. 50 and Wis. Admin. Code ch. DHS 83 that establish the standards for the operation of the Community Based Residential Facility in order to protect and promote the health, safety and welfare of the residents. AS SOON AS PRACTICABLE AND WITHOUT DELAY, within 45 days of receipt of this notice, the licensee shall achieve and maintain substantial compliance with all requirements. All operational and resident records required as evidence of compliance with applicable rules will be available to department representatives upon request ... ORDER NOT TO ADMIT NEW OR ADDITIONAL RESIDENTS Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b)7., EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Homme Residential Wittenberg NOT ADMIT ANY NEW OR ADDITIONAL RESIDENTS until all violations in Statement of Deficiency Y5HZ11 are corrected, compliance is verified by the Department, and this Order is rescinded in writing. SPECIAL ORDERS Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Homme Residential Wittenberg:	N 196		

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N 196	Continued From page 3 1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., the licensee shall develop and implement corrective measures to achieve compliance with requirements specified by Wis. Admin. Code § DHS 83.48(4)(f) and ensure an integrated smoke detector is installed in all required locations. The licensee will obtain the installation of any needed upgrades to the integrated smoke and heat detection system in order to meet the requirements specified by Wis. Admin. Code ch. DHS 83. Department approval is required before installing a smoke and heat detection system. WITHIN 45 DAYS of receipt of this notice, the licensee shall submit plans for review of any needed upgrades to the integrated smoke and heat detection system to the Office of Plan Review and Inspection (OPRI). The licensee will retain documentation to evidence OPRI completed the plan review and approved of the proposed changes to the existing smoke and heat detection system. Additionally, the licensee will obtain documentation from the service contractor to verify effective operation of the system after completion of the approved scope of work. This documentation will be maintained at the facility and made available to department representatives upon request. 2. Pursuant to Wis. Stat. §§ 50.03(5g)(b)3. and (b)6., effective immediately, the licensee will comply with all requirements specified by Wis. Admin. Codes § 83.59(4) (a). That is, no more than one delayed egress door device shall be present in a means of egress. Any changes, additions or upgrades to an existing delayed egress system will require review by the Office of Plan Review and Inspection (OPRI).	N 196		

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N 196	Continued From page 4 Pending full compliance with requirements specified by Wis. Admin. Codes §§ 83.59(4)(a)-(f), the licensee will implement all necessary measures to ensure the safety of residents. These measures will be detailed in a written procedure. All managers and caregivers will receive in-service training regarding the written policy/procedure. Documentation of training will be maintained in employee files and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content." On 06/26/2024 the provider requested and was granted a 6-month extension for the enforcement order completion ending on 11/01/2024. On 02/11/2025 and 02/19/2025, Surveyor conducted a verification visit and 2 complaint investigations at Homme Residential Wittenberg. Additional information was collected through 03/04/2025. As part of the survey process, Surveyor observed the building, residents, and staff during the tours, conducted multiple interviews including interviews with Administrator A, Board Member I and R, Maintenance L, Licensee M, and RN K, as well as reviewed resident and employee files and the provider's records, including physical plant, fire and emergency systems, and a binder that Administrator A stated contained the provider's plan of correction. The plan of correction included narrowing the licensed space within the building which resulted in citations N0507 DHS 83.46(1)(f) Combustibles, N0546 DHS 83.48(4)(f) Smoke Detectors In Non-Resident Living Areas, N0554 DHS 83.48(6)(e) Integrated Heat Detector In	N 196		

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N 196	Continued From page 5 Laundry Room, N0666 DHS 83.59(7)(a) Emergency Egress Lighting Provided, and N0700 DHS 83.64(5) Smoke Compartments Formed By Smoke Barriers to be corrected by default as their plan of correction proposed the areas that contained these deficient practices no longer be included in the licensed spaces. N0393 DHS 83.35(5)(a) Initial Evaluation Of Evacuation Limitations and N0525 DHS 83.47(2)(d) Fire Drills were the only 2 citations that were verified as corrected by means of the provider making corrective measures. The survey also revealed prior to submitting a plan of correction for approval to narrow the licensed space within the facility, the provider installed smoke detection systems within the building without BAL or OPRI approval as is required and was directed in the Enforcement Special Orders. Additionally, the provider did not complete all corrections within the extended 6-month correction period. The correction period ended on 11/01/2025 and the provider submitted plans for correction and information to OPRI on 12/11/2024 as it had not been completed within the extended timeframe. One of two complaints investigated from 02/11/2025 through 03/04/2025 was substantiated and the following 9 deficient practices were identified, including 5 repeat violations, all containing cross references: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws Based on observation, interview, and record review, the licensee did not ensure all the Community Based Residential Facility (CBRF) and its operation complied with all laws governing the CBRF. N0320 DHS 83.29(4) Admission Agreement Not	N 196		

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N 196	Continued From page 6 In Conflict Based on record review and interview the provider did not ensure all statements in the admission agreement were in compliance with Chapter 83. The admission agreement contained approximately 24 areas that were not congruent with resident rights as defined in Chapter 83. N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment 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 the emergency evacuation system, emergency horizontal evacuation plans that were unapproved and required residents to evacuate through unlicensed spaces without a waiver, breeches in the 2 hour fire wall in need of repair, fire detection and suppression systems that were not installed in required areas or had detection devices installed that were not equipped with the necessary aid features for the population served, barriers to exiting the facility including unapproved delayed egress doors, double barriers to exit, and unmaintained outdoor exits and pathways. This is a repeat deficient practice. (See Statement of Deficiency (SOD) SOD Y5HZ11, dated 02/27/2024.) N0454 DHS 83.42(1) Resident Record Maintained Based on Record review and interview the provider did not ensure Resident 1's record consistently described the resident's condition during a significant change in condition, and the provider's response, including documentation of	N 196		

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N 196	Continued From page 7 all health monitoring provided. N0491 DHS 83.44(2)(c) Interior Floors, Walls And Ceilings 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. This is a repeat deficient practice. (See Statement of Deficiency (SOD) SOD Y5HZ11, dated 02/27/2024.) N0527 DHE 83.47(2)(f) Horizontal Evacuation 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) SOD Y5HZ11, dated 02/27/2024.) N0547 DHS 83.48(4)(g) Smoke Detectors Where Lintels Exceed 8 Inches Based on observation, record review, and interview, the provider did not ensure smoke detection was installed in at least 50 compartments on the ceiling where lintels exceeded 8 inches. N0637 DHS 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways	N 196		

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N 196	Continued From page 8 Based on observation and interview the provider did not ensure all exits were maintained clear and unobstructed at all times. Surveyor observed an exit with ice and hazardous icicles in the pathway, and a ramp that was installed at an exit that was more than one foot of rise in 12 feet of run and was not at least 4 ft wide. This is a repeat deficient practice. (See Statement of Deficiency (SOD) SOD Y5HZ11, dated 02/27/2024.) N0649 DHS 83.59(4)(a) Delayed Egress: Only One Device Permitted Based on observation, record review, and interview the provider did not ensure delayed egress doors were approved by the Department prior to installation, did not ensure there was no more than 1 device present in means of egress. This is a repeat deficient practice. (See Statement of Deficiency (SOD) SOD Y5HZ11, dated 02/27/2024.) Cross Reference N0320 DHS 83.29(4) Admission Agreement Not In Conflict N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment N0454 DHS 83.42(1) Resident Record Maintained N0491 DHS 83.44(2)(c) Interior Floors, Walls And Ceilings N0527 DHE 83.47(2)(f) Horizontal Evacuation N0547 DHS 83.48(4)(g) Smoke Detectors Where Lintels Exceed 8 Inches N0637 DHS 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways N0649 DHS 83.59(4)(a) Delayed Egress: Only One Device Permitted	N 196		

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N 320	83.29(4) Admission agreement not in conflict Conflict with this chapter. No statement of the admission agreement may be in conflict with any part of this chapter, unless the department has granted a waiver or variance of a provision of this chapter. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure all statements in the admission agreement were in compliance with Chapter 83. The admission agreement contained areas that were not congruent with resident rights as defined in Chapter 83. Findings include: On 02/07/2024-02/27/2024 Surveyor conducted 4 complaint investigations and a standard survey. As part of the survey process Surveyor reviewed the admission agreement and identified statements within the document that were not congruent with resident rights and required removal or modification of the language to be in compliance with the code. Examples of statements/ rules that were identified as not in compliance with the code: " ...Guidelines for Admission, Retention and Discharge: g) Refuses or is unable to comply with a prescribed treatment program ... GRIEVANCE PROCEDURES AND RESIDENT RIGHTS Grievances and/or complaints must be submitted in writing and signed by the resident or the person filing the grievance or complaint on behalf of the resident ...	N 320		

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N 320	Continued From page 10 6. For a resident's personal safety, the accumulation of newspapers, magazines, and plastic items such as plastic flowers is not permitted ... 7. Certain items are considered health hazards and may not be kept in the room per state code. a. Aerosol cans ... c. Nail polish and remover ... e. Knives ... 9. Food preparation in the room is not permitted ... Any foods brought in must be checked at the nursing station. This requirement is to assure proper storage and to assist in following the resident's diet restrictions ..." On 02/16/2024 at approximately 2:30 PM, Surveyor conducted an exit interview with Administrator A and Board Member C present. Surveyor reviewed the identified statements within the admission agreement with Administrator A who verified his/her understanding of why the areas identified needed to be modified or removed. Administrator A stated the changes would be made and the admission agreements updated to reflect the changes. On 02/11/2025 and 02/19/2025 Surveyor was present at the facility for 2 complaint investigations and a verification visit. On 02/19/2024 at approximately 3:30 PM, Administrator A gave Surveyor a binder which s/he identified as the provider's current plan of correction. Surveyor reviewed the admission agreement contained within and noted statements previously identified as needing to be	N 320		

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N 320	Continued From page 11 corrected had not been corrected. On 02/26/2025 at 1:39 PM, Surveyor interviewed Administrator A. Administrator A recalled reviewing the statements that had been identified during the previous survey as in conflict with Chapter 83 and stated s/he believed s/he and a former employee had modified the statements in question. Surveyor reviewed the areas identified that had not been modified. Administrator A was unable to state why the changes had not been made and requested to review the identified areas again. On 02/27/2025 at approximately 3:00 PM, Surveyor reviewed the admission agreement and house rules with Administrator A and RN K. Administrator A and RN K stated they had no questions and were in agreement that the statements identified needed to be modified or removed. Cross Reference N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 320		
{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.	{N 358}		

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{N 358}	Continued From page 12 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 the emergency system, emergency egress, and fire detection and suppression systems that were not installed in required areas or had detection devices installed that were not equipped with the necessary aid features for the population served. This is a repeat deficient practice. (See Statement of Deficiency (SOD) SOD Y5HZ11, dated 02/27/2024.) 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: Enforcement for the previous SOD Y5HZ11 included an order not to admit any new residents and to conduct hourly fire watches through the facility. During an interview with Administrator A on 02/19/2024 at approximately 2:00 PM, Administrator A stated the building, including all licensed CBRF spaces, 2 hour fire wall areas surrounding the licensed spaces, and the CBRF's building systems, was so large that the provider had to have a staff member continually walk through the building for the hourly fire watches, as by the time it took to complete 1 check, the next hour would begin. Facility Layout The Community Based Residential Facility	{N 358}		

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{N 358}	Continued From page 13	{N 358}		

(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 staff accessible from the SNF space.

The CBRF is attached to a SNF that closed in 2022. The 1st floor SNF space is still open and accessible (open hallway with no doors or other separation) internally to the staff, however the SNF is not staffed, is dark and no longer in use, besides housing the main kitchen. The SNF space contained the main CBRF kitchen, storage, staff areas, and was connected to the CBRF on the first and 2nd floors.

The first floor licensed CBRF area had a main entrance with staff offices and a chapel, and 4 resident bedroom wings, including a secured 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 personal storage, maintenance storage, and building services storage. The basement included areas previously rented by private businesses such as physical therapy services, a salon, and a

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{N 358}	Continued From page 14 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 use. General Findings: On 02/11/2025 at approximately 1:15 PM, Surveyor toured the facility with Administrator A, state Office of Plan Review and Inspection (OPRI) Architect J (OPRI Architect J), Security Services Technicians O and P (SST O, SST P,) and Board Member and former Maintenance Director I (BM I.) Licensee M, and Board Member N (BM N) joined the tour at approximately 2 PM. Surveyor interviewed Administrator A and BM I throughout the tour. Egress During the tour on 02/11/2025, Surveyor observed an internal delayed egress door between the memory care and other CBRF space that had not been approved by the Department. Surveyor observed the delayed egress door did not function correctly. After 15 seconds of engaging the door, the lock did not disengage. This occurred during the previous survey and had been identified in SOD Y5HZ11, dated 02/27/2024. For greater than a year after it had been identified as in need of repair, the unapproved delayed egress door was left unrepaired. In the event of an emergency the residents in the memory care unit only had 1 exit leading directly to external stairs that were observed to be obstructed by ice and icicles during the tour, with no areas of refuge, as a means of egress during an emergency. Both Administrator A and BM I acknowledged the delayed egress had been unapproved, was still not functioning correctly, and caused a great risk to the safety of the residents.	{N 358}		

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{N 358}	Continued From page 15 The requirements were reviewed during the exit interview on 03/04/2025 at 11:00 AM with Administrator A, RN K, Licensee M, Maintenance L, and Board Members N, R, and S. Smoke Detection and Suppression On 02/19/2025 at approximately 10:00 AM, Surveyor toured the facility with Administrator A and Maintenance Person (Maintenance L.) Surveyor interviewed Administrator A and Maintenance L during the tour. Surveyor observed more than 18 habitable rooms and spaces with lintels exceeding 8 inches in the first floor CBRF that were not equipped with smoke detection and/ or heat detection. Administrator A entered each room with Surveyor and acknowledged each of the spaces that did not have smoke and/ or heat detection present. On 03/06/2025 at 1:37 PM, Surveyor interviewed SST O. SST O stated upon inspection of the licensed CBRF area, it was observed that the required smoke detectors that were present throughout the area, including 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 which is a common characteristic of the population served. Additionally, it was noted the bedrooms contained closet spaces that qualified them for requiring fire suppression (sprinklers) and/or smoke detection and did not have the detection and/or suppression systems installed. SST O estimated the licensed CBRF space was missing over 80 required devices. Areas without smoke detection/ and or sprinklers	{N 358}		

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{N 358}	Continued From page 16	{N 358}		

that are required to have it and the horn and strobe features the current installed detectors lack were reviewed during the exit interview on 03/04/2025 at 11:00 AM with Administrator A, RN K, Licensee M, Maintenance L, and Board Members N, R, and S.

Emergency System
During the tour on 02/11/2025, Surveyor observed the fire panel was located on the 1st floor in the unlicensed SNF space in a locked maintenance room. Surveyor observed a fire station on the 2nd floor located within an open charting area that is located within and open to the common area. The station was accessible to passersby when not within caregiver's visual control. (Photos 9 and 10.) Surveyor observed an access key was left sitting in the keyhole of the annunciator box while the touch screen displaying the facility map had a handwritten sign, "DO NOT TURN OFF."

Surveyor reviewed the emergency plans and interviewed Administrator A. Administrator A summarized when the fire alarm goes off throughout the facility, a caregiver on the 2nd floor has to go to the fire station, get on to a phone to access the facility wide intercom system, and announce where the fire is located to staff members throughout the building. The staff members then respond by going to the area of the fire to verify if it is a fire or not, and then have to get on the phone or walkie-talkie and respond back to the person on the second floor. The person on the 2nd floor will then announce on the intercom throughout the building if the fire is real or not, which will then notify residents if they should respond to the alarm they're hearing. If it is a false alarm, maintenance or an administrator has to go into the SNF locked maintenance room

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{N 358}	Continued From page 17 and disarmed the alarm. Administrator A could not state what components of the system could be accessed/ disengaged from the second-floor fire station. Administrator A could not state what would happen if the monitor was turned off (as is identified by their sign in the picture) or if the key to the annunciator box is always kept in the keyhole (as pictured.) Administrator A acknowledged when not within caregiver's visual control the fire station could be accessed by passersby. The regulations including Chapter 83's reference to NFP 72 and I NBC 10/10 were reviewed. Per interview with OPRI Architect J on 03/03/2025 at approximately 2:00 PM and SST O on 03/06/2025 at 1:37 PM, the emergency response plan is considered a voluntary emergency plan which requires the fire monitoring systems to be continually secured against unauthorized access and continually monitored by a trained personnel. Additionally, this type of system requires the communication lines to meet pathway survivability standards with two-hour fire rated protection for the wires. SST O stated after observing the emergency fire system, it was "highly unlikely" the system lines met the pathway of survivability standards. SST O stated concerns regarding the residents waiting after they hear the fire alarm for further instructions before evacuation begins. SST O stated the emergency system coupled with the lack of smoke detectors/ suppression system, lack of the current installed detectors not being fitted with horns and strobes, and the breeches in the fire walls created a substantial risk to resident safety. OPRI Architect J stated all the areas identified in the survey related to physical plant and fire safety created significant potential for harm and risk to resident safety.	{N 358}		

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{N 358}	Continued From page 18 Exit The requirements for the emergency system were reviewed during the exit interview on 03/04/2025 at 11:00 AM with Administrator A, RN K, Licensee M, Maintenance L, and Board Members N, R, and S. All the areas of concern identified during the survey were brought to the board's attention during the exit interview including the no new admission and fire watch orders continuing to be in effect as the verification visit identified the resident's safety continued to be an issue of great concern. Steps forward were discussed including OPRI Architect J noting the provider's hired professionals (SST O and their architect) had been informed about the areas of concern and requirements during a meeting on 03/28/20205. Those in attendance were given the opportunity to ask questions. No additional questions regarding the identified areas of concern and the risk they create when combine was asked at the time of exit. Per the provider's request, the exit interview was recorded, and a copy was sent to the provider on 03/05/2025 for board members who were not able to join the exit interview. On 03/07/2025, Surveyor was contacted by BM N who asked what the provider could do to lift the fire watches and no new admission orders. Surveyor referenced the areas that needed to be addressed and corrected had all been addressed in the exit interview and that the provider would need to be verified as in substantial compliance before the orders could be lifted. Cross Reference N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0491 DHS 83.44(2)(c) Interior Floors, Walls And Ceilings N0527 DHE 83.47(2)(f) Horizontal Evacuation	{N 358}		

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{N 358}	Continued From page 19 N0547 DHS 83.48(4)(g) Smoke Detectors Where Lintels Exceed 8 Inches N0637 DHS 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways N0649 DHS 83.59(4)(a) Delayed Egress: Only One Device Permitted	{N 358}		
N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care,	N 454		

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N 454	Continued From page 20 medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure Resident 7's record consistently described the resident's condition during a significant change in condition, and the provider's response, including documentation of	N 454		

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all health monitoring provided.

Findings include:
On 02/11/2024 at approximately 12;15 PM, Surveyor interviewed Administrator A and RN K. Administrator A stated the facility is typically staffed with at least 1 RN on AM and PM shifts and has an RN available by phone for emergency needs overnight. Administrator A and RN K stated the staff communicated via the Resident Progress Notes, 24-hour Shift Report, and verbally during a shift-to-shift report.

On 02/11/2025 At approximately 5:30 PM, Surveyor received Resident 7's medical record maintained by the provider after s/he had passed away. Surveyor reviewed the record and noted Resident 7 was admitted on 03/30/2023 with diagnoses including age related physical disability, urinary tract infection, mild cognitive impairment, and a pulmonary mass. Resident 7 had a history of falls and shortness of breath. Resident 7 was taken to the hospital on 05/29/2024 at 3:22 PM through 05/31/2024. The hospital record noted Resident 7 had altered mental status, worsening difficulty breathing, and enlarged right lung mass with extension to the liver, and right sided pleural effusion. The pleural effusion was drained, and the resident's family elected to place him/her on hospice services and return to the facility. Resident 7 passed away at the facility on 06/03/2024.

Surveyor reviewed the resident's record for the events leading to the hospitalization including the Medication Administration Record (MAR,) Task Administration Record (TAR,) Resident Progress Notes, and 24-hour Shift Notes:
05/25/2024 11:11 AM, LPN W noted in the Resident Progress Notes, "... Writer did vitals

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before [sic] fall this AM and noted O2 was stating low. Writer had O2 ranging from 83-89% RA [room air] writer informed RN on shift as well to eval [sic] and RN stated to monitor O2 ..."

No follow-up notes were written in the Resident Progress Notes for 5/26, 5/27, or 5/28. No additional vitals were documented in the resident records.

5/29/2024 5:38 AM, Caregiver T noted in the Resident Progress Notes, "[Sic]Resident appears to be in a lot of pain all NOC [sic.] Temp [sic] 99.2. [Sic] Moaning in bed most of the night. Tramadol [sic] given at 0400. [Sic] Pain level 9 out of 10 during AM cares approx.[sic] 0515."

On the 24-hour Shift Note for Resident 7 Caregiver T noted, "A lot of moaning, Tramadol given at 0400, diclofenac applied."

The note indicated the resident had been moaning in pain most of the night with no documentation of updating the POA or RN on call for directives or documentation of interventions provided other than giving diclofenac (external pain gel) and the scheduled morning Tramadol dose 2 hours earlier than was scheduled which, per the note, provided little to no pain relief. Additionally, the narcotic logs versus the MAR was reviewed by RN K, Administrator A, and Surveyor as Caregiver T referenced giving a PRN dose of Tramadol on the 24-hour Shift Note, but only took 1 Tramadol from the pack of scheduled Tramadol, which was not reflected in the documentation.

Surveyor interviewed RN K with Administrator A present on 02/19/2025 at approximately 12:00 PM. RN K stated Caregiver T would have been

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done with his/her shift at approximately 6:00 AM and would have given a verbal report to the next shift which included former RN Supervisor G (RN G.) RN K stated s/he believed RN G would have made rounds and checked on the resident after shift report was completed, however there was no associated documentation. No additional vital signs or RN medical evaluations were documented in the resident record until approximately 9 hours after the first note was written describing the resident's continued pain at 5:38 AM.

Surveyor reviewed a note written by Caregiver U on the 24-hour Shift Note without an associated time, "Ok day, didn't eat much for either meal about 10%. Seems like it [sic] taking a while to swallow." Caregiver U was not a licensed RN and did not have the qualifications to medically assess the resident.

On 02/19/2025 at approximately 12:00 PM, Surveyor interviewed RN K with Administrator A present. RN K stated s/he recalled coming into work at approximately 2:30 PM and being told by Therapist V that something was "not right" with Resident 7. Administrator A stated s/he immediately checked on the resident and followed up with a note in the Resident Progress Notes:

5/29/2024 3:01 PM RN K noted, "[Sic]Staff reported to writer that resident [sic] noted to be SOB [short of breath.] Writer assessed [sic]resident, [sic] Resident noted to have heavy abnormal/abdominal breathing, [sic] lips [sic]purple in color, T [temperature:] 99.4 R [Respirations:] 26-28 [sic] P [pulse:] 80 [sic] oxygen saturation: 80% on room air, b/p [blood pressure:] 120/ 56. Lung sounds clear in [sic]

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N 454	Continued From page 24 front lobes. [Sic] Resident stated [his/her] breathing does not feel very good and that it is heavy. [Sic] Resident [sic] unable to finish a sentence or speak without being SOB. [Sic] Resident able to correctly state [his/her] name and place [s/he] lives. [Sic] Rapid COVID testing [sic] negative. [Sic] Writer updated POA, [s/he] agreed for[sic]resident to be sent to Theda Care in Shawano to eval [sic] and treat. [Sic] Writer called 911. [Sic] Will continue to monitor. Surveyor reviewed the providers policy for change in a condition noted: "2. All changes in the resident's medical condition must be properly recorded in the resident's medical record. 3. Ongoing follow-up will occur through the 24-hour report." The provider did not follow their own policy and procedure for documentation during and after a change in Resident 1's condition. During the interview on 02/19/2025 at approximately 1:00 PM with RN K and Administrator A, both acknowledged the lack of documentation after the change in condition on 05/25/2024 and during Resident 7's change of condition on 05/29/2024 and that their own policy and procedure had not been followed. Administrator A stated they would be reeducating staff on the required documentation associated with health monitoring during a change in condition. Cross Reference N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 454		

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{N 491}	Continued From page 25	{N 491}		
{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. This is a repeat deficient practice. (See Statement of Deficiency (SOD) SOD Y5HZ11, dated 02/27/2024.) 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 02/07/2024-02/27/2024 Surveyor conducted 4 complaint investigations and a standard survey. As part of the survey, Surveyor identified the following deficient practices in SOD Y5HZ11, dated 02/27/2024: "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,	{N 491}		

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{N 491}	Continued From page 26	{N 491}		

leaks, holes, open areas from previous works, and areas where piping and/or electrical cords 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."

The plan of correction submitted to the Office of Plan Review and Inspection (OPRI) by the provider included plans to narrow the licensed space within the building by no longer allowing residents access to the basement and vacant Skilled Nursing Facility (SNF) areas of the building. The plan was contingent on ensuring the 2-hour fire barrier was maintained between the licensed and unlicensed spaces within the building.

On 02/11/2025 and 02/19/2025 Surveyor was present at the facility for 2 complaint investigations and a verification visit.

On 02/11/2025 at approximately 1:15 PM, Surveyor toured the facility with Administrator A, state Office of Plan Review and Inspection (OPRI) Architect J (Architect J), Per Mar Security Services Technicians O and P (PMT O, PMT P,) and Board Member and former Maintenance

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{N 491}	Continued From page 27 Director I (BM I.) Licensee M, and Board Member N (BM N) joined the tour at approximately 2 PM. Surveyor interviewed Administrator A and BM I throughout the tour. Surveyor observed the areas in need of repair previously identified in SOD Y5HD11. The cracks in the walls and ceilings had been filled with a gray material covered by a black material. The products used were observed by Surveyor, Architect J, Administrator A, BM I, and PMT O and P to be cracked in areas and flaking off of the areas of repair. (Photos 11, 22, 23, 24,32, 33, 34, and 35.) Surveyor observed the areas where the ceiling needed repair had either been repaired with fire rated putty, was left unrepaired, or was repaired with an unknown medium. (Photos 12-20, 20, 30, 31,32, 36, 37, and 38.) Surveyor conducted interviews during the tour including an interview with BM I. Regarding the cracks filled with the unidentified gray and back materials, MB I stated s/he was unsure what material had been used but would find the product for review. Architect J and Surveyor were presented with 1 product that Architect J identified as being a "fire blocking" material that did not meet the required "fire stopping" putty requirements. The provider was unable to specify which repairs had been made with which products. Surveyor observed previously identified breeches of the 2-hour smoke barrier in the ceiling that had been filled with an unknown material that were not repaired and had been cited in SOD Y5HZ11, dated 02/27/2024. BM I stated it was his/her belief that any areas not within the licensed space did not require correction. Surveyor reviewed part of the plan of correction was to narrow the licensed space, but that it was contingent on	{N 491}		

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{N 491}	Continued From page 28	{N 491}		

maintaining safe building systems and included ensuring the 2-hour fire barrier is intact surrounding the licensed spaces, which would include inspection of the fire barrier in the areas of the building surrounding the licensed spaces. BM I stated s/he was unaware of what material had been used to repair the barrier on the ceiling but stated it appear to him/her that some of the areas were repaired with a concrete mix. Surveyor observed some areas filled with the unidentified product were cracked and beginning to flake. BM I stated the cracking was "normal" during the drying process for the material used despite being unable to verify what material was used. Surveyor reviewed the areas where the 2 hour fire barrier was breached required repair with fire rated putty and would require the provider to be able to provide verification of which materials were used and the that the products were used as directed, including product and/or code specified depth and circumference of product used.

On 02/26/2025 at 1:39 PM, Surveyor interviewed Administrator A. Administrator A stated a former maintenance person (FM Q) had completed the corrections after the previous survey on 02/07/2024 but did not leave any documentation as to what products were used. Administrator A stated s/he may reach out to FM Q to see what products were used. As of 3/3/2025, no additional information has been received.

On 02/19/2025 at approximately 10:00 AM, Surveyor toured the facility with Administrator A and Maintenance Person (Maintenance L.) Maintenance L stated some of the repairs to the fire barrier in the ceiling had been completed since the last visit on 02/11/2025. Surveyor observed in the basement laundry room the areas

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{N 491}	Continued From page 29 where the ceiling was in need of repair and/ or replacement of materials now had fire rated putty on some of the areas of repair and had fire rated putty applied to half of an area of repair. (Photos 36 and 37.) It appeared the original unidentified product had not been removed, but fire rated putty had been applied over the area. Maintenance L stated s/he understood and commented had the provider painted over the areas, Surveyor would not have been able to discern that the products used had not been fire rated. On 02/26/2025 at 1:39 PM, Surveyor interviewed Administrator A. Administrator A stated after Surveyor visit on 2/19/2025, Maintenance L began work to remove the incorrect product from areas where the 2-hour fire barrier was breeched and replace it with the correct fire stopping putty in the correct application per product directions and/or code requirements. Cross Reference N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment N0527 DHE 83.47(2)(f) Horizontal Evacuation N0547 DHS 83.48(4)(g) Smoke Detectors Where Lintels Exceed 8 Inches N0637 DHS 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways	{N 491}		
{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	{N 527}		

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{N 527}	Continued From page 30	{N 527}		

evacuation shall document the total evacuation time of the fire zone evacuated.

This Rule is not met as evidenced by:
Based on observation, record review, and interview the provider did not ensure they received Department approval prior to implementing horizontal evacuation in their emergency plan. The provider utilized horizontal evacuation while it was unapproved.

This is a repeat deficient practice. (See Statement of Deficiency (SOD) SOD Y5HZ11, dated 02/27/2024.)

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:

SOD Y5HZ11 dated 02/27/2024 noted:

"02/16/2024 at approximately 1:00 PM, Surveyor interviewed Administrator A with Board Member C present ... 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 seek department approval before implementing horizontal evacuation as part of their emergency plan."

On 02/11/2025 at approximately 1:15 PM, Surveyor toured the facility with Administrator A, state Office of Plan Review and Inspection (OPRI) Architect J (Architect J), Per Mar Security Services Technicians O and P (PMT O, PMT P,)

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{N 527}	Continued From page 31	{N 527}		

and Board Member and former Maintenance Director I (BM I.) Licensee M, and Board Member N (BM N) joined the tour at approximately 2 PM. Surveyor observed the CBRF space contained smoke separation doors at both ends of the North wing, 1 on the end of the East wing leading to the unlicensed SNF, and 1 at the beginning of the hallway leading into the memory care wing. Surveyor observed the doors separating the memory care residential hall from the sunroom at the end of the memory care hall had been removed.

Surveyor conducted interviews during the tour including an interview with Administrator A and BM I. When asking questions about the evacuation plan BM I and Administrator A discussed a horizontal evacuation plan and at times (when unable to answer where the residents would go if a fire was in a certain location or another within the CBRF) they began to reference areas of refuge that were not included within the evacuation plans. BM I stated the provider's plan included horizontal evacuation and that areas of refuge could be used. BM I stated the sunroom had previously functioned as an area of refuge at the end of the memory care hall but acknowledged the doors that were identified in the last survey (dated 02/27/2024) as needing to be replaced with fire rated doors at the end of the memory care hall leading to the sunroom had been removed instead of replaced. Administrator A stated in the event of an emergency, the facility had a horizontal evacuation plan and a point of rescue plan for individual residents that were assessed as requiring it. Administrator A stated the local fire authority had approved the evacuation plan, but the plans had not been submitted for Department approval. Administrator A stated s/he had no

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{N 527}	Continued From page 32 current plans that included areas of refuge other than the individual residents who required point of rescue from their rooms. BM I and Administrator A discussed the requirements for areas of refuge with Architect J and stated they may consult with their hired architect. Administrator A and BM I could not clearly state if their plans going forward would include the use of areas of refuge. On 02/19/2024 at approximately 2:00 PM, Surveyor reviewed the providers records including fire drill documentation, exit diagrams, and emergency evacuation. The plan included the building being divided up into 4 zones. Zone 1 included the main lobby, staff offices, chapel, and all of the unlicensed Skilled Nursing Facility (SNF) space including the kitchen. Zone 2 included the entire 1st floor CBRF residential area including the all 4 room wings (memory care included) and common spaces. Zone 3 included the entire 2nd floor licensed CBRF space. Zone 4 included the entire basement. The plan noted: "Fire Evacuation: Zones 1, 2, 3, and 4 Fire in zone 1 move residents to zone 2 (horizontal evacuation) Fire in zone 2 move residents to zone 1 (horizontal evacuation) Fire in zone 3 (Homestead) move residents to zone 1 (vertical evacuation) Fire in zone 4 (lower level- LL) move residents to exterior exit path" Moving residents between zones 1 and 2 requires the resident to enter/exit through the North hallway or to enter/ exit through the east hallway into the unlicensed SNF area. Moving resident from zone 3 (2nd floor) to zone 1 requires the residents to exit stairs into the	{N 527}		

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{N 527}	Continued From page 33 unlicensed SNF space or exit stairs to the outside and then back in through the main entrance. On 02/26/2025 at 1:39 PM Surveyor interviewed Administrator A. Administrator A described the facility fire evacuation plan noting the use of horizontal evacuation to different smoke compartments within the zones of the facility and did not identify any areas of refuge. Surveyor reviewed with Administrator A that a copy of the provider's emergency horizontal evacuation plan had not been submitted to the Department for approval. Administrator A acknowledged the risk to the residents' safety by using unapproved horizontal evacuation that required resident to enter unlicensed spaces as their primary evacuation plan. Cross Reference N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment N0491 DHS 83.44(2)(c) Interior Floors, Walls And Ceilings N0547 DHS 83.48(4)(g) Smoke Detectors Where Lintels Exceed 8 Inches N0637 DHS 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways N0649 DHS 83.59(4)(a) Delayed Egress: Only One Device Permitted	{N 527}		
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	N 547		

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N 547	Continued From page 34	N 547		

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 smoke detection was installed in at least 50 compartments on the ceiling where lintels exceeded 8 inches.

Findings include:

On 02/11/2025 at approximately 1:15 PM, Surveyor toured the facility with Administrator A, state Office of Plan Review and Inspection (OPRI) Architect J (Architect J), Security Services Technicians O and P (SST O, SST P,) and Board Member and former Maintenance Director I (BM I.) Licensee M, and Board Member N (BM N) joined the tour at approximately 2 PM. Surveyor interviewed Administrator A and BM I throughout the tour.

Surveyor observed the common space within the first floor of the CBRF contained a room with a sloped ceiling and was open to a dining area with a flat ceiling. Between the 2 rooms there were 3 smoke detectors present, however there were at least 50 compartments on the ceiling created by beams that had lintels greater than 8 inches in depth. (Photos 1, 2, 3, 4, 5, and 8.) Surveyor reviewed there was no associated waiver for the spaces and Administrator A stated s/he was unaware of any records or waiver obtained. Administrator A acknowledged at least 50 areas identified did not have the required smoke detection.

The requirements were reviewed during the exit interview on 03/04/2025 at 11:00 AM with Administrator A, RN K, Licensee M, Maintenance

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N 547	Continued From page 35 L, and Board Members N, R, and S. As of 03/10/2025, no additional information has been received to verify the code requirements and as such, the linteled common space on the first floor with the sloped ceiling and dining area was not equipped with 50 required smoke detectors and did not have a waiver. Cross Reference N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment N0491 DHS 83.44(2)(c) Interior Floors, Walls And Ceilings N0527 DHE 83.47(2)(f) Horizontal Evacuation	N 547		
{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	{N 637}		

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{N 637}	Continued From page 36	{N 637}		

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 unobstructed at all times. Surveyor observed an exit with ice and hazardous icicles in the pathway, and a ramp that was installed at an exit that was more than one foot of rise in 12 feet of run and was not at least 4 ft wide.

This is a repeat deficient practice. (See Statement of Deficiency (SOD) SOD Y5HZ11, dated 02/27/2024.)

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 02/11/2025 at approximately 1:15 PM, Surveyor toured the facility with Administrator A, state Office of Plan Review and Inspection (OPRI) Architect J (Architect J), Per Mar Security Services Technicians O and P (PMT O, PMT P,) and Board Member and former Maintenance Director I (BM I.) Licensee M, and Board Member N (BM N) joined the tour at approximately 2 PM. Surveyor interviewed Administrator A and BM I throughout the tour.

At approximately 3:00 PM, Surveyor observed a ramp had been installed at the exit from the first floor South Wing (Photos 39 and 40.) Surveyor observed the width and slope of the ramp did not

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{N 637}	Continued From page 37 appear to be within compliance. Administrator A stated the ramp was installed after the previous survey identified the exit had a significant bump that would need to be brought to grade for residents with limited ability to negotiate the bump into or out of the exit. Administrator A verified the ramps dimensions 3 inches high x 9 inches long x 38 inches wide. The dimensions did not meet the code requirements for slope or width. 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. At approximately 5:00 PM, Surveyor observed the exit at the end of the memory care wing on the first floor leading out to a cement surface and down an extended stairway was not maintained clear of hazards and obstructions. The door exiting the facility required force to open and was obstructed by multiple large icicles hanging above that fell down on to Architect J as s/he attempted to access the door. (Photos 43-49.) Surveyor observed extensive icicle formation along the roof top of the facility that was at times near pathways. (Photo 42.) Surveyor observed a secured outdoor space in the memory care wing also had ice and icicles presenting hazards to any persons wanting to access the space. (Photo 41.) Administrator A commented that the ice and icicles by the memory care exit and pathways posed a hazard to anyone trying to access them. Administrator A acknowledged the safety concerns related to not maintaining clear and unobstructed exits. Cross Reference N0196 DHS 83.14(2)(a) Licensee Ensures	{N 637}		

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{N 637}	Continued From page 38 Facility Complies With Laws N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment N0491 DHS 83.44(2)(c) Interior Floors, Walls And Ceilings N0527 DHE 83.47(2)(f) Horizontal Evacuation N0649 DHS 83.59(4)(a) Delayed Egress: Only One Device Permitted	{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 delayed egress doors were approved by the Department prior to installation, did not ensure there was no more than 1 device present in means of egress. This is a repeat deficient practice. (See Statement of Deficiency (SOD) SOD Y5HZ11, dated 02/27/2024.) The facility is licensed to serve up to 75 residents who may be physically disabled, of advance age, emotionally disturbed/ mental illness, and /or	{N 649}		

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{N 649}	Continued From page 39 irreversible dementia/ Alzheimer's disease. Findings Include: SOD Y5HZ11 dated 02/27/2024 noted: "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 [sic] approval." 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 approval from the North Eastern Regional Office in 2021. The provider was required to then 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, or any new submissions for approval since the deficient practices was identified in SOD Y5HZ11 dated 02/27/2024. On 02/11/2025 at approximately 1:15 PM, Surveyor toured the facility with Administrator A, state Office of Plan Review and Inspection (OPRI) Architect J (Architect J), Per Mar Security Services Technicians O and P (PMT O, PMT P,) and Board Member and former Maintenance Director I (BM I.) Licensee M, and Board Member N (BM N) joined the tour at approximately 2 PM. Surveyor interviewed Administrator A and BM I	{N 649}		

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 _____	R-C 03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{N 649}	Continued From page 40 throughout the tour. The building, including the unlicensed spaces and 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 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 maintenance storage, and building services storage. The basement included areas no longer in use 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 use. 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 for any staff who would be in the basement. The second floor of the CBRF, located above the former SNF, had resident bedrooms and common space that was added in 2020 and had exit doors equipped with delayed egress on both ends leading to the stairwells. 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.	{N 649}		

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{N 649}	Continued From page 41 The CBRF is attached to the SNF that closed in 2022. The SNF space is still open and accessible internally to staff, however the SNF is not staffed and is dark and no longer in use by residents. The SNF space contained the main CBRF kitchen, storage, staff areas, and was 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, and common space. The first floor had exit doors equipped with delayed egress that lead from one area of the CBRF into another area. Locations of the 1st floor delayed egress doors: In the stairwell shared with the CBRF East wing leading into the unlicensed SNF dining area. At the end of the CBRF East wing leading to the stairwell At the end of the CBRF North wing leading from the main office spaces to the outdoors At the CBRF washer room leading to the outside Internally between the CBRF washer room and the CBRF café At the CBRF dining room exit to the outside At the end of the CBRF South wing leading to the outside Internally between the entrance to the memory care wing and the other areas of the CBRF. At the end of the memory care wing leading outside to steps. At approximately 2:40 PM, Surveyor observed the lighted exit main entrance to the memory care unit was a locked door that had a delayed egress and/or required a staff badge to open. (Photo 50.) Once opened, the exit path led to the main CBRF common space dining area. If the residents chose to exit through the east wing, the dining exit, or the café that were equipped with delayed	{N 649}		

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{N 649}	Continued From page 42 egress doors it would cause a 2nd delay in the exit path. Administrator A acknowledged exiting the secured internal memory care door followed by any of the other delayed egress doors caused a second delay in exiting the facility. Cross Reference N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment N0491 DHS 83.44(2)(c) Interior Floors, Walls And Ceilings N0527 DHE 83.47(2)(f) Horizontal Evacuation N0637 DHS 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways	{N 649}		