STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525546	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Health Services	1712 Monroe St New Holstein, WI 53061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on staff interview and record review, the facility did not ensure a potential allegation of neglect was investigated for 1 resident (R) (R1) of 1 sampled resident.On 4/20/25, R1 incurred bilateral femur fractures when staff did not transfer R1 in accordance with R1's plan of care. The facility did not thoroughly investigate the potential allegation of negelct. Findings include:The facility's Abuse, Neglect and Exploitation policy, revised 7/15/22, indicates: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property .Investigation of alleged abuse, neglect and exploitation: .An immediate investigation is warranted when an allegation or suspicion of abuse, neglect or exploitation, or a report of abuse, neglect or exploitation occurs. B. Written procedures for investigations include Identifying staff responsible for the investigation .identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations, focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred .and providing complete and thorough documentation of the investigation .4. Taking all necessary actions as a result of the investigation, which may include, but are not limited to the following: Analyzing .what changes may be needed to prevent future occurrences, defining whether care provisions should be changed and/or improved to protect residents .training staff on changes made and demonstration of staff competency after training is implemented, identification of staff responsible for corrective actions .On 6/27/25, Surveyor reviewed a facility-reported incident (FRI) that indicated on 4/20/25, R1 was transferred via sit-to-stand lift from the edge of R1's bed. R1 was sitting at the edge of the bed when Certified Nursing Assistant (CNA)-D fastened a medium-size sling around R1 and attached the sling to the lift. R1 indicated R1 was ready and held the bar. As CNA-D began to lift R1, R1's legs immediately buckled and R1 fell to the left. When CNA-D called for help, another CNA and Licensed Practical Nurse (LPN)-C responded. Staff lowered the bed and lifted R1 back to the edge of the bed. LPN-C assessed R1 who complained of bilateral leg pain. LPN-C administered Tylenol and checked back with R1 at approximately 9:15 AM. R1 only allowed LPN-C to lift R1's knees a few inches without screaming in pain and reported pain at a level 10 out of 10. R1 was transferred to the emergency room (ER) and diagnosed with bilateral distal femur fractures that required surgical intervention. Surveyor noted the FRI did not contain an interview with R1 regarding the lift and sling that were used or CNA-D's technique during the transfer. Surveyor also noted residents were not interviewed to ensure there were no further allegations of neglect or improper transfers. On 6/27/25, Surveyor reviewed R1's medical record. R1 had diagnoses including bilateral distal femur fractures (4/20/25), fibromyalgia, unspecific dementia, age-related osteoporosis, anemia, and left artificial hip joint. A Minimum Data Set (MDS) assessment, dated 5/1/25, indicated R1 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R1 had moderate cognitive impairment. R1 was R1's own decision maker. R1's medical record contained a care plan that indicated on 4/20/25, R1 was a two-person assist for all transfers with a sit-to- stand lift. The care plan contained a revision on 4/25/25 that indicated R1 was a two-person assist for all transfers with a full body lift.On 6/27/25 at 1:55 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated NHA-A did not interview other residents about transfers or care provided by CNA-D. NHA-A indicated a summary of an interview with R1 was included in the FRI.On 6/27/25 at 2:15 PM, Surveyor interviewed Director of Nursing (DON)-B who verified residents were not interviewed to rule out further neglect by CNA-D and indicated resident interviews were missed during the investigation. Surveyor requested copy of the FRI from DON-B and confirmed the FRI did not contain an interview with R1.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on staff interview and record review, the facility did not ensure staff transferred 1 resident (R) (R1) of 1 sampled resident in accordance with their plan of care and the facility's policy. On 4/20/25, R1 fell during a mechanical lift transfer and incurred bilateral distal femur fractures when Certified Nursing Assistant (CNA)-D did not follow R1's care plan or the facility's transfer policy.Findings include:The facility's Safe Resident Handling and Transfers policy, revised 8/5/22, indicates: It is the policy of this facility to ensure residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure, and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines .All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. While manual lifting techniques may be used dependent upon the resident's condition and mobility, the use of mechanical lifts are a safer alternative and should be used .The facility will ensure there are appropriate amounts of varying sling sizes to accommodate residents and residents are measured correctly per manufacturer's instructions .Ensure the sling designed for the lift is used with that specific lift .Two staff must be used when transferring residents with a mechanical lift .Staff are expected to maintain compliance with safe handling/transfer practices . Resident lifting and transferring will be performed according to the resident's individual plan of care .Staff will perform mechanical lifts/transfers according to the manufacturer's instructions for use of the device .On 6/27/25, Surveyor reviewed a facility-reported incident (FRI) that indicated on 4/20/25 at approximately 7:50 AM, R1 sat at the edge of R1's bed and CNA-D fastened a medium-size sling around R1 and attached the sling loops to a sit-to-stand lift. When CNA-D lifted R1, R1's legs buckled and R1 fell to the left. When CNA-D called for help, another CNA and Licensed Practical Nurse (LPN)-C provided assistance and lifted R1 back to the edge of the bed via lift. LPN-C assessed R1 who reported bilateral leg pain. Tylenol was administered. When LPN-C checked on R1 at approximately 9:15 AM, R1 only allowed LPN-C to lift R1's knees a few inches without screaming in pain and reported pain at a level 10 out of 10. R1 was transferred to the emergency room (ER) and diagnosed with bilateral distal femur fractures that required surgical intervention. The FRI indicated the root cause of the fall was that CNA-D did not follow R1's care plan or the facility's Safe Resident Handling and Transfers policy. On 6/27/25, Surveyor reviewed R1's medical record. R1 had diagnoses including bilateral distal femur fractures (4/20/25), fibromyalgia, unspecific dementia, age-related osteoporosis, generalized osteoarthritis, and left artificial hip joint. A Minimum Data Set (MDS) assessment, dated 5/1/25, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R1 had moderate cognitive impairment. R1 was R1's own decision maker. A care plan indicated on 4/20/25, R1 required the assistance of two staff for all transfers with a sit-to-stand lift. The care plan was revised on 4/25/25 to indicate R1 required the assistance of two staff for all transfers with a full body lift.A progress note, dated 4/23/25 by Director of Nursing (DON)-B, indicated Primary Care Physician (PCP)-E was notified of R1's fall from the lift and that R1 was transferred with the assistance of one staff instead of two. PCP-E was informed that R1 was transferred to the ER and then to a second hospital due to bilateral distal femur fractures.An Interdisciplinary Team (IDT) meeting note, dated 4/25/25, indicated DON-B, Activity Director (AD)-F, and Nursing Home Administrator (NHA)-A were in attendance. The note indicated CNA-D completed Activities of Daily Living (ADLs) for R1 on 4/20/25 and attempted to transfer R1 into a wheelchair via mechanical lift. Prior to the transfer, R1 was sitting at the edge of R1's bed with the lift sling securely attached to the lift and the lift belt strapped around R1's waist. CNA-D indicated R1 was a few inches off the bed when R1 fell from the lift. After CNA-D called for help, LPN-C entered the room and observed R1 on the floor with R1's feet on the lift platform. R1's legs were in one direction and R1's upper body was in another direction. R1 complained of pain and stated, It hurts, both of my legs hurt. I think they're broke. R1 indicated R1 slid out of the lift as it was raised. LPN-C assessed R1's legs and noted moderate swelling to R1's left lateral knee. R1 could not participate in range of motion due to pain and was assisted back into bed. LPN-C called the on-call provider who gave an order for therapy to evaluate R1 for safe transfers on 4/21/25. As needed (PRN) Tylenol was administered for pain. When LPN-C checked back with R1, R1's pain had gotten worse and was at a level 10 out of 10. After LPN-C notified the on-call provider of R1's worsening pain and range of motion impairment, R1 was transferred to the ER. Staff were educated on the facility's lift policy which requires the assistance of two staff for all lift transfers. Mechanical lift competencies were completed. The note indicated R1 was to be transferred with a Drive brand Hover lift with a Drive brand large sling. On