STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019426	A. BUILDING: _____ B. WING _____	R 11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSBURG HOME	**5813 WILLIAMSBURG WAY FITCHBURG, WI 53719**

(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
{M 000}	INITIAL COMMENTS From 11/05/2025 to 11/10/2025, Surveyor conducted a verification visit at Williamsburg Home, an AFH in Fitchburg. Five deficiencies were identified. Five deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) OIBW11, dated 07/15/2025. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 4	{M 000}		
{M 216}	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure the home and its operations complied with all laws governing the home and its operation. This is a repeat deficiency. See Statement of Deficiency (SOD) OIBW11, dated 07/15/2025. Findings include: From 11/05/2025 to 11/10/2025, Surveyor conducted a verification visit that resulted in the following repeat concerns: License Limitations:	{M 216}		

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

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{M 216}	Continued From page 1 - The home was licensed to serve ambulatory clients; however, the provider continued to provide care for 2 residents that required assistive devices for mobility. Environment: - The home was not fully accessible from the outside and within the home for 2 of 4 residents. - The home was not well-maintained. Resident 1's bedroom walls had unfinished drywall with holes and rips in it. Resident 1's bedroom door was off the hinges and in the hallway. - An electrical outlet in the kitchen was missing the faceplate and an outlet in the living room had a cracked faceplate, exposing wire. Resident Care: - Three of 3 residents reviewed had not been evaluated annually for their ability to evacuate the home. On 11/05/2025 at approximately 1:20 p.m., Surveyor reviewed repeat concerns with Manager A. Manager A made note of each of Surveyor's concerns and stated s/he would address the concerns. Cross Reference: M0260 DHS 88.05(2) Access To Home And Within Home M0262 DHS 88.05(2)(a) Difficulty Walking M0276 DHS 88.05(3)(a) Homelike Environment M0346 DHS 88.05(4)(d)2.b. Fire Evacuation Annual Evaluation	{M 216}		

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{M 260}	Continued From page 2	{M 260}		
{M 260}	88.05(2) ACCESS TO HOME AND WITHIN THE HOME RESIDENT ACCESS TO THE HOME AND WITHIN THE HOME. An adult family home shall be physically accessible to all residents of the home. Residents shall be able to easily enter and exit the home, to easily get to their sleeping rooms, a bathroom, the kitchen and all common living areas in the home, and to easily move about in the home. Additional accessibility features shall be provided as follows, if needed to accommodate the physical limitations of the resident or if specified in the resident's individual service plan: This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure the home was physically accessible to all residents of the home. This is a repeat deficiency. See Statement of Deficiency (SOD) OIBW11, dated 07/15/2025. Findings include: On 11/05/2025 at approximately 12:45 p.m., Surveyor reviewed resident records, which indicated the following: - Resident 2 was admitted to the provider's home on 10/24/2025. Resident 2's individual service plan	{M 260}		

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{M 260}	Continued From page 3 (ISP), dated 04/24/2025, did not indicate s/he required assistance with mobility. - Resident 3 was admitted to the provider's home on 08/26/2024. Resident 3's ISP, dated 02/30/2025, stated s/he required assistance with mobility and transfers. The ISP stated s/he needed cues and reminders to use durable medication equipment, standby assistance to ambulate safely and required assistance to transfer to prevent falls. On 11/05/2025 at approximately 12:45 p.m., Surveyor shared that Resident 3's ISP stated s/he required durable medical equipment and standby assistance to ambulate safely with Manager A. Manager A stated the date of 02/30/2025 was an error and that Resident 3's ISP needed to be updated to indicate s/he mobilized independently. On 11/05/2025 at 1:00 p.m., Surveyor toured the provider's home. The home was a split-level home that required navigating 2 flights of stairs to go from one floor to the other. The upper level included Resident 1's room, Resident 4's room, the kitchen, the dining room, a bathroom and a living room. The lower level included Resident 2's room, Resident 3's room, the laundry, a common area and a bathroom. Surveyor observed a wheelchair outside Resident 3's room. Resident 3 was not present. Surveyor observed 2 wheeled walkers in Resident 2's room. On 11/05/2025 at approximately 1:15 p.m., Surveyor interviewed Resident 2. Resident 2 stated s/he stayed s/he needed the walkers for mobility, but didn't use a wheeled walker to use the bathroom because s/he used the wall. Resident 2 stated s/he didn't go to the upper level of the home and was last out of the home 1 month ago.	{M 260}		

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{M 260}	Continued From page 4 Resident 2 stated s/he required assist of staff to get upstairs. On 11/05/2025 at approximately 1:20 p.m., Surveyor reviewed concern with Manager A that the provider currently had 2 residents requiring assistive devices for mobility, which limited the residents' ability to access the entire home. Manager A stated Resident 3 did not require a wheelchair for mobility, but rather preferred to use one while in the lower level of the home. Manager A stated Resident 2 had been issued a 30-day notice but had yet to find alternate placement. On 11/10/2025 at 8:00 a.m., Surveyor reviewed hospice records, obtained by Surveyor. The records included a care plan, dated 08/01/2025, that indicated Resident 3 used a wheelchair for mobility and required assist of 1 for transfers. The documentation indicated Resident 3 was observed sitting in a wheelchair during visits on 09/03/2025, 09/05/2025, 09/19/2025, 09/26/2026, 10/03/2025 and 10/23/2025.	{M 260}		
{M 262}	88.05(2)(a) DIFFICULTY WALKING If a resident is not able to walk at all or able to walk only with difficulty, or only with the assistance of crutches, a cane, or walker or is unable to easily negotiate stairs without assistance: 1. The exits from the home shall be ramped to grade with a hard surfaced pathway with handrails. 2. All entrance and exit doors and interior doors serving all common	{M 262}		

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{M 262}	Continued From page 5 living areas and all bathrooms and bedrooms used by a resident not able to walk at all shall have a clear opening of at least 32 inches. 3. Toilet and bathing facilities used by a resident not able to walk at all shall have enough space to provide a turning radius for the resident's wheelchair and provide accessibility appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure the home had exits ramped to grade with a hard surfaced pathway and handrails and bathrooms with enough space to provide a turning radius for residents utilizing assistive devices for mobility. This is a repeat deficiency. See Statement of Deficiency (SOD) OIBW11, dated 07/15/2025. Findings include: On 11/05/2025 at approximately 12:45 p.m., Surveyor reviewed resident records, which indicated the following: - Resident 2 was admitted to the provider's home on 10/24/2025. Resident 2's individual service plan (ISP), dated 04/24/2025, did not indicate s/he required assistance with mobility. - Resident 3 was admitted to the provider's home on 08/26/2024. Resident 3's ISP, dated 02/30/2025, stated s/he required assistance with mobility and transfers. The ISP stated s/he needed	{M 262}		

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{M 262}	Continued From page 6	{M 262}		

cues and reminders to use durable medication equipment, standby assistance to ambulate safely and required assistance to transfer to prevent falls.

On 11/05/2025 at 1:00 p.m., Surveyor toured the provider's home and observed the front entrance required 1 step to enter the home (no ramp) and upon entrance to the home, required an individual to go up 1 flight of stairs to reach the upper level or down 1 flight of stairs to reach the lower level. Surveyor observed the back door required individuals to go down 1 flight of stairs (no ramp) which led to an area of weeds and trees (no hard surfaced path). Inside the home Surveyor observed the bathrooms did not have adequate space to navigate an assistive device, such as a walker or wheelchair. Surveyor observed a wheelchair outside Resident 3's room and 2 wheeled walkers in Resident 2's room.

On 11/05/2025 at approximately 1:15 p.m., Surveyor interviewed Resident 2. Resident 2 stated s/he stayed s/he needed the walkers for mobility, but didn't use a wheeled walker to use the bathroom because s/he used the wall. Resident 2 stated s/he didn't go to the upper level of the home and was last out of the home 1 month ago. Resident 2 stated s/he required assist of staff to get upstairs.

On 11/05/2025 at approximately 1:30 p.m., Surveyor interviewed Manager A and shared concern that 2 of 4 residents required assistance with mobility and did not have the ability to access the entire home. Manager A stated Resident 2 had been issued a 30-day notice but had not found alternate placement yet. Manager A stated Resident 3 didn't truly need assistance with

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{M 262}	Continued From page 7 mobility. On 11/10/2025 at 8:00 a.m., Surveyor reviewed hospice records, obtained by Surveyor. The records included a care plan, dated 08/01/2025, that indicated Resident 3 used a wheelchair for mobility and required assist of 1 for transfers. The documentation indicated Resident 3 was observed sitting in a wheelchair during visits on 09/03/2025, 09/05/2025, 09/19/2025, 09/26/2025, 10/03/2025 and 10/23/2025.	{M 262}		
{M 276}	88.05(3)(a) Homelike Environment An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the home was well-maintained. This is a repeat deficiency. See Statement of Deficiency (SOD) OIBW11, dated 07/15/2025. Findings include: On 11/05/2025 at approximately 1:15 p.m., Surveyor toured the provider's home and identified the following concerns:	{M 276}		

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{M 276}	Continued From page 8 - Resident 1's room had walls with drywall boards from the floor to approximately halfway up the wall. The drywall had areas that were ripped and had holes. Resident 1's bedroom door was off the hinges and resting against the wall in the hallway. - An electrical outlet in the kitchen was missing the faceplate and an electrical outlet in the living room was cracked, exposing wire. As Surveyor toured the home with Manager A, Surveyor shared the above concerns with Manager A. Manager A stated Resident 1's room was in the condition it was because Resident 1 was extremely behavioral. Manager A stated Resident 1 had just tore the door off the hinges within the past 24 hours. Manager A stated unless Resident 1 was given soda or driven around by staff, s/he engaged in property destruction. Manager A stated s/he was working with the managed care organization in hopes of covering Resident 1's bedroom walls with some other material. Manager A made note of Surveyor's concern related to electrical outlets and stated the outlet in the kitchen was not used.	{M 276}		
{M 346}	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated annually for evacuation time, using the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than 2 minutes.	{M 346}		

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{M 346}	Continued From page 9 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 residents who had resided at the home for greater than 1 year were evaluated annually for evacuation time, using the department's form. Resident 1, Resident 2 and Resident 3 had not had their evacuation time, using the department's form, for greater than 1 year. This is a repeat deficiency. See Statement of Deficiency (SOD) OIBW11, dated 07/15/2025. Findings include: On 11/05/2025 at approximately 1:00 p.m., Surveyor reviewed resident records, which documented the following: - Resident 1 was admitted to the provider's home on 04/11/2024. Resident 1's evacuation assessment was dated 04/15/2024. The record did not include an evacuation assessment completed within the past year. - Resident 2 was admitted to the provider's home on 10/24/2024. Resident 2's evacuation assessment was dated 10/25/2024. The record did not include an evacuation /assessment completed within the past year. - Resident 3 was admitted to the provider's home on 08/26/2024. Resident 3's evacuation assessment was dated 08/26/2024. The record did not include an evacuation assessment completed within the past year. On 11/05/2025 at approximately 1:20 p.m.,	{M 346}		

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{M 346}	Continued From page 10 Surveyor reviewed concern with Manager A that 3 of 3 residents that had resided at the home greater than 1 year did not have an evacuation assessment, using the department's form, completed within the past year. Manager A reviewed resident records and confirmed the records did not include evacuation assessments completed within the past year. Manager A made note of Surveyor's concern.	{M 346}		