

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525546	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2026
NAME OF PROVIDER OR SUPPLIER Homestead Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on staff and resident representative interview and record review, the facility did not ensure an activated Power of Attorney for Healthcare (POAHC), physician, or Hospice services were notified of a change in condition for 1 resident (R) (R2) of 3 sampled residents.R2 had a change in condition on 9/25/25. R2's activated POAHC (POAHC-C), physician, and Hospice service were not notified of the change in condition.Findings include:The facility's Change in Condition of a Resident policy, revised 9/20/22, indicates the facility should immediately inform the resident, consult with the residents' physician, and notify, consistent with his or her authority, the resident's representative when there is a significant change in the resident's physical, mental, or psychosocial status.On 1/21/26, Surveyor reviewed R2's medical record. R2 received Hospice services and had diagnoses including heart failure, COVID-19, hypertension, diabetes, and atrial fibrillation. R2's Minimum Data Set (MDS) assessment, dated 9/21/25, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R2 had intact cognition. POAHC-C assisted R2 with medical decisions. A progress note, dated 9/25/25 at 5:22 AM, indicated R2 moaned during cares, had an increased respiratory rate, was diaphoretic (excessive sweating), and did not talk. R2's blood pressure was 130/51, respirations were 26, oxygen saturation was 85%, and blood sugar was 286. R2's medical record did not indicate POAHC-C, the physician, or Hospice services were notified of R2's change in condition. A Hospice note indicated R2 passed away on 9/25/25 at 9:45 AM.On 1/21/26 at 9:44 AM, Surveyor interviewed POAHC-C who stated POAHC-C was not notified of R2's change in condition which was identified hours before R2's death. POAHC-C was upset that POAHC-C was not able to be with R2 when R2 passed away. POAHC-C was on the way to the facility when POAHC-C was notified that R2 had passed.On 1/21/26 at 12:22 PM, Surveyor interviewed Director of Hospice Services (DHS)-D who indicated the description of R2 in the progress note on 9/25/25 at 5:22 AM was a change in condition and should have been reported to Hospice at the time the change in condition was identified.On 1/21/26 at 1:07 PM, Surveyor interviewed Unit Manager (UM)-E who indicated the progress note on 9/25/25 at 5:22 AM, should have been considered a change in condition for R2. UM-E indicated POAHC-C, the physician, Hospice services, and Director of Nursing (DON)-B should have been notified.On 1/21/26 at 1:21 PM, Surveyor interviewed DON-B who indicated the progress note on 9/25/25 at 5:22 AM was a change in condition for R2. DON-B verified the change in condition should have been reported to POAHC-C, the physician, and Hospice services at the time the change in condition was identified.</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 525546	If continuation sheet Page 1 of 1