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 04/15/2026

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 04/08/2026 to 04/15/2026, Surveyor conducted a verification visit and complaint investigation at Williamsburg Home, an AFH in Fitchburg. Six deficiencies were identified. Four deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) OIBW11, dated 07/15/2025 and SOD OIBW12, dated 11/102/2025. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 3	{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 and SOD OIB12, dated 04/15/2026. Findings include: From 04/08/2026 to 04/15/2026, Surveyor conducted a complaint investigation and	{M 216}		

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

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{M 216}	Continued From page 1 verification visit, which resulted in the following concerns: Repeat Deficienicies: - The provider, which is licensed as an ambulatory home, continued to care for a resident that required assistance for mobility. The resident's non-ambulatory status limited physical access throughout the home. - The provider did not ensure the home had 2 exits ramped to grade with a hard surfaced pathway and handrails and bathrooms with enough space to provide a turning radius for a resident that used a wheelchair. - The provider did not ensure the home was safe and homelike. A resident's room had drywall boards covering the wall with numerous areas that were ripped, pushed in and stained. Blinds were ripped and broken, leaving the windows not fully covered. An outlet was missing a faceplate. A resident's window was filled with Kleenex's pushed into the frame. Substantiated Complaint: - 1:1 dedicated staffing with line of sight supervision was not provided on 01/03/2026 resulting in Resident 4 eloping from the home. Non-Compliance of Special Orders: On 01/22/2026, the provider was issued special orders with SOD OIBW12, dated 11/10/2024. The special orders stated the following: - "WITHIN 7 DAYS of receipt of this notice, the licensee shall provide each resident's legal representative and case manager (if any) with a copy of Statement of Deficiency OIBW12 and a copy of this Notice and Order letter. The licensee shall retain evidence, acceptable to the department, to verify compliance with this Order.	{M 216}		

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{M 216}	Continued From page 2 Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from each legal representative and case manager. " - "WITHIN 21 DAYS of receipt of this notice, the licensee shall hold a separate care conference for Resident 2 and Resident 3, with their legal representative, and case manager (if any), for the purpose of discussing the resident's mobility needs and the resident's access to the home and within the home." - "WITHIN 45 DAYS of receipt of this notice, if compliance with Wis. Admin. Code § DHS 88.05(2)(a) is not achieved, the licensee shall establish a relocation plan addressing the discharge of any resident who 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." On 04/08/2026 at approximately 1:40 p.m., Surveyor discussed concern with Manager A that Resident 3, who was observed using a wheelchair, remained in the home, which was licensed as a non-ambulatory home. Manager A stated s/he didn't believe Resident 3 truly required the use of a wheelchair, so Resident 3 was not discharged. Manager A stated Resident 2 discharged due to his/her non-ambulatory status. On 04/13/2025 at approximately 11:30 a.m., Surveyor requested documentation to indicate notifications to legal representatives and case managers occurred upon receiving SOD OIBW12, dated 11/10/2025. On 04/14/2026 at approximately 2:30 p.m., Manager A stated all notifications were completed via telephone. Acceptable documentation, as	{M 216}		

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{M 216}	Continued From page 3 identified in the enforcement letter as certified mail or email, was not provided.	{M 216}		
{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 and SOD OIBW12, 11/10/2025. Findings include: On 04/08/2026 at 11:30 a.m., Surveyor toured the provider's home. The home was a split-level	{M 260}		

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{M 260}	Continued From page 4	{M 260}		

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 3's room, the laundry, a common area and a bathroom.

On 04/08/2026 at 11:40 a.m., Surveyor observed Resident 3 sitting in a wheelchair in his/her room.

On 04/08/2026 at approximately 12:00 p.m., Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider's home on 08/26/2024 with diagnosis of dementia. Resident 3's individual service plan (ISP), dated 02/30/2025 [sic], indicated s/he required standby assist to ambulate safely and cues/reminders to use durable medical equipment. A managed care organization (MCO) referral form, dated 02/29/2024, documented Resident 3 used a wheelchair and walker for mobility and needed assist to transfer. The referral form indicated Resident 3 could not safely climb stairs. Resident 3's record included a wellness visit, dated 12/18/2025, that documented Resident 3 used a wheelchair for assistance, felt unsteady when standing or walking and worried about falls.

On 04/08/2026 at 1:30 p.m., Surveyor observed Resident 3 sitting outside. Manager B stated Resident 3 had navigated the stairs from his/her room to the exterior of the home independently. Surveyor observed that Managed Care Case Manager C was present visiting Resident 3. Surveyor shared concern with Managed Care Case Manager C that Resident 3, who was observed earlier in a wheelchair and had a record indicating s/he required durable medical equipment for mobility, was residing in an

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{M 260}	Continued From page 5 ambulatory home and did not have full access to the home. Managed Care Case Manager C stated Resident 3 was in need of emergent placement at the time of admission On 04/08/2026 at approximately 1:35 p.m., Surveyor observed Resident 3 get up to re-enter the home. Resident 3 required a hand to navigate up 1 concrete step to reach the front door of the home before navigating down the stairs to his/her room with the use of handrails on both side and staff following behind. On 04/08/2026 at approximately 1:40 p.m., Surveyor reviewed concern with Manager A that Resident 3, who required assistance for mobility, resided in an ambulatory home and did not have full access to the home. Manager A stated s/he didn't believe Resident 3 truly required assistance to mobilize throughout the home, but that s/he would issue a 30-day notice to terminate placement if necessary.	{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 living areas and all bathrooms and bedrooms used by a resident not able to walk at all shall have a clear	{M 262}		

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

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 and SOD OIBW12, dated 11/10/2025.

Findings include:

The provider is licensed to provide care for individuals with primary diagnoses including developmentally disabled, emotionally disturbed/mental illness and alcohol/drug dependent. The provider is licensed to provide care to individuals who are ambulatory. Chapter DHS 88 defines "ambulatory" as able to walk without difficulty or help.

On 04/08/2026 at 11:30 a.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 3's

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{M 262}	Continued From page 7	{M 262}		

room, the laundry, a common area and a bathroom.

On 04/08/2026 at 11:40 a.m., Surveyor observed Resident 3 sitting in a wheelchair in his/her room.

On 04/08/2026 at approximately 12:00 p.m., Surveyor reviewed Resident 3's record provided by Manager B. Resident 3 was admitted to the provider's home on 08/26/2024 with diagnosis of dementia. Resident 3's individual service plan (ISP), dated 02/30/2025 [sic], indicated s/he required standby assist to ambulate safely and cues/reminders to use durable medical equipment. A managed care organization (MCO) referral form, dated 02/29/2024, documented Resident 3 used a wheelchair and walker for mobility and needed assist to transfer. The referral form indicated Resident 3 could not safely climb stairs. Resident 3's record included a wellness visit, dated 12/18/2025, that documented Resident 3 used a wheelchair for assistance, felt unsteady when standing or walking and worried about falls.

On 04/08/2026 at approximately 12:30 p.m., Surveyor observed the emergency exits. The home had a front exit, which required a flight of stairs from the upper level and lower level to reach. The lower level's second exit, where Resident 3's bedroom was located, was an egress window. The egress window led to uneven terrain (no hard surface path). The upper level's second exit was a balcony with a full flight of stairs leading to uneven terrain (no hard surface path).

On 04/08/2026 at approximately 1:40 p.m., Surveyor reviewed concern with Manager A that Resident 3, who required assistance for mobility,

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{M 262}	Continued From page 8 resided in an ambulatory home and did not have full access to the home. Manager A stated s/he didn't believe Resident 3 truly required assistance to mobilize throughout the home, but that s/he would issue a 30-day notice to terminate placement if necessary.	{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 homelike and comfortable. This is a repeat deficiency. See Statement of Deficiency (SOD) OIBW11, dated 07/15/2025 and SOD OIBW12, dated 11/10/2025. Findings include: On 04/08/2026, Surveyor conducted a verification visit and observed the following concerns: - Resident 1's room had walls with drywall boards from the floor to approximately halfway up the wall. The drywall board had numerous areas that were ripped, pushed in and stained. - Resident 1's blinds were ripped and broken,	{M 276}		

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{M 276}	Continued From page 9 leaving the blinds unable to completely cover the window. - An electrical outlet in the lower level was missing a faceplate. - Resident 3's bedroom windows had Kleenex pressed along the perimeter of the window and did not have a screen to allow for ventilation. Resident 3 reported there was a draft coming in his/her windows. On 04/08/2026 at approximately 1:20 p.m., Surveyor reviewed environmental concerns with Manager A and House Manager B. Manager A stated s/he would speak to Resident 1's managed care organization to see if they would fund alternate options for Resident 1's walls. House Manager B stated Resident 3 hallucinated and shoved Kleenex in his/her window. House Manager B denied a draft in Resident 3's room.	{M 276}		
M 338	88.05(4)(c)1 EXITING FROM THE FIRST FLOOR Exiting from the first floor. The first floor of the home shall have at least 2 means of exiting which provides unobstructed access to the outside. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the home had 2 unobstructed exits to the outside. The provider's front door required 3 locks to be disengaged to exit the home. Findings include: The provider is licensed to serve up to 4	M 338		

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M 338	Continued From page 10	M 338		

individuals with diagnoses including emotionally disabled/mental illness, alcohol/drug dependent, developmentally disabled and correctional clients.

On 04/08/2026 at 11:36 a.m., Surveyor observed the home had 3 separate locks to exit the home via the front door. The front door had a chain lock at the top of the door, a deadbolt lock and a lock on the doorknob. Surveyor toured the remainder of the home and observed the front door was 1 of 2 emergency exits from the home and marked with an emergency light.

On 04/08/2026 at 12:00 p.m., Surveyor reviewed resident records, which documented the following:

- Resident 1 admitted to the home on 04/11/2024 with history of self-injurious behaviors. Resident 1 had a legal guardian.
- Resident 3 was admitted to the provider's home on 08/26/2024 with diagnosis of dementia. Resident 3 had a legal guardian.
- Resident 4 was admitted to the provider's home on 06/23/2025 with diagnoses including encephalopathy, prolonged institutionalization, reported childhood abuse and history of sexual offenses requiring intensive supervision. Resident 4 had a legal guardian.

On 04/08/2026 at approximately 1:20 p.m., Surveyor reviewed concern with Manager A that the provider's front door was obstructed with 3 locks. Manager A stated s/he thought s/he was in compliance because there was not a keycode lock present to exit the home. Surveyor asked why the provider installed 3 locks to exit the home. Manager A stated s/he wasn't sure. Manager A explained that s/he had been away from the home for greater than 1 month and

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M 338	Continued From page 11 wasn't sure who installed the 3 locks.	M 338		
M 436	88.07(2)(a) SERVICES The licensee shall provide or arrange for the provision of individualized services specified in a resident's individual service plan that are the licensee's responsibility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure services specified in a resident's individual service plan (ISP) were provided. On 01/03/2026, Resident 4's dedicated staff did not provide continuous line of sight supervision resulting in an elopement. Findings include: From 04/08/2026 to 04/15/2026, Surveyor conducted a complaint investigation alleging supervision concerns at the home. On 04/08/2026 at 12:00 p.m., Surveyor reviewed Resident 4's record, provided by Manager B. Resident 4 was admitted to the provider's home on 06/23/2025 with diagnoses including encephalopathy, prolonged institutionalization, reported childhood abuse and history of sexual offenses requiring intensive supervision. Resident 4's record included an incident report, dated 01/03/2026, that stated Resident 4 exited the	M 436		

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M 436	Continued From page 12	M 436		

home without staff awareness while assigned staff briefly used the bathroom. The report documented staff immediately initiated a search of the home and surrounding premises and after approximately 10 minutes of being unable to locate Resident 4, staff contacted law enforcement. The report documented law enforcement later contacted the provider's staff and stated Resident 4 had been located nearby, transported to a hospital and was transported back to the home at approximately 8:00 a.m. with no injuries.

On 04/08/2026 at 12:30 p.m., Surveyor interviewed Manager A. Manager A stated Resident 4 had left the home in January while staff used the bathroom. Manager A stated after Resident 4 exited the home, s/he flagged down a cab that was driving by and the driver took him/her to the hospital. Manager A stated s/he determined Resident 4 exited the home at approximately 6:45 a.m. per staff report and an exterior camera. Manager A stated Resident 4's dedicated staff was using the bathroom at the time of Resident 4's elopement. Manager A stated the dedicated staff member should have asked another staff member to cover while s/he used the bathroom and that Manager A provided re-education after the incident.

On 04/10/2026 at approximately 1:45 p.m., Surveyor received the following from Manager A:

- A "Dedicated Staffing" inquiry form that defined dedicated staffing as a staffing pattern in which 1 or more staff were assigned to one specific member, for a pre-determined duration of time per day, to support the member's high acuity needs due to behavioral, cognitive, or medical conditions. The form stated staff must always be

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M 436	Continued From page 13 at minimum within line-of-sight of the member receiving the dedicated staffing. The form indicated dedicated staffing was requested on 07/10/2025 due to unsafe behaviors including sexual exhibitionism, elopement attempts and physical aggression. The form stated Resident 4 had frequently attempted to exit the home at night, requiring redirection multiple times per shift. - A behavioral support plan, dated 07/17/2025, that indicated all staff assigned to Resident 4 must review the behavioral support plan, including supervision protocols, triggers and escalation signs, the provider must maintain 24/7 awake 1:1 line-of-sight supervision in a manner that is respectful and least restrictive and the provider must maintain continuous door awareness, especially during early mornings, staff transitions, or brief staff absences (ex. Restroom use). On 04/15/2026 at 1:00 p.m., Surveyor reviewed concern with Manager A that Resident 4 was able to elope from the home on 01/03/2026 when s/he did not receive line of sight supervision as indicated in his/her behavioral support plan. Manager A acknowledged concern.	M 436		