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 06/01/2026

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 05/26/2026, Surveyor conducted a verification visit, self-report review, and 1 complaint investigation at Homme Residential Wittenberg. Additional information was gathered through 06/01/2026. The complaint and self-report were unsubstantiated. As a result of the verification visit, 2 deficient practices were identified. The deficient practices identified were repeat x2 and x3. Under statutory provisions, a $200 revisit fee is being assessed for the follow-up licensing visit. Census: 28	{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 the Community Based Residential Facility (CBRF) and its operation complied with all laws governing the CBRF. The licensee did not provide accurate information about the facility plant for the Department to verify compliance with Chapter 83 fire codes. This is a repeat deficient practice x2. See Statement of Deficiency (SOD) Y5HZ12 (dated 03/04/2025) and SOD Y5HZ13 (dated 10/08/2025.) The facility is licensed to serve up to 75 residents	{N 196}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{N 196}	Continued From page 1 who may have diagnoses including: physically disabled, of advance age, emotionally disturbed/ mental illness, and /or irreversible dementia/ Alzheimer's disease. Findings include: On 12/16/2025, the provider received the Statement of Deficiency (SOD) Y5HZ13 (dated 10/08/2025) and enforcement orders to comply with requirements as soon as practicable and without delay. SOD Y5HZ13 noted: "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 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.	{N 196}		

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{N 196}	Continued From page 2 On 11/24/2025 a stipulated agreement was signed into effect which noted " ... e. All plans submitted to OPRI must be verified by the architect for accuracy prior to submission to OPRI. The plan submissions must include a signed statement from the architect that the plans have been reviewed and confirmed for completeness and accuracy." SOD Y5HZ13 noted the provider's submitted plans were not accurate to the building's physical plant and structural composition in relation to their fire rating. Both SOD Y5Z13 and the stipulated agreement (entered into with the Department on 11/24/2025) noted the provider was required to have professionally certified and accurate building plans as the provider is required to be able to verify the composition and fire rating of their building to verify compliance with fire safety regulations. As such, a verification visit was conducted on 05/26/2026 to verify that certified and accurate plans were obtained to allow for a review of the facilities fire rating and ensure compliance with the Chapter 83 fire codes. Survey on 05/26/2026 On 05/26/2026, Surveyor conducted a verification visit and at 9:20 AM requested to review the provider's updated and professionally certified facility floor plans. Maintenance Director Z gave Surveyor a copy of the floor plans (Plan 3). Surveyor noted Plan 3 did not have a stamp or signature of certification. Board Member I (BM I) then gave Surveyor a copy of a floor plan (Plan 4) and stated it was the most recent and up to date plan from the provider's hired professionals. Plan 4 was certified by the provider's hired professionals on 11/03/2025. Surveyor reviewed Plan 4 and discovered it was the same as Plan 1, including all the inaccuracies that were identified	{N 196}		

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{N 196}	Continued From page 3 in SOD Y5HZ13. Upon review, State Architect AA stated s/he had not recieved Plan 4 for OPRI review. Neither Surveyor nor State Architect AA could determine the fire rating of the buildings walls and floors within Plan 4 as the plan, although certified, was visibly not accurate to the structures observed on tour. As the certified plans continued to contain inaccuracies, Surveyor was unable to rely upon them for verification of compliance with Chapter 83 regulations related to the fire rating for the walls and floors and locations and installation of required smoke detectors. State Architect AA noted in a Building Inspection Report sent to the provider on 05/27/2026: "Architectural Plans/Fire & Smoke Rated Assemblies 1) During the building tour it was discovered that the approved plans do not accurately match the existing conditions of the facility in all areas. The following locations were areas noted to be inaccurate: Lower-level within the stair enclosure adjacent to the 'B Occupancy'. Lower-level equipment and mechanical room area adjacent to the 'B Occupancy'. Lower-level on the south side of the corridor within the 'B Occupancy' and adjacent to the bath and tub/shower room. 1st floor Oxygen room is missing from plan. 2) During the inspection, [BM I] provided a revised architectural plan from [the provider's hired professionals.] The plan was a revised version of the previously approved architectural plan (originally approved on 04/08/25). This plan had not been sent to OPRI for review as a revision. The revised plan included updates to fire barrier wall ratings and locations as well as wall	{N 196}		

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{N 196}	Continued From page 4 assembly details for the fire barrier walls. These plans still indicated that the horizontal assembly between the lower-level and first floor was a 2-hour rated assembly. Per the inspection from [State Architect J] on 09/25/25, it was determined that the floor assembly did not meet a 2-hour fire rating. No construction activities to the floor assembly have taken place since that inspection. Any updated plans that denote this floor system to have an hourly fire rating shall include a detail with UL listing for the assembly. Per DHS 83.63/SPS 361.31, this plan will require a seal/signature from the supervising professional and will require submittal as a revision to OPRI. The plans will also be required to provide a referenced UL listing for each wall assembly detail for the fire barriers. 3) The fire barrier wall between the Skilled Nursing Occupancy and the business/Main entry area of the CBRF is indicated on the approved plan to be a 2-hour fire barrier ... Additionally, on this wall over the double doors, the plan indicates this wall assembly consists of 2 layers of gypsum board on each side to meet a 2-hour fire rating. This will require confirmation by creating a small opening into the wall where both layers of gypsum board can be viewed. Please send a photo for confirmation." On 05/26/2026 at 2:00 PM, Surveyor interviewed Administrator X, RN Supervisor K, Accounting Manager R, Maintenance Director Z, and Licensee M. Surveyor reviewed with the provider the inconsistencies within the different versions of the floor plans, and the requirement for an accurate plan to verify compliance. Administrator X acknowledged the areas of the plan that were not accurate and required a professional review and certification. Administrator X acknowledged	{N 196}		

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{N 196}	Continued From page 5 the provider needed to take ownership of their own records they need to prove compliance and ensure the professionals they choose to hire conduct a thorough review, including construction ratings and correction of the errors prior to submitting the plan to the Department. Administrator X acknowledged each of the identified areas that needed to be addressed and stated s/he would take immediate corrective action to come into compliance. As a result of not being in compliance with the laws governing a CBRF, 2 repeat violations were issued 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 the Community Based Residential Facility (CBRF) and its operation complied with all laws governing the CBRF. The licensee did not provide accurate information about the facility plant for the Department to verify compliance with Chapter 83 fire codes. This is a repeat deficient practice x2. See Statement of Deficiency (SOD) Y5HZ12 (dated 03/04/2025) and SOD Y5HZ13 (dated 10/08/2025.) 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. 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.	{N 196}		

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{N 196}	Continued From page 6 This is a repeat deficient practice x3. See Statement of Deficiency (SOD) Y5HZ11 (dated 02/27/2024,) SOD Y5HZ12 (dated 03/04/2025,) and SOD Y5HZ13 (dated 10/08/2025.) Cross Reference: N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment	{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 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. The facility's physical plant was not in compliance including the emergency system, emergency egress, and fire detection systems that were not installed in required areas. This is a repeat deficient practice x3. See Statement of Deficiency (SOD) Y5HZ11 (dated 02/27/2024,) SOD Y5HZ12 (dated 03/04/2025,) and SOD Y5HZ13 (dated 10/08/2025.) The facility is licensed to serve up to 75 residents	{N 358}		

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{N 358}	Continued From page 7 who may have diagnoses including: physically disabled, of advance age, emotionally disturbed/ mental illness, and /or irreversible dementia/ Alzheimer's disease. Findings Include: Facility Layout The Community Based Residential Facility (CBRF) is built into a hill resulting in half of the basement being ground level for exit and half of the basement requiring ascension to the first floor to exit at ground level. Additionally, the first floor was half at ground level for exit and half required 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 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	{N 358}		

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{N 358}	Continued From page 8 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. 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. Enforcement for the previous SOD Y5HZ13 dated 10/08/2025, included reinstatement of the order not to admit new residents and to reinstate the fire watch as the survey discovered the fire safety system installation was not completed. General Findings	{N 358}		

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{N 358}	Continued From page 9 On 05/26/2026 at 9:30 AM, Surveyor toured the facility with Administrator X, State Regional Director Y, Office of Plan Review and Inspection (OPRI) State Architect AA, and Maintenance Director Z, with Board Member B, and Accounting Manager R present at times. Surveyor interviewed Administrator X throughout the tour. Surveyor observed areas within the building that were not in compliance: Path of Egress -The internal corridor main entrance door to the memory care (MC) wing was equipped with a magnetic lock that required a code to enter through the door into the MC wing. The locked door was within an emergency exit path of egress and created a barrier. -The South wing had a door that lead into the activity room space of the MC wing that was locked from the South wing side. The locked door was within a path of egress and created a barrier. -At the end of the MC wing the door that leads to exterior steps for evacuation required Surveyor to use great force to open. Signage Emergency doors were observed to be without emergency signage including: -The 1st floor stair enclosure on West side of the skilled nursing had a door exiting to the exterior that did not have the required exit sign. - The adjacent door leading into the SNF did not have a sign to indicate it is not an emergency exit. -The lower-level stair enclosure (enclosure that leads to east side of the 2nd floor) did not have a sign on the door leading into the corridor to indicate it is not an emergency exit. Construction -The West exit on the first floor had sidewalk with	{N 358}		

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{N 358}	Continued From page 10 uneven concrete creating a lip of greater than 1 inch that residents who require ambulatory equipment may not be able to negotiate. Additionally, there was patchwork that had a slope that was greater than 1 inch of rise per 1 foot of run. -State Architect AA noted in a Construction Inspection Report sent to the provider on 05/27/2026, "...3) The fire barrier wall between the Skilled Nursing Occupancy and the business/Main entry area of the CBRF is indicated on the approved plan to be a 2-hour fire barrier. During the inspection it was observed that this wall contained 2 'scab patches' (above the ceiling) which do not meet a through penetration firestop system or meet a listed and tested wall assembly. These patches will require correction ..." -The door by the main lobby leading to the SNF had the fire rating sticker occluded by paint and could not be verified as a 90-minute fire rated door. Smoke Detection Surveyor observed rooms where smoke detectors were not installed or required a 2nd smoke detector to cover the space: -The lower-level laundry area (room adjacent to dryer room) had a smoke detector that was placed towards the south end of the ceiling. State Architect AA noted in the Construction Inspection Report the space, " ...requires relocation of the existing detector or an additional detector to ensure the detection device is not located greater than 15-feet from any wall." -The 2nd floor Living room (east side of 2nd floor) contained a space separated with a lintel that	{N 358}		

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{N 358}	Continued From page 11 exceeded 8-inches. The space contained a notification appliance but was not equipped with the required smoke detector. -The 1st floor Tub/Shower Room in the South Wing had the bathing fixtures removed and was no longer used as a bathing room. The room contained an area (former tiled shower) that had lintels greater than 8 inches. Both the room and the area separated by the lintel required smoke detection. Evacuation Plan Surveyor reviewed the provider's evacuation plan and noted the plan described utilizing an area of refuge at the end of the MC wing in the event of a fire. Surveyor observed the area of refuge that was included in their evacuation plan and on the facility floor plan was not updated to meet the code requirements for an area of refuge. State Architect AA noted in the Construction Inspection Report, "4) During the inspection it was discussed that the 1-hour fire resistance rated Area of Refuge as indicated in the approved plans, at the end of the Memory Care Wing, had not undergone any repairs to correct the items noted from [State Architect J's] inspection on 09/25/25. Those items were as follows: Extend fire barrier walls to the roof-sheathing. The door to have positive latching or provided with smoke gaskets. IBC section 716.5.3.1 requires the doors to be smoke and draft control tested in accordance with UL 1784. Areas of refuge are required to include two-way communication systems in accordance with IBC section 1009.8. If this area is utilized as an Area of Refuge as indicated in the facility's emergency evacuation plan, then the noted items will require correcting ..."	{N 358}		

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{N 358}	Continued From page 12 During the tour on 05/26/2026 at 1:30 PM, Administrator X stated the provider was unsure if they would pursue the modifications required to use the space as an area of refuge. At 2:30 PM Administrator X acknowledged the provider's evacuation plan included the area of refuge. Administrator X stated the evacuation plan would be modified to accurately reflect the physical plant of the facility and plan for evacuation. On 05/26/2026 at 2:00 PM, Surveyor interviewed Administrator X, RN Supervisor K, Accounting Manager R, Maintenance Director Z, and Licensee M. Surveyor reviewed the observations and finding from the tour of the facility and records submitted for compliance verification. Administrator X acknowledged each of the identified areas that needed to be addressed and stated s/he would take immediate corrective action to come into compliance. Cross Reference N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	{N 358}		