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 10/08/2025

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 09/17/2025 and 09/25/2025, Surveyor conducted a verification visit at Homme Residential Wittenberg. Additional information was gathered through 10/08/2025. As a result of the verification visit, 5 repeat deficient practices were identified. Under statutory provisions, a $200 revisit fee is being assessed for the follow-up licensing visit. Census: 31	{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. This is a repeat deficient practice. (See Statement of Deficiency (SOD) Y5HZ12, dated 03/04/2025.) 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 09/17/2025, the census was 31. 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}		

History
Surveyor reviewed the provider's 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 04/04/2025 the provider received the Statement of Deficiency (SOD) Y5HZ12 (dated 03/04/20245) and enforcement orders:

"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. Complaint #46556 was substantiated and resulted in 1 identified deficient practice. As a result of the verification visit, 7 additional deficient practices were identified. The Survey resulted in the identification of 8 deficient practices total; 5 of 8 were repeat violations.

N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws
N0320 DHS 83.29(4) Admission Agreement Not In Conflict
N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment (repeat)
N0454 DHS 83.42(1) Resident Record Maintained
N0491 DHS 83.44(2)(c) Interior Floors, Walls And Ceilings(repeat)
N0527 DHE 83.47(2)(f) Horizontal Evacuation(repeat)
N0637 DHS 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways(repeat)
N0649 DHS 83.59(4)(a) Delayed Egress: Only One Device Permitted (repeat)"

"NOTICE OF VIOLATION
On March 4, 2025, a verification visit and

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{N 196}	Continued From page 2 complaint investigation were concluded for Homme Residential Wittenberg by the Division of Quality Assurance, Bureau of Assisted Living, to determine if the above-referenced facility was in substantial compliance with Wis. Stat. ch. 50 or Wis. Admin. Code ch. DHS 83, or both, which set forth requirements for the administration and operation of a community-based residential facility (CBRF). The Department is issuing Statement of Deficiency (SOD) # Y5HZ12 for violations of Wis. Stat. ch. 50 or Wis. Admin. Code ch. DHS 83, which establish the grounds for this action. SOD # Y5HZ12 is enclosed. ORDER TO COMPLY WITH REQUIREMENTS 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. The Department may, without notice, conduct an inspection to verify the licensee's corrective action at any time after the date of compliance. Pursuant to Wis. Stat. § 50.03(5g)(cm), the department may impose a $200 inspection fee for an on-site inspection to review compliance of violations resulting in enforcement action. ORDER NOT TO ADMIT NEW OR ADDITIONAL RESIDENTS - EXTENDED Based on the results of the Department's	{N 196}		

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{N 196}	Continued From page 3 investigation, and pursuant to Wis. Stat. § 50.02(2)(am)2., and Wis. Admin. Code § DHS 88.03(6)(g)2.f., EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services hereby extends the order issued on May 1, 2024, with Statement of Deficiency (SOD) Y5HZ11 that Homme Residential Wittenberg Not Admit any New or Additional Residents until all violations in SOD Y5HZ12 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: 1. 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). 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 ..."	{N 196}		

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{N 196}	Continued From page 4 On 04/14/2025, the provider requested and was granted a 6-month extension for the enforcement order completion ending on 10/14/2025. On 09/15/2025, the provider requested a stipulated settlement agreement that ended the granted extension. The agreement was approved as the provider attested they were in substantial compliance with the majority of the fire safety system works completed and were requesting a verification visit to expedite the process. On 09/17/2025 and 09/25/2025, Surveyor conducted a verification visit at Homme Residential Wittenberg. Additional information was collected through 10/03/2025. 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 RN K, as well as reviewed the provider's records, including physical plant, fire and emergency systems, and a floor plan that BM I stated contained the provider's "Phase II" plan of correction. Surveyor discovered all required operational plans were not coordinated to match conditionally approved exit locations, safe zones, areas of refuge, and smoke compartments as identified on the architectural plans. Surveyor discovered since the previous survey completed on 03/04/2025, some works were completed, however the majority of fire protections systems that were required were not installed: Completed works since 03/04/2025: The provider had the cracks and holes in the floors, walls and ceilings professionally sealed, the provider cleared out and decluttered storage areas, modified an area of sidewalk for correct slope, modified door locks, and submitted 2 plans for approval and 1 waiver request (both plans	{N 196}		

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{N 196}	Continued From page 5 submitted were found to be incomplete and/or contained errors.) Incomplete Works: The required fire systems were not updated; no horns and strobes were added, the 75+ smoke detectors were not installed, the 2 annunciators boxes were not installed, the 1-hour fire barrier wall (per the floor plan) and communication for the area of refuge was not installed, the smoke doors separating the area of refuge were not in compliance, the unapproved delayed egress doors remained in place, the emergency plan and plan for horizonal evacuation was not comprehensive, the provider did not submit a waiver for the linteled space in the South sunroom, and the 4 additional smoke detectors to be installed per the variance request in the atrium space had not been installed yet. Additionally, it was not identified by the provider's hired professionals that the memory care wing does not have 2-hour fire walls surrounding it as was part of their previous plan of correction to minimize the area of licensed space. As a result of not being out of compliance with the laws governing a CBRF, 5 repeat violations were issued, 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. This is a repeat deficient practice. (See Statement of Deficiency (SOD) Y5HZ12, dated 03/04/2025.)	{N 196}		

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{N 196}	Continued From page 6 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 system, emergency egress, and fire detection 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 x2. (See Statement of Deficiency (SOD) Y5HZ11, dated 02/27/2024 and SOD Y5HZ12, dated 03/04/2025.) N0546 DHS 83.48(4)(f) Smoke Detectors In Non-Resident Living Areas Based on observation, record review, and interview, the provider did not ensure smoke detection was installed in at least 7 non-resident living rooms in the basement that contained Community Based Residential Facility (CBRF) building systems. This is a repeat deficient practice. (See Statement of Deficiency (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 58 compartments on the ceiling where lintels exceeded 8 inches. This is a repeat deficient practice. (See	{N 196}		

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{N 196}	Continued From page 7 Statement of Deficiency (SOD) Y5HZ12, dated 03/04/2025.) 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, and did not ensure there was no more than 1 device present in means of egress. This is a repeat deficient practice x2. (See Statement of Deficiency (SOD) Y5HZ11, dated 02/27/2024 and SOD Y5HZ12, dated 03/04/2025.) Cross Reference: N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment N0546 DHS 83.48(4)(f) Smoke Detectors In Non-Resident Living Areas N0547 DHS 83.48(4)(g) Smoke Detectors Where lintels exceed 8 Inches N0649 DHS 83.59(4)(a) Delayed Egress: Only One Device Permitted	{N 196}		
{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	{N 358}		

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{N 358}	Continued From page 8 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. Concerns were identified regarding the safety of the facility's physical plant including the emergency system, emergency egress, and fire detection 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 x2. See Statement of Deficiency (SOD) Y5HZ11, dated 02/27/2024 and SOD Y5HZ12, dated 03/04/2025. Findings Include: 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. 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 dissension 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	{N 358}		

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{N 358}	Continued From page 9 SNF space. The CBRF is attached to a SNF that closed in 2022. The 1st floor SNF space is still open and accessible 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 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 an area rented by a private business as a thrift store. During the tour on 09/17/2025 at approximately 11:00, Administrator A stated the privately rented thrift store space was patroned by the public and acknowledged the public had access directly into the CBRF via elevator and stairs. The basement additionally contained a connected hallway to an apartment complex and a wing for resident inpatient therapy that was no longer in use. Enforcement History Enforcement for the previous SOD Y5HZ11 dated 02/27/2024, included an order not to admit any new residents and to conduct hourly fire watches through the facility.	{N 358}		

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{N 358}	Continued From page 10 Enforcement for the previous SOD Y5HZ12 dated 03/04/2025, included an extension of the order not to admit new residents and the fire watch was not lifted. On 06/18/2025, the fire watch order was lifted after the provider submitted horizontal evacuation plans that were conditionally approved by the Department and the plan showed works in progress for fire safety compliance. General Findings On 09/17/2025 at approximately 10:00 AM, Surveyor toured the facility with Administrator A, Licensee M, and with Board Member and former Maintenance Director I (BM I) joining at approximately 12:00 PM. Surveyor interviewed Administrator A and BM I throughout the tour. A second tour was conducted on 09/25/2025 with Surveyor, State Regional Director Y, State Office of Plan Review and Inspection (OPRI) Architect J (Architect J), Licensee M, Administrator X, Accounting Manager Y, RN K, and Board Member and former Maintenance Director I (BM I.) Per the provider's request, the second tour and exit interview was recorded on Accounting Manager R's phone for board members who were not present. On 09/17/2025 and 09/25/2025, Surveyor reviewed the plans the provider submitted for correcting SOD Y5HZ12 which the provider described as "Phase II" plans. The plans were conditionally approved by OPRI but noted in a letter dated 04/08/2025, "All required operational plans shall be coordinated to match conditionally approved exit locations, safe zones, areas of refuge, and smoke compartments as identified on these architectural plans." The plan included a	{N 358}		

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{N 358}	Continued From page 11 floor plan of the facility with fire systems to be updated and physical plant specifications. Surveyor noted areas on the floor plan that were not congruent with the physical findings within the building. There were doors, walls and rooms that were present on the map that were not in the facility along with doors, walls and rooms that were absent from the map that were present in the facility. Surveyor discovered all required operational plans were not coordinated to match conditionally approved exit locations, safe zones, areas of refuge, and smoke compartments as identified on the architectural plans. As Surveyor toured the facility on 09/17/2025 Surveyor observed all the works noted in the Phase II plan had yet to be completed. In corroboration of findings, on 10/08/2025, Office of Plan Review and Inspection (OPRI) Architect J sent the provider a Progress Inspection Report (PIR) (dated 09/25/2025) from the tour jointly conducted on 09/25/2025: "1) This inspection was conducted alongside BAL Surveyors and addressed physical environment requirements that were related to a previous BAL Survey and Statement of Deficiencies. The Office of Plan Review and Inspection (OPRI) has received three plan review submittals to date: Fire Alarm Submittal "Phase 1" - 12026-23570 Egress Analysis / Architectural Submittal - 12026-23849 Fire Alarm Submittal "Phase 2" - 12026-24177 2) Facility tour made apparent that the submitted plans do not accurately match the actual facility in all areas. Numerous areas on the plans were missing walls, doors, or have room configurations that are not accurate. DHS 83 requires that all	{N 358}		

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{N 358}	Continued From page 12 rooms and areas separated by a minimum 8" ceiling projection are provided with either a smoke detector or heat detector in accordance with DHS 83.48(4)&(6). BAL Surveyor identified numerous areas that were not accurate and were not included on the recently conditionally approved "Phase 2" fire alarm plans. Owner and Supervising Professionals shall verify the accuracy of the plans and the completeness of the required systems." Fire Detection Systems During the tour on 09/17/2025, Surveyor observed the basement contained at least 6 rooms that held building systems that were not equipped with smoke and/ or heat detection and at least 2 rooms that were not equipped with heat detection. The Phase II plans did not encompass all the rooms in the basement which contained building systems and required fire detection. During a tour on 09/25/2025, Surveyor observed the smoke doors and wall separating the area of refuge at the end of the memory care unit did not qualify as a 1-hour smoke barrier as was specified on the Phase II plans submitted to the Department. Additionally discovered was the memory care wing, including the unoccupied basement space below, had been an addition to the building and the floor between the basement and memory care unit was not a 2-hour fire barrier as was required. The space below the memory care unit was not in compliance with the fire detection requirements. The Phase II plan incorrectly identified the building structural composition in relation to fire rating and therefore did not identify the areas in the basement below that needed to be brought into compliance. During the tour on 09/17/2025, Surveyor	{N 358}		

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(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 358}	Continued From page 13 observed more than 17 habitable rooms and spaces with lintels exceeding 8 inches on the first floor of the CBRF that were not equipped with smoke detection and/ or heat detection. Administrator A entered each area with Surveyor and acknowledged each of the spaces that did not have smoke and/ or heat detection present. The Phase II plans did not encompass all the areas that required fire detection on the first floor within the licensed CBRF space. During the tour on 09/17/2025, Surveyor observed the facility had 1 annunciator box installed on the second floor and the 2 additional annunciator boxes that were to be installed per the provider's Phase II plan of correction had not yet been installed on the first floor. During the previous survey (Y5HZ12 dated 03/04/2025,) Surveyor noted, "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." On 09/17/2025, Surveyor observed the previously identified areas requiring smoke/ heat detection, and/ or horn and strobes had not been installed.	{N 358}		

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{N 358}	Continued From page 14 OPRI J corroborated the findings within the PIR (dated 09/25/2025): "2) ... Owner and Supervising Professionals shall verify the accuracy of the plans and the completeness of the required systems. The CBRF fire alarm system requirements shall extend through all areas of the building that are not separated by 2-hour fire resistance rated construction and additionally, shall include all building system spaces (mechanical, sprinkler risers, electrical rooms, etc) that serve the CBRF if those spaces are outside of the 2-hour fire resistance rated CBRF boundary. 3) Observation above the ceiling in the basement below the CBRF memory care wing confirmed that the floor system separating the CBRF from the proposed Business occupancy below was not 2-hour fire resistance rated construction. The architectural plans indicated that this basement area would be outside of the CBRF boundary (separated by 2-hour rated construction), however, the existing floor system is estimated to be only 1 hour fire resistance rated. As such, either the basement area needs to be provided with a complete CBRF fire alarm system - or - the floor (and possibly some walls) need to be upgraded to have a complete 2-hour separation from the CBRF. Observation above the ceiling on the first floor, in the Lounge outside of the memory care wing, verified the extent of the 1968 construction and the complicated connection between the 1955 construction and the 1968 construction. To fully separate the non-compliant basement space, additional analysis and design will be required by the Supervising Professionals and Owners. Revised architectural plans will need to be provided for review if additional construction	{N 358}		

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{N 358}	Continued From page 15 is proposed. 4) Architectural plans indicate a 1-hour fire resistance rated area of refuge, in accordance with IBC section 1009.6, at the far end of the Memory Care wing. Observation above the ceiling revealed that the existing wall does not extend to the roof sheathing as required for a 1-hour fire resistance rated fire barrier. Additionally, the doors leading into the Area of Refuge are not positive latching or provided with smoke gaskets. IBC 1009.6.4 requires areas of refuge to be separated from the remainder of the building by 1-hour fire resistance rated smoke barriers per IBC section 709. Section 709.5 requires openings to be protected per section 716. And section 716.5.3.1 requires the doors to be smoke and draft control tested in accordance with UL 1784. Additionally, areas of refuge are required to include two-way communication systems in accordance with IBC section 1009.8. A system was proposed in the fire alarm "Phase 2" proposal, however, this system was not installed yet. ...6) Fire watch may be needed again for the facility or areas that are not yet in compliance as the Phase 2 fire alarm work is completed and as any additional missing devices are added that were not included in the Phase 2 plans. Final acceptable boundary of the CBRF is critical in determining all required locations. See note 3 above regarding non-compliant 2-hour separations. 7) Fire doors by the elevator lobby are only 20 min. Architectural plans indicate that 90-minute doors will be installed in the required 2-hour fire barrier separation wall."	{N 358}		

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{N 358}	Continued From page 16 Evacuation During an interview with Administrator A (SOD Y5HZ11 dated 02/27/2024) 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. On 06/18/2025, the provider submitted a horizontal evacuation plan that was conditionally approved by the Department. On 09/17/2025 and 09/25/2025, Surveyor reviewed the plan with Administrator A and BM I throughout the tour. The horizontal plan did not include the time each smoke compartment/corridor took to evacuate. Administrator A stated minimal staffing during a 24-hour period would be 2 caregivers on the second floor (Acre and Rustic wings,) 1 caregiver in the memory care unit (Sunburst wing,) 1 caregiver for the other wings on the first floor (North, South, and East wings) and occasionally 1 additional staff member to "float" throughout the facility as needed for a 3 story building with 3 separated CBRF areas, including 6 wings. Administrator A described in the event of a fire alarm, staff on the second floor would respond to the annunciator box and determine where the fire was located. The staff would then use a cellular phone to call down to the other staff on the first floor to let them know where the fire was located. Administrator A stated there were 3 cell phones total, 1 for the 2nd floor, 1 for the memory care, and one for the other first floor CBRF wings. Administrator A stated the cell phones were kept in the central nurse's station. The plan was	{N 358}		

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{N 358}	Continued From page 17	{N 358}		

written to presume the facility was fully staffed (as it may be during the day, but not at night when there would be only 4-5 caregivers for the entire facility.) The plan presumed a full fire department response/arrival from surrounding towns within minutes, which is unrealistic given travel time from the surrounding areas. The plan included staff members being required to perform different duties at once and did not extrapolate on how the plan would function with minimal staff. While reviewing the plan, various tasks which needed to occur immediately upon a fire alarm were discussed. When situational conflicts within the plan were identified, Administrator A and BM I addressed each by stating a caregiver would need to be assigned to the task. The provider was proposing the minimal available caregivers would be able to perform multiple roles at once, such as stating the person on the second floor would notify the staff on the 1st floor (but would be required to physically make contact with them if they did not answer the cell phone,) but was also expected to still be on the 2nd floor assisting the residents to the smoke corridor, securing the wings and point of rescue residents, while meeting the fire department at the front door and holding the door open for residents to exit the 1st floor East wing. The provider couldn't say what would happen if a caregiver on the 2nd floor was unable to get to the annunciator box or cell phone, as the 2 annunciator boxes that were to be installed on the first floor were not installed. There were continued concerns identified in the previous survey regarding the residents waiting after they hear the fire alarm for further instructions before evacuation begins. It was noted on the resident roster that there were 6 residents residing on the 2nd floor that were non-ambulatory with 3 of the 6 being noted as requiring a point of rescue. Additionally, the

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{N 358}	Continued From page 18 submitted horizontal evacuation plan identified and area of refuge at the end of the memory care wing that was not equipped with fire rated doors or walls. OPRI J corroborated the findings within the PIR (dated 09/25/2025): "5) Discussions regarding the facility's emergency preparedness plans raised concerns about the facility's consistent approach to training based on the proposed smoke compartments, written plan submitted to BAL, and knowledge of required emergency communication equipment (where the emergency phones are stored and who has access to them), where to evacuate and how, should the residents evacuate or stay and wait for direction, etc. The facility needs to fully own their emergency plan and train based on a concise, consistent emergency response plan that includes accurate facility floor plans, written plans, equipment, training, communication, leadership chain of command protocol for different shifts and when typical leaders are not in the facility, etc." The emergency system, horizontal evacuation plan, and use of unapproved delayed egress doors coupled with the lack of smoke detectors, lack of the current installed detectors not being fitted with horns and strobes, and the discovery of the construction fire rating in the memory care wing, created a substantial risk to resident safety. Exit The Surveyor, Regional Director Y and OPRI J reviewed the requirements for the emergency system during an exit interview on 09/25/2025 at 2:30 PM with Administrator A, RN K, Licensee M,	{N 358}		

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{N 358}	Continued From page 19 BM I, Administrator X and Accounting Manager R. Items of noncompliance identified during the survey were brought to the provider's attention during the exit interview including discussion of the no new admission and potential reinstatement of the fire watch orders to be in effect as the verification visit identified the resident's safety continued to be of concern. Steps forward were discussed including OPRI Architect J noting the provider's hired professionals (SST O and their architect) would need to be informed about the areas of concern and requirements. Those in attendance were given the opportunity to ask questions. No additional questions regarding the identified areas of concern were asked at the time of exit. Per the provider's request, the exit interview was recorded on Accounting Manager R's phone for board members who were not able to join the exit interview. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0546 DHS 83.48(4)(f) Smoke Detectors In Non-Resident Living Areas N0547 DHS 83.48(4)(g) Smoke Detectors Where lintels exceed 8 Inches N0649 DHS 83.59(4)(a) Delayed Egress: Only One Device Permitted	{N 358}		
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.	N 546		

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N 546	Continued From page 20 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 6 non-resident living rooms in the basement that contained Community Based Residential Facility (CBRF) building systems. This is a repeat deficient practice. (See Statement of Deficiency (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: Surveyor reviewed letters sent to the provider by Office of Plan Review and Inspection (OPRI) Architect J. In letters dated 12/16/2024 and 08/27/2025 OPRI J included Chapter 83 regulations for the requirements to have smoke detection in non-resident living areas including the basement. On 10/08/2025 OPRI J sent the provider a Progress Inspection Report from the tour conducted on 09/25/2025. The report included observations regarding continued noncompliance of the fire detection systems throughout the building including non-resident living areas and the basement rooms containing building systems: "1) This inspection was conducted alongside BAL Surveyors and addressed physical environment requirements that were related to a previous BAL Survey and Statement of Deficiencies ...	N 546		

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N 546	Continued From page 21 2) ... DHS 83 requires that all rooms and areas separated by a minimum 8" ceiling projection are provided with either a smoke detector or heat detector in accordance with DHS 83.48(4)&(6). BAL Surveyor identified numerous areas that were not accurate and were not included on the recently conditionally approved "Phase 2" fire alarm plans. Owner and Supervising Professionals shall verify the accuracy of the plans and the completeness of the required systems. The CBRF fire alarm system requirements shall extend through all areas of the building that are not separated by 2-hour fire resistance rated construction and additionally, shall include all building system spaces (mechanical, sprinkler risers, electrical rooms, etc) that serve the CBRF if those spaces are outside of the 2-hour fire resistance rated CBRF boundary. 3) Observation above the ceiling in the basement below the CBRF memory care wing confirmed that the floor system separating the CBRF from the proposed Business occupancy below was not 2-hour fire resistance rated construction. The architectural plans indicated that this basement area would be outside of the CBRF boundary (separated by 2-hour rated construction), however, the existing floor system is estimated to be only 1 hour fire resistance rated. As such, either the basement area needs to be provided with a complete CBRF fire alarm system - or - the floor (and possibly some walls) need to be upgraded to have a complete 2-hour separation from the CBRF. Observation above the ceiling on the first floor, in the Lounge outside of the memory care wing, verified the extent of the 1968 construction and the complicated connection between the 1955 construction and the 1968	N 546		

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N 546	Continued From page 22	N 546		

construction. To fully separate the non-compliant basement space, additional analysis and design will be required by the Supervising Professionals and Owners. Revised architectural plans will need to be provided for review if additional construction is proposed.

6) Fire watch may be needed again for the facility or areas that are not yet in compliance as the Phase 2 fire alarm work is completed and as any additional missing devices are added that were not included in the Phase 2 plans. Final acceptable boundary of the CBRF is critical in determining all required locations. See note 3 above regarding non-compliant 2-hour separations. "

On 09/17/2025 at approximately 10:00 AM, Surveyor toured the facility with Administrator A, Board Member and former Maintenance Director I (BM I,) Licensee M, and Lead RN K. Surveyor interviewed Administrator A and BM I throughout the tour.

The 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 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 an area

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N 546	Continued From page 23 rented by a private business as a thrift store. During the tour on 09/17/2025 at approximately 11:00, Administrator A stated the privately rented thrift store space was patroned by the public and acknowledged the public had access directly into the CBRF via elevator and stairs. The basement additionally contained a connected hallway to an apartment complex and a wing for resident inpatient therapy that was no longer in use. Surveyor observed over 6 rooms in the basement that contained CBRF building systems that were not equipped with smoke detection and at least 2 rooms that were not equipped with heat detection. Administrator A entered each room with Surveyor and acknowledged each of the 8 plus rooms that contained building systems did not have smoke and/ or heat detection present. BM I stated his/her belief that the rooms did not require smoke detection and stated all plans to upgrade the fire detection system were detailed on the provider's "Phase II" floor plans that were created by their hired professionals. Surveyor reviewed the provider's Phase II facility floor plans and noted they did not include plans to add smoke detection to all the required building systems rooms in the basement. 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 N0649 DHS 83.59(4)(a) Delayed Egress: Only One Device Permitted	N 546		
{N 547}	83.48(4)(g) Smoke detector where lintels exceed 8 inches	{N 547}		

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{N 547}	Continued From page 24 Pursuant to s. 50.035(2)(b), Stats., all facilities shall have at least one smoke detector located at each of the following locations: Additional smoke detectors shall be located where wall projections from the ceiling or lintels exceed 8 inches. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure smoke detection was installed in at least 58 compartments on the ceiling where lintels exceeded 8 inches. This is a repeat deficient practice. (See Statement of Deficiency (SOD) Y5HZ12, dated 03/04/2025.) Findings include: On 04/04/2025, the provider received an enforcement letter for SOD Y5HZ12 (dated 03/04/2025) that directed all citations be corrected, "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." During both previous surveys conducted (Y5HZ11, dated 02/27/2024 and Y5HZ12, dated 03/04/2025) the atrium room and the South wing sunroom (identified as within smoke compartment 1-C) were identified as requiring additional smoke detectors or an approved variance for the linteled ceilings. The requirement was also reviewed in letters sent to the provider on by Office of Plan Review and Inspection (OPRI) Architect J:	{N 547}		

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{N 547}	Continued From page 25 04/08/2025: "4) Conditional approval does not include any additional scope of work for the existing fire alarm system. Additional plan review information is anticipated regarding: ...b. The numerous ceiling pockets created by structural lumber in the vaulted ceiling of the dining / lounge area in smoke compartment 1-C;" 08/27/2025: "Please provide signed / sealed drawings and/or calculations showing that smoke detectors located in between ceiling beams comply with the requirements of NFPA 72 2002 and 2013 editions. DHS 83 requires all areas with a ceiling projection of 8" be provided with a smoke detector. Full compliance with both 2002 and 2013 editions (as referenced per DHS 83 and the Wisconsin Commercial Building Code) may allow the proposed configuration to be accepted." On 09/12/2025, the provider submitted a variance request to the Department for the linteled ceiling within the first-floor atrium room. The variance was approved pending the addition of 4 smoke detectors to be installed no later than 10/01/2025. The variance did not include the lounge space/ South wing sunroom ceiling within compartment 1-C. On 09/17/2025 at approximately 10:00 AM, Surveyor toured the facility with Administrator A, Board Member and former Maintenance Director I (BM I,) Licensee M, and Lead RN K. Surveyor interviewed Administrator A and BM I throughout the tour. Surveyor observed the common space within the first floor of the CBRF contained an atrium room with a sloped ceiling and was open to a dining	{N 547}		

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{N 547}	Continued From page 26 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 X) Administrator A acknowledged at least 50 areas identified did not have the required smoke detection and discussed the approved variance plan for the space. Administrator A stated the required additional 4 smoke detectors to be installed no later than 10/01/2025 had not been installed yet. Surveyor observed a second lounge area at the end of the South wing that was referred to as the sunroom. The sunroom had sloped ceilings with 1 smoke detector present, however there were 8 compartments on the ceiling created by beams that had lintels greater than 8 inches in depth. (Photos 1 and 2.) The space was identified and discussed during previous surveys as in need of additional smoke detectors or for the provider to submit a variance request. Surveyor reviewed there was no associated waiver for the space and Administrator A stated s/he was unaware of any records or waiver obtained. Administrator A acknowledged at least 8 areas identified did not have the required smoke detection and stated the provider would submit a variance request for the space. As of 10/09/2025, no additional variance request for the South sunroom have been received. 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	{N 547}		

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	410107	A. BUILDING: _____ B. WING _____	R-C 10/08/2025

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{N 649}	Continued From page 27	{N 649}		
{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, and did not ensure there was no more than 1 device present in means of egress. This is a repeat deficient practice x2. (See Statement of Deficiency (SOD) Y5HZ11, dated 02/27/2024 and SOD Y5HZ12, dated 03/04/2025.) 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: "On 02/16/2024 at approximately 1:00 PM, Surveyor interviewed Administrator A with Board Member C present. Both acknowledged the	{N 649}		

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{N 649}	Continued From page 28 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 practice was identified in SOD Y5HZ11 dated 02/27/2024 and SOD Y5HZ12, dated 03/04/2025. As a result of SOD Y5HZ12 dated 03/04/2025, the provider received an enforcement letter on 04/04/2025 that noted: "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: 1. 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,	{N 649}		

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{N 649}	Continued From page 29	{N 649}		

additions or upgrades to an existing delayed egress system will require review by the Office of Plan Review and Inspection (OPRI). 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."

In addition to the previous surveys (SOD Y5HZ11, dated 02/27/2024 and SOD Y5HZ12, dated 03/04/2025) addressing the delayed egress doors were not approved, the requirement was also reviewed in letters sent to the provider by Office of Plan Review and Inspection (OPRI) Architect J:

12/16/2024:
" ... Additional submittals and review will be provided by the Owner for: delayed egress door locking devices, horizontal evacuation plans, and overall CBRF egress system analysis / modifications.
This conditional approval is exclusively for the new fire alarm system detection and notification devices ..."

The letter listed out the Chapter 83 requirements for the use of a delayed egress door that included the requirement for Department approval prior to their use.

04/08/2025:
"Conditions of Approval:
1) Conditional approval of submitted CBRF

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{N 649}	Continued From page 30 building analysis and egress system does not constitute approval or acceptance of any of the required policies, procedures, emergency response plans, delayed egress locations, point of rescue plans, or any other operational documentation that is required to be submitted, reviewed, and accepted by the Bureau of Assisted Living (BAL). All required operational plans shall be coordinated to match conditionally approved exit locations, safe zones, areas of refuge, and smoke compartments as identified on these architectural plans. Local emergency responders shall be provided with updated plans and procedures for all required locations of rescue assistance. Additional egress system modification and/or substantiation may be required in the future if BAL is unable to accept any of the operational emergency plans. 2) Please submit delayed egress plans for review after final locations have been approved by BAL in accordance with DHS 83.59(4) ... 4) Conditional approval does not include any additional scope of work for the existing fire alarm system. Additional plan review information is anticipated regarding: ... c. Replacement of non-compliant devices identified by the fire alarm contractor throughout the existing CBRF areas ..." A third letter written by OPRI J (dated 08/27/2025) again included the Chapter 83 requirements for the use of a delayed egress door that included the requirement for Department approval prior to their use. A fourth letter sent to the provider on 10/08/2025, included OPRI J's Progress Inspection Report	{N 649}		

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{N 649}	Continued From page 31 from the tour on 09/25/2025. The report noted potential harm the unapproved delayed egress door at the end of the East wing caused and the continued need to remove the remaining disengaged delayed egress mechanisms: "... 8) Doors between the CBRF smoke compartment 1-C and the vacated SNF Dining / Kitchen area. BAL and OPRI raised concerns about residents becoming trapped on the upper stair landing during an emergency. Facility proposed adding power operators to the doors so that during an emergency residents could move more freely through to the safe zone on the dining room side. Proposed equipment would need to be submitted for review prior to installation. 9) Magnetic locks (decommissioned delayed egress locations) in the basement level need to be fully removed. Stair near the thrift store leading to the adjacent building; exit door near the maintenance areas. " On 09/17/2025 at approximately 10:00 AM, Surveyor toured the facility with Administrator A, Board Member and former Maintenance Director I (BM I,) Licensee M, and Lead RN K. Surveyor interviewed Administrator A and BM I 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.	{N 649}		

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{N 649}	Continued From page 32 The basement was located below the main CBRF and the unused former 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, and a salon. The basement included a private business thrift store open to the public. 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, or the delayed egress had been disengaged however the doors were still fitted with the delayed egress mechanism. Surveyor observed all delayed egress exit doors were listed as exits on the provider's emergency exit maps for any staff or members of the public 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. 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.	{N 649}		

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{N 649}	Continued From page 33 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 on 09/17/2025 included: At the end of the CBRF East wing leading to the stairwell. Internally between the CBRF washer room and the CBRF café. 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. Additionally, since the last survey on 03/04/2025, a new delayed egress door had been added to an exit within the memory care to the outdoor fenced in space. (Photo 5.) Surveyor observed areas that previously had delayed egress doors that were now disengaged but were still fitted with the delayed egress mechanism: 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. At the CBRF dining room exit to the outside. At the end of the CBRF South wing leading to the outside. At approximately 2:00 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. (Photos 3 and 4.) Once opened, the exit path led to the main CBRF common space dining area. If the	{N 649}		

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{N 649}	Continued From page 34 residents chose to exit through the east wing or the café that were equipped with delayed 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. Surveyor interviewed Administrator A with BM I and Licensee M present throughout the tour. Administrator A acknowledged the safety concerns related to the exit paths with delayed egress doors and secondary delays. Administrator A acknowledged the delayed egress doors were previously identified in 2 surveys as not approved by the Department. Both Administrator A and BM I acknowledged the provider would need to consult with a professional to review the delayed egress and exit plans and submit for Department approval. 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 N0546 DHS 83.48(4)(f) Smoke Detectors In Non-Resident Living Areas	{N 649}		