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	12/10/2024

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 47248 Based on staff, resident, and resident representative interview and record review, the facility did not ensure 1 resident (R) (R17) of 1 resident reserved the right to make choices about an aspect of their life that was significant to them. R17 was removed from the dining room table where R17 usually sat and moved to a table where staff assisted residents with eating. The facility did not consult with R17 or R17's Power of Attorney (POA) prior to the change. Findings include: The facility's Resident Rights policy, revised 7/2022, indicates: To ensure that resident rights are respected, protected, and promoted. To inform a resident of their rights and provide an environment in which they can be exercised .Residents do not leave their individual personalities or basic human rights behind when they move to a long-term care facility. Residents will be treated with respect and dignity and care for each resident will be given in a manner and an environment that promotes maintenance or enhancement of his/her quality of life and recognizes each resident's individuality .17. The resident has the right and this facility promotes and supports the right to make choices about aspects of his/her life in the facility that are significant to the resident .26. The resident has the right to be fully informed, in advance about the care and treatment and of any changes in the care or treatment that may affect the resident's well-being . On 12/3/24, Surveyor reviewed R17's medical record. R17 had diagnoses including type 2 diabetes mellitus with diabetic chronic kidney disease, transient ischemic attack (stroke), and dementia. R17's Minimum Data Set (MDS) assessment, dated 11/28/24, had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R17 had severe cognitive impairment. R17 had an activated POA for healthcare decisions. R17's care plan indicated R17 was at risk for nutritional status change related to diabetes, history of stroke, mental status deficits, and history of repeated urinary tract infections (UTIs). The care plan contained an intervention to supervise/assist with eating as needed. R17's dementia care plan contained an intervention to attempt to provide consistent routines/caregivers. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 11/17/24, indicated R17 was moved to the feeder table after R17 asked someone to feed R17 at lunch on 11/16/24 and had trouble standing for extended periods of time in the EZ Stand (lift). On 12/2/24 at 8:20 AM, Surveyor observed R17 eating breakfast independently in the dining room without assistance. On 12/2/24 at 9:56 AM, Surveyor interviewed R17 who indicated missing the ladies that R17 sat with in the dining room. R17 indicated R17 did not like the dining room table where R17 currently sat. R17 stated those were all my ladies and we just talked all the time. R17's POA was also interviewed and indicated they were not part of the conversation and did not have the ability to advocate for R17 to stay at the table where R17 previously sat and knew the residents. R17's POA indicated R17 expressed dislike of R17's new table and indicated R17's choice of dining table and a consistent routine were not provided. On 12/2/24 at 12:02 PM, Surveyor observed R17 eating lunch independently in the dining room without assistance. On 12/3/24 at 8:07 AM, Surveyor observed R17 eating breakfast independently in the dining room without assistance. On 12/4/24 at 8:05 AM, Surveyor observed R17 eating breakfast independently in the dining room without assistance. On 12/4/24 at 9:31 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated NHA-A expects residents and POAs to be involved in the discussion of a table move and why a move is necessary. NHA-A was unsure if R17 or R17's POA were included in a discussion regarding the move. When Surveyor indicated the move occurred on 11/17/24, NHA-A reviewed the progress note that indicated R17 moved to the feeder table after R17 asked staff to feed R17 at lunch and had trouble standing for extended periods in the EZ Stand. NHA-A indicated a one time request for assistance did not constitute a move to another table. NHA-A indicated NHA-A was confused on how that was missed in stand-up meeting and indicated feeder table was not appropriate language. On 12/4/24 at 10:27 AM, Surveyor interviewed DON-B who indicated R17 began to roll back from the table when food was placed in front of R17 and R17's meal consumption was approximately 50% at the time of the move. DON-B indicated R17 was moved to the feeder table to receive more assistance. DON-B indicated R17 had increased food consumption since being moved to the feeder table and socialized at the table with residents and staff. DON-B confirmed a resident should be consulted prior to a table move but indicated DON-B did not always consult POAs. DON-B was unsure if there was a discussion with R17 and R17's POA regarding the need to move R17 to a different table. DON-B verified if a resident or POA declined a table move, a resident who required more assistance could remain at their present table and staff could sit with the resident at their table of choice.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on staff interview and record review, the facility did not ensure the medical record for 1 resident (R) (11) of 13 sampled residents contained a signed advance directive. R11 was admitted to the facility on [DATE]. R11's medical record contained a signed statement of incapacity (SOI). R11's medical record did not contain a signed advance directive. Findings include: The facility's admission agreement indicates: .E. Provision of Advanced Directive and Legal Representative Designation. You are asked to participate in advance care planning discussions, including providing a complete and current copy of any advance directive or any other written statement of your desires regarding treatment options or designation of health care agent or other person with any authority to make healthcare decisions on your behalf, and any document authorizing an attorney in fact, health care agent, or guardian to act on your behalf . From 12/2/24 to 12/4/24, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] with diagnoses including dementia, diabetes, and congestive heart failure. R11's Minimum Data Set (MDS) assessment, dated 3/19/24, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R11 had intact cognition. R11 had an activated Power of Attorney for Healthcare (POAHC). R11's medical record contained a scanned unsigned POAHC document dated 11/15/24 and an SOI that was signed on 5/16/24. On 12/3/24 at 3:00 PM, Surveyor interviewed Director of Nursing (DON)-B regarding why R11's paperwork was not signed by R11's spouse who was R11's named POAHC. DON-B was not aware that the paperwork was not signed and indicated DON-B would have Social Services Director (SSD)-C speak to Surveyor. On 12/4/24 at 11:11 AM, Surveyor interviewed SSD-C who verified R11's paperwork was not signed and was unsure why. SSD-C indicated the facility should have obtained R11's POAHC's signature when R11 was admitted to the facility.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47248 Based on staff and resident representative interview and record review, the facility did not notify a Physician, Guardian and/or Power of Attorney for Healthcare (POAHC) of changes in condition for 2 residents (R) (R3 and R4) of 13 sampled residents. R3 did not received prescribed Depakote for seizures on 11/13/24, 11/17/24, 11/25/24 and 11/26/24. R3 had seizures on 8/30/24 and 11/26/24. R3's Physician and Guardian were not notified of R3's change in condition. R4's Physician and POAHC were not notified when the facility was not able to provide R4 with prescribed seizure medication. Findings include: The facility's Change in Condition of the Resident policy, revised 9/20/22, indicates: A facility should immediately inform the resident, consult with the resident's Physician, and notify consistent with his or her authority, the resident representatives when there is an accident which results in injury, and has the potential for requiring Physician intervention, a significant change in the resident's physical, mental or psychosocial status, or a need to alter treatment significantly .Documentation needs to include, but is not limited to the following: Description of the change in condition noted and assessment or observation of findings . Notification of provider .Notification of responsible party . The facility's Medication Administration: General Guidelines policy, dated 1/24, indicates at Section 7.1-2: If two consecutive doses of a vital medication are withheld or refused, the Physician is notified. 1. On 12/4/24, Surveyor reviewed R3's medical record. R3 had diagnoses including dementia with behaviors, seizures, and anxiety. R3's Minimum Data Set (MDS) assessment, dated 11/26/24, had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which indicated R3 had severely impaired cognition. R3 had a court-appointed Guardian for healthcare decisions. R3 had orders for 750 milligrams (mg) of Depakote in the AM and 1000 mg of Depakote at bedtime (HS) for seizures. A progress note, dated 9/1/24 at 12:02 AM, indicated R3 was on follow-up for what could have been a seizure on the 8/30/24 AM shift. R3's medical record did not indicate R3's Physician or guardian were notified. A progress note, dated 9/20/24 at 2:36 PM, indicated the facility was out of Depakote 500 mg. The pharmacy indicated they sent a 30-day supply on 9/6/24 and were unable to send more at that time. R3's medical record did not indicate R3's Physician or Guardian were notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 10/11/24 at 9:45 AM, indicated R3 was out of Depakote 500 mg. The computer indicated refills were received on 10/9/24 but were no cards. The pharmacy indicated they would send the medication that night. R3's medical record did not indicate R3's Physician or Guardian were notified. A progress note, dated 10/14/24 at 9:15 AM, indicated the facility was out of R3's Depakote 250 mg and a dose was taken from contingency. The pharmacy said 15 tablets were sent on 10/9/24 but the card was gone. R3's medical record did not indicate R3's Physician or Guardian were notified. A progress note, dated 11/12/24 at 9:16 AM, indicated the facility was out of R3's Depakote 500 mg which was on order since 11/11/24 and was not sent by the pharmacy. The pharmacy said a 15-day supply was sent on 11/4/24 and they could not send a refill until 11/16/24. R3's medical record did not indicate R3's Physician or Guardian were notified. A progress note, dated 11/17/24 at 8:53 AM, indicated the facility was out of R3's Depakote 250 mg and did not have any in contingency. R3's medical record did not indicate R3's Physician or Guardian were notified. R3's November 2024 Medication Administration Record (MAR) indicated R3 did not received Depakote on 11/13/24, 11/17/24, and 11/25/24. R3's medical record did not indicate R3's Physician or Guardian were notified. R3's medical record indicated R3's Physician was notified of a seizure and missing medication on 11/26/24, however, R3's Guardian was not notified. On 12/4/24 at 1:03 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated DON-B could not find Physician or Guardian notification for R3's missing Depakote doses or seizures. DON-B indicated when a medication is not available and not administered, DON-B expects staff to notify the resident's Physician and representative. 43361 2. From 12/2/24 to 12/4/24, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including dementia and epilepsy. R4's MDS assessment, dated 9/16/24, had a BIMS score of 14 out of 15 which indicated R4 was not cognitively impaired. R4 had an activated POAHC (POAHC-F). R4 was prescribed the following medications: ~ One 10 mg tablet of clobazam (Onfi) by mouth two times a day for seizures ~ One 12 mg tablet of Fycompa given by mouth one time a day for seizures Surveyor noted R4 did not receive clobazam between 6/11/24 and 7/2/24 because the pharmacy did not have a prescription to fill. R4's medical record indicated staff attempted to call R4's Neurologist on several occasions to get a prescription with no response. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/24, staff notified R4's Physician that R4 had seizure activity on 6/13/24 (after missing 4 doses of the medication). The Physician asked if R4 was provided all of R4's epilepsy medications. Staff handwrote on a note that the pharmacy did not have a prescription and listed several dates where they attempted to contact R4's Neurologist for a prescription. R4's medical record indicated Fycompa was not provided from 7/2/24 through 7/10/24, 9/20/24 through 10/1/24, 10/21/24 through 10/29/24, 11/13/24 through 11/21/24, and 11/29/24 through 12/2/24. R4's medical record indicated R4's Physician was only notified after the two missed doses on 9/21/24. R4's medical record indicated POAHC-F was only notified on 12/2/24. On 12/3/24 at 1:03 PM, Surveyor interviewed DON-B who verified staff should notify R4's Physician and POAHC-F when medications are missed. Surveyor requested Physician and POAHC notification for the other times the facility did not have R4's prescribed medication but the information was not provided. DON-B indicated the facility began staff education on 12/2/24 to be sure to notify the Physician and POA for any missed doses of medication. On 12/4/24 at 10:37 AM, Surveyor interviewed POAHC-F who indicated the facility called POAHC-F that week because R4 had missed doses of Fycompa. POAHC-F could not recall any other time staff called POAHC-F regarding R4 missing medications.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 50467 Based on staff interview and record review, the facility did not ensure 3 residents (R) (R231, R81, and R26) of 4 sampled residents received a timely copy of a Notice of Medicare Non-Coverage (NOMNC) form when their Medicare services ended. The facility did not provide a NOMNC form (used to inform Medicare beneficiaries when their covered services are ending and their appeal rights) to R231, R81, and R26 at least two calendar days before their Medicare services ended. Findings include: The Centers for Medicare and Medicaid Services (CMS) form CMS-10123 indicates a NOMNC form must be delivered at least two calendar days before Medicare-covered services end or the second-to-last-day of service if care is not being provided daily. Note: The two-day advance requirement is not a 48-hour requirement .The provider must ensure the beneficiary or representative signs and dates the NOMNC form to demonstrate the beneficiary or representative received the notice and understands the termination decision can be disputed. On 12/4/24, Surveyor reviewed a NOMNC form for R231 that indicated R231's Medicare services ended on 7/7/24. Surveyor noted R231's Power of Attorney for Health Care (POAHC) signed the form on 7/8/24. On 12/4/24, Surveyor reviewed a NOMNC form for R81 that indicated R81's Medicare services ended on 11/28/24. Surveyor noted R81 signed the form on 11/27/24. On 12/4/24, Surveyor reviewed a NOMNC form for R26 that indicated R26's Medicare services ended on 11/27/24. Surveyor noted R26 signed the form on 11/26/24. On 12/4/24 at 10:54 AM, Surveyor interviewed Social Services Director (SSD)-C who confirmed residents should be notified and NOMNC forms should be signed two days prior to the end of their Medicare services.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 50467 Based on staff interview and record review, the facility did not ensure their abuse policy was implemented for 4 of 8 employees reviewed for caregiver background checks. The facility did not complete background checks within a 4-year time frame for Certified Nursing Assistant (CNA)-L, CNA-M, CNA-N, and CNA-P. Findings include: The facility's Abuse, Neglect and Exploitation policy, revised 7/15/22, indicates: .I. Screening: A. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1. Background, reference, and credentials checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. Background checks including re-checks, will be completed consistent with applicable state laws and regulations. Responsibility of performance of compliance checks on contracted temporary staff will be established via contractual agreement . On 12/3/24 Surveyor requested background check and registry information for CNA-L, CNA-M, CNA-N, and CNA-P. Surveyor reviewed the background check information and noted CNA-L, CNA-M, CNA-N, and CNA-P were hired by the facility on 12/1/19. CNA-P's caregiver background check was completed on 11/10/19. CNA-L and CNA-M's caregiver background checks were completed on 11/13/19. CNA-N's caregiver background check was completed on 11/14/19. Surveyor noted CNA-L, CNA-M. CNA-N, and CNA-P's caregiver background checks were past the 4-year background check time frame. On 12/3/24 at 11:30 AM, Surveyor interviewed Business Office Manager (BOM)-O who indicated the regional recruiter was responsible for completing background checks. BOM-O indicated BOM-O would check to see if those were the most current background checks for CNA-L, CNA-M, CNA-N, and CNA-P. On 12/4/24 at 8:00 AM, Surveyor reviewed background checks for the above CNAs with an issue date of 12/3/24. On 12/4/24 at 12:00 PM, Surveyor interviewed BOM-O who confirmed background checks for CNA-L, CNA-M, CNA-N, and CNA-P were rerun on 12/3/24. BOM-O confirmed the original background checks provided to Surveyor were from 11/2019 and were out of compliance.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47248 Based on staff interview and record review, the facility did not report injuries of unknown origin to the State Agency (SA) for 2 residents (R) (R3 and R4) of 2 residents. R3's medical record indicated R3 had multiple injuries of unknown origin that were were not reported to the SA. R4's medical record indicated R4 had an injury of unknown origin that was not reported to the SA. 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 .B. Possible indicators of abuse include, but are not limited to: Resident, staff or family report of abuse .2. Physical marks such as bruises or patterned appearances such as a hand print or ring mark on a resident's body. 3. Physical injury of a resident, of unknown source .Protection of resident: .A. Respond immediately to protect the alleged victim and integrity of the investigation .Reporting/Response: .Report all alleged violations to the Administrator, State Agency, Adult Protective Services and to all other required agencies (i.e., law enforcement when applicable) within specified time frames: a. Immediately but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury .B. The Administrator will follow up with government agencies to report the results of the investigation within 5 working days of the incident . On 12/4/24, Surveyor reviewed R3's medical record. R3 had diagnoses including seizures, major depression, dementia with behaviors, and anxiety. R3's Minimum Data Set (MDS) assessment, dated 11/26/24, had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which indicated R3 had severe cognitive impairment. R3 had a court-appointed Guardian for healthcare decisions. A progress note, dated 8/26/24, indicated R3 had redness on the lateral side of the left foot. An Interdisciplinary Team (IDT) Clinical Review note, dated 8/27/24, indicated R4 had a reddened area on the left lateral foot. R3 denied pain or discomfort. R3 was unable to state where the redness came from but denied harm from staff and residents. Staff felt R3 bumped the foot on R3's wheelchair pedal. Progress notes, dated 9/1/24, indicated R3 was stable and staff spoke with R3's Nurse Practitioner (NP) who ordered a cold compress and to monitor and include Hospice suggestions. (The note did not indicate where or how R3 was injured.) An IDT Clinical Review Note, dated 9/4/24, indicated R3 sustained a small bump on the head when R3 hit R3's head on a dresser (on 9/1/24) when staff rolled R3 during cares. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An IDT Clinical Review Note, dated 9/9/24, indicated R3 had a new bruise on the left hand. R3 stated the hand was tender and hurt. R3 indicated R3 was not harmed by a staff or resident. Staff determined the bruise occurred when staff rolled R3 and R3's dresser was too close to the bed (on 9/1/24). A progress note, dated 9/12/24 indicated R3 had a bruised left thumb. On 12/4/24 at 9:15 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated injuries of unknown origin were treated as reportable incidents. NHA-A indicated R3's injuries of unknown origin were not reported to the SA because the facility completed investigations within the two hour reporting window and concluded R3 was not abused. NHA-A indicated R3's head bump, bruised left hand, and bruised left thumb were all attributed to an incident on 9/1/24 during cares even though the injuries developed over the course of ten days. NHA-A indicated R3 was on anticoagulant medication which could cause bruises to form if R3 bumped something. 43361 2. From 12/2/24 to 12/4/24, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including epilepsy and dementia. R4's MDS assessment, dated 9/16/24, had a BIMS score of 14 out of 15 which indicated R4 was not cognitively impaired. R4 had an activated Power of Attorney for Healthcare (POAHC). A progress note, dated 8/5/24 at 4:53 AM, indicated staff discovered a large bruise that went around the the front of R4's chest to the back. A smaller bruise was noted above the larger bruise. R4 was unsure how the bruises occurred. An IDT Clinical Review note, dated 8/6/24 at 12:26 PM, indicated R4 had a large bruise on the left chest that spread to R4's back. R4 stated R4 had no idea how the bruise occurred. R4 denied harm by a staff or resident. Staff stated they felt the bruise occurred when R4 was turned on the left side and placed R4's left arm over the back of R4's wheelchair which caused R4's left side/arm to rub against the wheelchair's metal arm. On 12/4/24 at 9:15 AM, Surveyor interviewed NHA-A who indicated NHA-A expects staff to report injuries of unknown origin to the SA if there is a timely investigation and a cause can not be identified. NHA-A confirmed an investigation should include staff and resident interviews to rule out abuse. NHA-A indicated NHA-A would document interviews and skin checks as part of the investigation. NHA-A indicated NHA-A did not work at the facility when R4's injury of unknown origin was discovered and contacted Director of Nursing (DON)-B. DON-B did not provide documentation that indicated an investigation was completed within two hours to determine if the injury of unknown origin was reportable to the SA.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47248 Based on staff interview and record review, the facility did not ensure injuries of unknown origin were thoroughly investigated for 2 residents (R) (R3 and R4) of 2 sampled residents. The facility did not thoroughly investigate multiple injuries of unknown origin for R3. The facility did not thoroughly investigate an injury of unknown origin for R4. 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 .Identification of abuse, neglect and exploitation: .B. Possible indicators of abuse include . 2. Physical marks such as bruises or patterned appearances such as a hand print or ring mark on a resident's body. 3. Physical injury of a resident of unknown source .Investigation of alleged abuse, neglect and exploitation: .An immediate investigation is warranted when allegation or suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. 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 further occurrences, defining whether care provision should be changed and or improved to protects residents .training staff on changes made and demonstration of staff competency after training is implemented, identification of staff responsible for corrective actions . 1. On 12/4/24, Surveyor reviewed R3's medical record. R3 had diagnoses including seizures, major depression, dementia with behaviors, and anxiety. R3's Minimum Data Set (MDS) assessment, dated 11/26/24, had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which indicated R3 had severe cognitive impairment. R3 had a court-appointed Guardian for healthcare decisions. A progress note, dated 8/26/24, indicated R3 had redness on the lateral side of the left foot. An Interdisciplinary Team (IDT) Clinical Review note, dated 8/27/24, indicated R4 had a reddened area on the left lateral foot. R3 denied pain or discomfort and was unable to state where the redness came from. R3 denied harm from staff and residents. Staff felt R3 bumped the foot on R3's foot pedal. Progress notes, dated 9/1/24, indicated R3 was stable and staff spoke with R3's Nurse Practitioner (NP) who ordered a cold compress and to monitor and include Hospice suggestions. (The note did not indicate how or where R3's injury occurred.) (continued on next page)

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	12/10/2024

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An IDT Clinical Review Note, dated 9/4/24, indicated R3 sustained a small bump on the head when staff rolled R3 during cares and R3 hit R3's head on a dresser. An IDT Clinical Review Note, dated 9/9/24, indicated R3 had a new bruise on the left hand. R3 stated the hand was tender and hurt. R3 indicated R3 was not harmed by a staff or resident. Staff determined the bruise occurred when staff rolled R3 during cares (on 9/1/24) and R3's dresser was too close to the bed. A progress note, dated 9/12/24 indicated R3 had a bruised left thumb. On 12/4/24 at 9:15 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated the facility completed investigations and would provide the investigations to Surveyor. NHA-A indicated while looking at R3's medical record that NHA-A felt the facility needed more documentation of the steps the facility took to reach the conclusion that the injuries of unknown origin were not due to abuse or neglect. NHA-A indicated the facility's investigation should outline what steps were taken and what was done to rule out abuse NHA-A indicated the facility had no documentation of a root cause analysis, steps taken to protect R3, care plan updates or staff education. R3 also indicated staff and resident interviews were not completed and the investigation was not documented. NHA-A indicated the two-hour time frame the facility used to determine the injuries were not reportable could not be verified because documentation of the investigation was not available. NHA-A indicated R3's head bump, bruised left hand, and bruised left thumb were all attributed to an incident on 9/1/24 during cares even though the injuries developed over the course of ten days. 43361 2. From 12/2/24 to 12/4/24, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including epilepsy and dementia. R4's MDS assessment, dated 9/16/24, had a BIMS score of 14 out of 15 which indicated R4 was not cognitively impaired. R4 had an activated Power of Attorney for Healthcare (POAHC). A progress note, dated 8/5/24 at 4:53 AM, indicated staff discovered a large bruise that went around the the front of R4's chest to the back. A smaller bruise was noted above the larger bruise. R4 was unsure how the bruises occurred. An IDT Clinical Review note, dated 8/6/24 at 12:26 PM, indicated R4 had a large bruise on the left chest that spread to R4's back. R4 stated R4 had no idea how the bruise occurred. R4 denied harm from staff or residents. Staff stated they felt the bruise occurred when R4 turned on the left side and placed R4's left arm over the back of R4's wheelchair which caused R4's left side and arm to rub against the wheelchair's metal arm. R4 denied discomfort to the area. An intervention was added to evaluate R4 for a proper fitting wheelchair. On 12/4/24, Surveyor requested the facility's investigation of the bruise and was provided a copy of the 8/6/24 IDT note and a skin assessment. Surveyor also requested a copy of R4's therapy screen. (continued on next page)

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	525546	A. Building B. Wing	12/10/2024

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 9:15 AM, Surveyor interviewed NHA-A who indicated staff should report injuries of unknown origin to the SA if there is a timely investigation and a cause can not be identified. NHA-A confirmed a thorough investigation should be completed and documented and should include staff and resident interviews to rule out abuse. NHA-A indicated NHA-A would document interviews and skin checks as part of the investigation. NHA-A indicated NHA-A did not work at the facility when R4's injury of unknown origin was discovered. On 12/4/24 at 3:30 PM, Surveyor interviewed Director of Nursing (DON)-B who did not provide documentation of a thorough investigation for R4's injury of unknown origin. DON-B also indicated therapy did not screen R4 at the time the intervention was added. DON-B indicated therapy screened R4 the week of 12/2/24 and did not have any recommendations. DON-B confirmed R4 should have been evaluated timely after the IDT's recommendation.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on staff interview and record review, the facility did not ensure 1 resident (R) (R11) of 5 sampled residents met the Pre-Admission Screening and Resident Review (PASRR) requirements. R11 had a negative PASRR Level I Screen upon admission. A Level II Screen was not completed when R11 received a qualifying diagnosis and was prescribed medication. Findings include: The Wisconsin Department of Health Services' (DHS) PASRR for current or prospective nursing home residents-Level II Screen facesheet indicates: .Nursing home should retain a copy of this facesheet and attached documentation in the person's current medical record. If the person's condition or diagnoses change so that he/she later may meet the federal definition of a developmental disability or a serious mental illness, the nursing home will need to submit an updated Level II Screen to the appropriate PASRR contract agency . From 12/2/24 to 12/4/24, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] and had diagnoses including dementia, diabetes, and depression. R11's Minimum Data Set (MDS) assessment, dated 3/19/24, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R11 had intact cognition. R11 had an activated Power of Attorney for Health Care (POAHC). R11's Medication Administration Record (MAR) indicated bupropion extended release 24 hour 150 milligrams (mg) was started on 9/24/24 for a diagnosis of depression. On 12/3/24 at 3:00 PM, Surveyor interviewed Director of Nursing (DON)-B regarding the facility's PASRR process. DON-B indicated the facility referenced the Wisconsin DHS website. On 12/4/24 at 11:11 AM, Surveyor interviewed Social Services Director (SSD)-C who confirmed psychotropic medication was ordered for R11, however, SSD-C unsure of the PASRR process when new psychotropic medication was ordered. On 12/4/24 at 11:15 AM, Surveyor interviewed DON-B who indicated DON-B was unsure if a new PASRR needed to be completed after a new mental illness diagnosis or new psychotropic medication was ordered.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47248 Based on staff interview and record review, the facility did not provide the necessary care and services to maintain the highest practicable physical well-being for 2 residents (R) (R17 and R11) of 5 sampled residents. Staff did not follow through on lab orders or complete an appropriate assessment when R17 had symptoms of generalized weakness, pain with urination and pericare, and low urine output. As a result, R17 did not receive the necessary care and services to diagnose and treat an infection of vulvovaginitis (vaginal inflammation). R11 was hospitalized for heart failure from 3/11/24 to 3/13/24 and had orders for daily weights. Staff did not consistently complete daily weights for R11. Findings include: The facility's Change in Condition of the Resident policy, revised 9/20/22, indicates: The facility should immediately inform the resident, consult with the resident's physician, and notify consistent with his or her authority, the resident's representative when an accident involving the resident results in injury, has the potential to require physician intervention, involves a significant change in the resident's physical, mental or psychosocial status or a need to alter treatment significantly .When a resident presents with a possible change of condition, after a fall or other possible injury, or trauma, or noted changes in mental or physical functioning: Asses the resident's need for immediate care/medial attention. Provide emergency care as needed. Assess/evaluate the resident. This assessment/evaluation could include, but is not limited to .vital signs, oxygen saturation, blood glucose level .pain, location type, intensity, duration, causative factors .bowel and bladder control .sensory weakness or change .Notify the resident's physician .when to report: Immediate notification for any symptom, sign or apparent discomfort that is: acute or sudden in onset, and a marked change in relation to usual symptoms or unrelieved by measures already prescribed requires a phone call to the the provider .Documentation needs to include but is not limited to the following: Description of the change in condition noted and an assessment or observation of the findings Notification of provider Notification of responsible party . 1. On 12/3/24, Surveyor reviewed R17's medical record. R17 had diagnoses including dementia, type 2 diabetes mellitus with diabetic chronic kidney disease, and transient ischemic attack (stroke). R17's Minimum Data Set (MDS) assessment, dated 11/28/24, had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R17 had severely impaired cognition. R17 had an activated Power of Attorney for Healthcare (POAHC). A progress note, dated 11/2/24, indicated R17 screamed it burns, it burns during pericare. R17 requested to see a doctor. R17 was sent to the hospital and admitted for observation for a urinary tract infection (UTI). R17's symptoms included confusion, incontinence, and increased frequency. A progress note, dated 11/5/24, indicated R17 returned to the facility. A follow-up visit was recommended. The note indicated R17 was most likely experiencing decreasing function symptoms due to vascular dementia because R17's UA culture was negative. (continued on next page)

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	525546	A. Building B. Wing	12/10/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted a follow-up visit was not conducted. Change of condition documentation, dated 11/17/24, indicated R17 reported pain during urination and had trouble standing for extended periods of time in the EZ Stand. R17's primary care provider responded and indicated the on-call Nurse Practitioner (NP) ordered a urinalysis and culture and the facility should update the NP on 11/18/24. A progress note, dated 11/19/24, indicated R17 was on follow-up for for increased generalized weakness and painful urination. R17 was alert and confused and able to make R17's needs known. R17's mentation was at baseline. No complaints of pain with urination were noted. R17 started UTI-Stat cranberry drink for a UTI. A progress note, dated 11/23/24, indicated R17 had 39 milliliters (ml) of urine output and a bladder scan was completed with 59 ml of output. R17 required more assistance with activities of daily living (ADLs) and had increased weakness, decreased mobility with increased peri-area pain, and painful urination. R17's medical record did not indicate R17's physician was updated or that any action was taken for R17's change in condition. A progress note, dated 11/25/24, indicated R17's prednisone was discontinued. The NP reviewed R17's labs. R17 winced with pain when wiped after urination. A urine sample was obtained for delivery to the lab on 11/26/24. A progress note, dated 11/26/24, indicated the writer updated the NP via phone that R17's UA was positive and they were awaiting a culture. A progress note, dated 11/30/24, indicated the NP reviewed R17's final urine culture results (negative) with no new orders. R17 had an order, dated 12/1/24, for a repeat UA/culture due to continued concerns of painful urination, painful pericare, and generalized weakness. A progress note, dated 12/1/24, indicated R17 was on follow-up for painful urination but had no complaints on the PM shift. A progress note, dated 12/1/24, indicated R17 was on follow-up for painful urination. R17 had no complaints of pain but yelled out. On 12/3/24 at 12:10 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated a urinalysis and culture were completed and the results were negative. DON-B confirmed R17's timeline of low urine output and pain during urination and pericare and indicated DON-B was not sure what went on between 11/5/24 when R17 was discharged from the hospital and the culture obtained in the hospital came back negative for a UTI, and 11/17/24 when symptoms were documented in R17's medical record and labs were not completed. DON-B indicated the progress note regarding low urine output on 11/23/24 had lots of missing parts and confirmed no action was taken by staff to notify the required parties, complete labs, and ensure the appropriate treatment was initiated. DON-B indicated the order on 12/1/24 to collect a UA/culture was documented in R17's medical record. DON-B was unsure if the lab was obtained and sent for testing. DON-B indicated it appeared there was incomplete follow-up on the ordered tests and R17's change in condition. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/3/24 at 1:39 PM, DON-B approached Surveyor and verified the previously collected UA and culture results were negative. DON-B confirmed the ordered UA and culture on 12/1/24 were not completed. DON-B instructed staff to obtain the sample and send it to the lab for testing. DON-B confirmed there was no additional action taken by staff regarding R17's low urine output or complaints of pain during urination and pericare. DON-B confirmed the Interdisciplinary Team (IDT) did not meet to discuss R17's symptoms and did not involve R17's physician to determine a cause for R17's painful urination, low urine output, pain during pericare, and generalized weakness. On 12/4/24 at 9:26 AM, DON-B informed Surveyor that R17's UA and culture were obtained on 12/3/24 and R17 was prescribed an antibiotic for vulvovaginitis. 45942 2. From 12/2/24 to 12/4/24, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] and had diagnoses including dementia, diabetes, and hypertensive heart disease with heart failure. R11's MDS assessment, dated 3/19/24, had BIMS score of 13 out of 15 which indicated R11 had intact cognition. R11 had an activated POAHC. R11 orders for daily weights (dated 4/8/24 to 4/15/24 and 4/15/24 to 4/23/24) for one week and update the provider if R11's weight gain was equal to or greater than three pounds in a day or five pounds in a week. Update provider in one week of weight trend. The orders were related to heart failure which R11 was hospitalized for from 3/11/24 to 3/13/24. Surveyor noted R11's medical record did not contain weights on 4/8/24, 4/10/24, 4/13/24, 4/14/24, 4/16/24, 4/19/24, and 4/23/24. On 12/4/24 at 11:07 AM, Surveyor interviewed DON-B who confirmed R11's weights should have been obtained daily per for the physician's order in April 2024. DON-B verified R11's medical record contained missing weights and stated nurses were responsible for ensuring daily weights were recorded.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on observation, staff and resident interview, and record review, the facility did not ensure adequate assistive devices were in place to prevent falls for 1 resident (R4) of 2 sampled residents. R4 had a care plan intervention to add anti-rollback bars to R4's wheelchair after R4 had a fall that resulted in a head laceration. The facility did not install the anti-rollback bars in a timely manner. Findings include: The facility's Fall Prevention and Management Guidelines policy, with a review date of 7/18/24, indicates: .7. When any resident experiences a fall, the facility will: d. Review the resident's care plan and update with any new interventions put in place to try to prevent additional falls. 8. Review each fall/fall investigation the next morning meeting/clinical meeting with the Interdisciplinary Team (IDT). Actions of the IDT may include: .c. Additional revisions to the plan of care including including any physical adaptation to room, furniture, wheelchair, and/or assistive devices. From 12/2/24 to 12/4/24, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including dementia and epilepsy. R4's Minimum Data Set (MDS) assessment, dated 9/16/24, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R4 was not cognitively impaired. R4 had an activated Power of Attorney for Health Care (POAHC). A progress note, dated 11/26/24 at 5:20 PM, indicated R4 had a witnessed fall in the dining room during supper. R4 had a seizure and slid out of R4's wheelchair. When R4's buttocks hit the floor, the wheelchair moved back. R4 fell backwards and hit R4's head on the floor. R4 was bleeding from the back of head. R4 was unable to describe the fall but stated it happened during a seizure. An Registered Nurse (RN) applied pressure to the back of R4's head and called 911. A progress note, dated 11/26/24 at 9:44 PM, indicated staff received a call from an emergency room (ER) nurse who stated R4 would return to the facility that night. R4 had two head staples. No other injuries were reported. An IDT note, dated 11/27/24 at 9:41 AM, indicated R4 was in the dining room at the time of the fall. A tablemate asked if R4 was okay because R4 was leaning on the table experiencing a small body tremor. A family member at the table reassured the tablemate that R4 was fine. R4's arms, torso, and head then began to involuntarily shake. R4 slid out of the wheelchair and onto R4's buttocks. R4's wheelchair rolled back. R4 fell backwards and hit R4's head on the dining room floor. R4 was unable to describe the fall, but stated it happened during a seizure. On 11/28/24, R4's care plan was updated to include anti-roll back bars on wheelchair. On 12/2/24 at 10:17 AM, Surveyor was interviewing R4 when Maintenance Director (MD)-E entered R4's room with anti-roll back bars to install on R4's wheelchair. (continued on next page)

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	525546	A. Building B. Wing	12/10/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/2/24 at 1:52 PM, Surveyor interviewed R4 who indicated R4 fell during a seizure in the dining room and required staples to the back of R4's head. Surveyor noted the anti-roll back bars were not on R4's wheelchair. When Surveyor asked if MD-E put them on, R4 indicated there was an issue with the bars. On 12/3/24 at 11:07 AM, Surveyor interviewed MD-E who indicated MD-E could not put anti-rollback bars on R4's wheelchair because the wheelchair was too wide. MD-E indicated MD-E did not have anti-roll back bars that fit and needed to order some. On 12/3/24 at 1:03 PM, Surveyor interviewed Director of Nursing (DON)-B who verified care plan interventions should be put in place immediately. On 12/3/24, Surveyor received a copy of R4's care plan which included an updated approach (dated 12/3/24) for anti-roll back bars to wheelchair (when available). On 12/4/23 at 9:24 AM, DON-B indicated anti-roll back bars were installed on R4's wheelchair after staff went to a sister facility and brought back the appropriate size.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47248 Based on staff and resident interview and record review, the facility did not provide pharmaceutical services to ensure medications were received as ordered for 3 residents (R) (R3, R4, and R18) of 13 sampled residents. R3's Depakote (an anticonvulsant medication used to treat seizures) order was increased to two 500 milligram (mg) tablets to equal 1000 mg at bedtime (HS) on 5/28/24 following a hospital discharge. The Depakote order was not sent to the pharmacy which caused R3 to miss multiple doses of the medication until 11/26/24. The facility did not consistently have R4's prescribed medications available for administration. In addition, staff documented medications were given when the medications were not available. R18 refused R18's prescribed sertraline (an antidepressant medication and refused to sign consent for sertraline. The facility continued to provide R18 with sertraline. Findings include: The facility's Medication Reconciliation policy, revised 10/24/22, indicates: This facility reconciles medication frequently throughout a resident's stay to ensure that the resident is free of any signification medication errors .Medication reconciliation refers to the process of verifying that the resident's current medication list matches the physician's orders for the purposes of providing the correct medications to the resident at all points throughout his or her stay .Medication reconciliation involves collaboration with the resident/representative and multiple disciplines, including admission liaisons, licensed nurses, physicians, and pharmacy staff .Compare orders to hospital discharge records .Obtain clarification orders as needed. Transcribe orders in accordance with procedures for admission orders. Have a second nurse review transcribed orders for accuracy indicating the review. Order medications from the pharmacy in accordance with facility procedures for ordering medications. Verify medications received match the medication orders . Daily process: Address any clinically significant medication irregularities reported by pharmacy consultant . Obtain and transcribe any new orders in accordance with facility procedures. Obtain clarification as needed. New orders should have a second nurse to review the orders for accuracy .Order medications from pharmacy in accordance with facility procedures for ordering medications . The facility's Medication Administration General Guidelines policy, dated 1/24, indicates .The individual who administers the medication dose, records the administration on the resident's Medication Administration Record (MAR) immediately following the medication being given. 2. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time, the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for as needed (PRN) documentation. If two consecutive doses of a vital medication are withheld or refused, the physician is notified. 4. The resident's MAR/Treatment Administration Record (TAR) is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration and time . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. On 12/4/24, Surveyor reviewed R3's medical record. R3 had diagnoses including dementia with behaviors, seizures, major depression, and anxiety. R3's Minimum Data Set (MDS) assessment, dated 11/26/24, had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which indicated R3 had severe cognitive impairment. R3 had a court-appointed Guardian for healthcare decisions. R3 had a physician order for one Depakote 250 mg tablet and one 500 mg tablet for a total of 750 mg in the AM. R3 was discharged from a hospital stay on 5/28/24 with a new order for two 500 mg Depakote tablets for a total of 1000 mg at bedtime (HS) for seizures. A progress note, dated 9/20/24 at 2:36 PM, indicated the facility was out of R3's divalproex (generic name for Depakote) 500 mg. The pharmacy indicated they sent a 30-day supply on 9/6/24 and were unable to send more at that time. A progress note, dated 10/11/24 at 9:45 AM, indicated R3 was out of divalproex 500 mg. The computer said refills were received on 10/9/24 but there were no cards. The pharmacy indicated the medication would be sent that night. A progress note, dated 10/14/24 at 9:15 AM, indicated the facility was out of R3's divalproex 250 mg and a dose was taken from contingency. The pharmacy indicated 15 tablets were sent 10/9/24 but the card was gone. A progress note, dated 11/12/24 at 9:16 AM, indicated the facility was out of R3's divalproex 500 mg which was on order since 11/11/24 and was not sent by the pharmacy. A pharmacy technician indicated a 15-day supply was sent on 11/4/24 and could not be refilled until 11/16/24. A progress note, dated 11/17/24 at 8:53 AM, indicated: Divalproex sodium (Depakote) oral tablet delayed release 250 mg give 1 tablet by mouth one time a day for seizures. Take 1 tablet (250 mg) daily with a 500 mg tablet to equal a morning dose of 750 mg. Unavailable, contingency empty. A progress note, dated 11/26/24 at 3:42 PM, indicated the pharmacy was called to send Depakote 750 mg every AM and 1000 mg every PM. The pharmacy stated they never received the order for 1000 mg every PM which was dated 5/28/24. Staff depleted the facility's contingency supply of Depakote. The Nurse Practitioner (NP) was notified R3 had not received the medication and had a small seizure that day. A clarification order was sent to pharmacy. The writer verified the medication would be sent that night. R3's November 2024 Medication Administration Record (MAR) indicated R3's 11/26/24 HS dose of Depakote was not given. (continued on next page)

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	12/10/2024

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

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/3/24 at 1:03 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated if a medication is not available, staff should contact the pharmacy to send the medication, contact the resident's physician, contact the resident's decision maker, and inform DON-B. DON-B indicated staff should reorder medications when there are five doses left. DON-B indicated the facility initiated education on 12/2/24 due to issues with medications not being available. DON-B did not receive notification of medications that were used and refilled in contingency and was unsure who monitored contingency medications. DON-B confirmed the facility's contingency supply of Depakote contained ten 500 mg tablets. DON-B started reviewing all progress and dashboard notes daily in September of 2024. DON-B confirmed DON-B did not always read the notes daily and did not know staff depleted the facility's Depakote contingency on a weekly basis or that R3's 5/28/24 Depakote order was not sent to the pharmacy. DON-B stated DON-B would find contingency refill orders and pharmacy invoices for medications that were ordered and received. Surveyor was not provided with pharmacy refills, deliveries, invoices, or contingency medication refills by DON-B. On 12/4/24 at 2:47 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-I who indicated R3's HS Depakote order was frequently taken from contingency because the pharmacy would not fill the order. LPN-I indicated the facility usually had enough Depakote in contingency to provide R3's HS dose. 43361 2. From 12/2/24 to 12/4/24, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including dementia and epilepsy. R4's MDS assessment, dated 9/16/24, had a BIMS score of 14 out of 15 which indicated R4 was not cognitively impaired. R4 had an activated Power of Attorney for Healthcare (POAHC) (POAHC-F). R4's medical record indicated R4 was prescribed 6 medications related to seizures. Two of the prescribed medications were: ~ One 10 mg tablet of clobazam (Onfi) given by mouth two times a day for seizures. ~ One 12 mg tablet of Fycompa given by mouth one time a day for seizures. R4's June and July 2024 MARs indicated R4 had not received clobazam between 6/11/24 and 7/2/24. R4's medical record indicated staff attempted to contact R4's Neurologist multiple times to send the pharmacy a prescription because the pharmacy did not have a prescription to fill. A progress note, dated 6/13/24 at 1:01 PM, indicated the writer called the pharmacy who didn't have a script. The writer called the doctor who prescribed the medication, gave a nurse pharmacy contact information, and requested the script be sent prior to 3:00 PM STAT (immediately) for delivery that night. A progress note, dated 6/15/24 at 9:25 PM, indicated R4 reported two seizures at 9:11 AM and 9:13 AM and stated the only symptom was dizziness. A progress note, dated 6/17/24 at 7:56 AM, indicated staff contacted R4's physician to send a prescription to the pharmacy on 6/13/24 and indicated the writer would follow-up with the pharmacy and doctor again that day. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 6/20/24 at 10:24 AM, indicated the writer followed-up on calls to the pharmacy and doctor's office from the previous week. The pharmacy still hadn't received a script. Staff called R4's Neurologist's office a second time. An assistant initiated an urgent message requesting a script be sent to the pharmacy immediately. A progress note, dated 6/21/24 at 1:28 PM, indicated staff called R4's Neurologist's office again to send a script for clobazam. A progress note, dated 6/21/24 at 6:35 PM, indicated clobazam was still unavailable and there was no response from R4's physician. The writer notified DON-B and R4's Advanced Practice Nurse Prescriber (APNP). A progress note dated 6/22/24 at 12:33 PM, indicated the pharmacy delivery did not contain clobazam. The pharmacy indicated they did not receive an order from R4's Neurologist. A progress note, date 6/23/24 at 10:07 AM, indicated last night's pharmacy deliver did not contain clobazam. The pharmacy told staff to call back when the weekday staff returned. A progress note, dated 6/24/24 at 1:43 PM, indicated clobazam was unavailable. DON-B and R4's APNP were notified that the pharmacy and R4's Neurologist were called at least 3 times over the past 3 weeks to get a script sent. A progress note, dated 6/29/24 at 8:28 AM, indicated the pharmacy did not send clobazam. A progress note, date 7/1/24 at 8:17 PM, indicated the Neurologist had not or would not send a script despite the fact seven messages were left over the past three weeks to refill the medication. R4's July through December 2024 MARS indicated Fycompa was not available to administer from 7/2/24 through 7/10/24, 9/20/24 through 9/30/24, 10/21/24 through 10/29/24, 11/13/24 through 11/21/24, and 11/29/24 through 12/2/24. A progress note, dated 7/7/24 at 5:28 PM, indicated Fycompa would arrive on 7/8/24 due to an insurance issue. A progress note, dated 7/10/24 at 11:51 AM, indicated Fycompa had to be signed for by staff due to the cost. The writer followed-up with pharmacy and received a signed request. The pharmacy ordered the medication and said it would be delivered that day. A progress note, dated 7/10/24 at 7:31 PM, indicated the facility was awaiting receipt of Fycompa from pharmacy. A progress note, dated 9/21/24 at 9:36 PM, indicated the on-call NP was aware the pharmacy hadn't delivered Fycompa due to an insurance issue. A progress note, dated 10/1/24 at 5:10 PM, indicated Fycompa was on order. A progress note, dated 10/24/24 at 5:28 PM, indicated the facility was waiting for Fycompa which was reordered on 10/23/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 11/16/2 at 5:20 PM, indicated the facility was waiting for a refill of Fycompa. A progress note, dated 11/21/24 at 10:21 AM, indicated the facility was out of Fycompa. The pharmacy indicated Fycompa was last sent on 10/15/24 and was eligible for a refill, however, R4's insurance denied it. The pharmacy indicated they would update the facility later that day. A progress note, 11/21/24 at 11:27 AM, indicated the pharmacy notified the facility that R4's insurance denied the price/quantity and the pharmacy could only send enough for seven days. A progress note, dated 12/2/24 at 10:06 PM, indicated the pharmacy had issues getting R4's insurance to pay for Fycompa. The last dose was administered on 11/28/24. R4's physician and POAHC were updated. There was no increase in the amount of R4's seizures. The pharmacy stated Fycompa would be delivered that night. There was no substitute for Fycompa and Fycompa was not available in contingency. On 12/3/24 at 10:34 AM, Surveyor interviewed Registered Nurse (RN)-G who verified the facility had issues getting medication from the pharmacy. RN-G indicated when R4 was first admitted , the facility did not have all of R4's medications. RN-G confirmed Fycompa was not available on and off throughout R4's stay. When medications were not available, RN-G thought it was a combination of facility staff and agency staff not reordering the medication timely and indicated sometimes it was a pharmacy issue. RN-G indicated RN-G had been told by the pharmacy that medications would be there soon. When RN-G asked what soon meant, the pharmacy said they were unsure because due to short staffing. RN-G indicated R4's Neurologist did not send a script for Fycompa after admission and staff contacted the pharmacy and left messages several times. On 12/3/24 at 1:03 PM, Surveyor interviewed DON-B who verified it was important for R4 to receive seizure medication as prescribed. DON-B indicated if a medication is not available, staff should contact the pharmacy to send the medication, contact the resident's physician, contact the resident's decision maker, and inform DON-B. DON-B indicated staff should reorder medications when there are five doses left. DON-B indicated the facility initiated education on 12/2/24 due to issues with medications not being available. DON-B indicated not all staff had received the education yet. When Surveyor informed DON-B that R4's clobazam and Fycompa were not available at various times throughout R4's stay, DON-B indicated Fycompa helped R4 the most as they had tried everything for R4. DON-B indicated Fycompa was a costly medication that insurance did not always cover. DON-B indicated DON-B had to sign a pre-authorization for Fycompa each time but lately the pharmacy only sent enough to last a week. Surveyor asked DON-B about R4's clobazam and the number of times staff attempted to contact Neurology with no response and indicated R4 went over three weeks without the medication. When Surveyor asked DON-B if it was possible for staff to contact the facility's physician to send a prescription to the pharmacy since R4's Neurologist did not respond, DON-B indicated it might have been an option if the physician was willing to send the prescription to the pharmacy. (continued on next page)

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	525546	A. Building B. Wing	12/10/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 10:37 AM, Surveyor interviewed POAHC-F who indicated R4 had been on seizure medication most of R4's life. POAHC-F indicated the only time R4 got in trouble was when R4's medications were cut back which caused R4 to have grand mal seizures. POAHC-F indicated the facility called POAHC-F that week because R4 had missed two doses of Fycompa. POAHC-F indicated they were playing with fire when R4 didn't get R4's medications. POAHC-F indicated staff informed POAHC-F the pharmacy said Fycompa was expensive and the pharmacy did not have any in stock. POAHC-F wanted to know why a pharmacist gets to decide that a drug is too expensive. POAHC indicated POAHC needed to follow-up with the facility because it was upsetting that R4 was not getting R4's seizure medication. R4's MAR indicated the following: ~On 6/28/24, Fycompa was not administered. A note, dated 6/28/24 at 8:22 PM, indicated Fycompa was on order. ~On 6/29/24, Fycompa was administered. An order administration note, dated 6/29/24 at 6:27 PM, indicated Fycompa was not available. R4's MAR indicated the medication was administered. ~On 6/30/24, Fycompa was not administered. An order administration note, dated 6/30/24 at 8:45 PM, indicated Fycompa was still on order. ~On 7/1/24, Fycompa was administered. ~On 7/2/24 at 8:46 PM, Fycompa was not administered. An order administration note, dated 7/2/24 at 8:46 PM, indicated Fycompa was unavailable. ~On 7/3/24, Fycompa was administered. ~On 7/4/24 at 9:54 PM, Fycompa was administered. An order administration note, dated 7/4/24 at 9:54 PM, indicated Fycompa was unavailable. R4's MAR indicated from 7/5/24 through 7/10/24, Fycompa was not administered. Several progress notes indicated Fycompa was unavailable and was on order. A physician note, dated 7/7/24, indicated R4 stated R4 had more seizures in the past week than ever before. R4's Fycompa prescription ran out last week and a new script was needed if Fycompa was still part of R4's treatment plan. The physician's response indicated DON-B would contact Neurology. An order was sent, however, the price needed verification. R4's MAR indicated from 10/21/24 through 10/24/24, Fycompa was not administered. Progress notes indicated Fycompa was unavailable. ~On 10/25/24, Fycompa was administered. An order administration note indicated Fycompa was unavailable. R4's MAR indicated from 10/26/25 through 10/29/24, Fycompa was not administered and unavailable due to issues getting the medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/3/24 at 1:03 PM, Surveyor interviewed DON-B who confirmed if a medication is not available and not administered, the medication should not be documented as administered on a resident's MAR. 3. From 12/2/24 to 12/4/24, Surveyor reviewed R18's medical record. R18 was admitted to the facility on [DATE] and had diagnoses including vascular dementia and anxiety disorder. R18's MDS assessment, dated 12/3/24, had a BIMS score of 12 out of 15 which indicated R18 had moderately impaired cognition. R18 was R18's own decision maker. On 11/14/24, R18 saw Psychiatry who indicated R18 had an increase in depressive symptoms and recommended R18 start sertraline 25 mg by mouth daily and follow-up in one month. The note indicated if R18 moved to another facility, they should monitor R18's mood and possibly increase sertraline to 50 mg daily. A progress note, dated 11/19/24 at 2:48 PM, indicated R18 refused to take sertraline. The writer explained what the medication was for but R18 continued to refuse sertraline and refused to sign a medication consent form. A progress note, dated 11/20/24 at 6:39 AM, indicated sertraline was unavailable and was reordered. A progress note, dated 11/20/24 at 11:20 AM, indicated the writer discussed R18's sertraline refusal with R18's APNP. Sertraline was discontinued and Behavioral Health was updated. A pharmacy note, dated 11/21/24 at 10:20 AM, indicated R18 did not have sertraline. The pharmacy indicated a 15-day supply was sent and signed for on 11/14/24, however, it was not in the cart. R18's MAR indicated R18 received sertraline despite R18's refusal to take the medication. On 12/4/24 at 12:54 PM, Surveyor interviewed R18 who indicated R18 recalled talking to someone about taking a medication for mood management that R18 did not want to take. R18 indicated R18 did not want to take any medication. On 12/4/24 at 3:53 PM, Surveyor interviewed [NAME] President of Success (VPS)-H who indicated R18's sertraline was now discontinued but should have been discontinued when R18 refused the medication.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on staff interview and record review, the facility did not ensure 2 residents (R) (R11 and R14) of 5 sampled residents were monitored for adverse reactions or the effectiveness of antipsychotic medication. R11 was prescribed Seroquel (an antipsychotic medication) for dementia with behaviors. Staff did not monitor R11 for side effects, adverse reactions, or the effectiveness of the medication. R14 was prescribed lorazepam as needed (PRN) with a start date of 7/19/24. R14's lorazeapm order did not contain a stop date and was not reviewed by R14's provider after 14 days. Findings include: The National Institute for Health, www.ncbi.nlm.nih.gov Tardive Dyskinesia, updated 4/24/23, indicates: Numerous rating scales determine the presence and severity of tardive dyskinesia. The most widely used instrument is the Abnormal Involuntary Movement Scale (AIMS). It is recommended to administer the AIMS at baseline before initiating antipsychotic medications, with a follow-up screening performed no longer than three months later. Upon evaluation of the patient, it can be noted that tardive dyskinesia is present at rest and somewhat diminished when there is any form of volitional movement. For example, tongue dyskinesias reduce when the patient is asked to protrude their tongue. The facility's Psychotropic Medications policy, revised 10/24/22, indicates: Residents should not receive psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s) .Residents who receive an antipsychotic medication will have an AIMS test performed on admission, at least every 6 months, when the antipsychotic medication is changed, and PRN .PRN orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record and for a limited duration (i.e., 14 days). 1. Between 12/2/24 and 12/4/24, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] and had diagnoses including dementia, diabetes, and depression. R11's Minimum Data Set (MDS) assessment, dated 3/19/24, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R11 had intact cognition. R11 had an activated Power of Attorney for Healthcare (POAHC). R11 had an order for Seroquel 25 milligrams (mg) give 1 tablet by mouth two times a day for psychosis that was prescribed on 10/28/24 and discontinued on 11/21/24. R11's medical record did not contain an AIMS assessment or antipsychotic monitoring care plan. On 12/4/24 at 9:29 AM, Surveyor received an AIMS assessment for R11 that was dated 12/4/24. (continued on next page)

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	525546	A. Building B. Wing	12/10/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 11:05 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated residents who are prescribed antipsychotic medication should have an AIMS assessment completed on admission and every 6 months. DON-B verified R11's AIMS assessment was completed on 12/4/24. DON-B also indicated residents should have a care plan to monitor for side effects, adverse reactions, and the effectiveness of antipsychotic medications. 2. Between 12/2/24 and 12/4/24, Surveyor reviewed R14's medical record. R14 was admitted to the facility on [DATE] and had diagnoses including dementia, Alzheimer's disease, and anxiety. R14's MDS assessment, dated 10/11/24, had a BIMS score of 4 out of 15 which indicated R14 had severe cognitive impairment. R14's POAHC was activated on 1/22/19. R14 had an order (dated 7/19/24) for lorazepam 0.5 mg give 1-2 tablets every 2 hours PRN for anxiety, agitation, or nausea. On 12/3/24 at 2:17 PM, Surveyor reviewed R14's PRN lorazepam administration and noted lorazepam was not administered in July, August, October, and November 2024 and was only administered on 9/3/24 and 9/13/24. On 12/4/24 at 11:04 AM, Surveyor interviewed DON-B who verified R14's PRN lorazepam order did not contain a stop date. DON-B indicated the medication should have been stopped after 14 days or reviewed by R14's provider with a rationale to continue it.

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	525546	A. Building B. Wing	12/10/2024

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility did not ensure residents 2 residents (R) (R3 and R4) of 10 sampled residents were free from significant medication errors. R4 has a diagnosis of epilepsy and is prescribed six medications for seizures, including clobazam (a benzodiazepine used to help control seizures) and Fycompa (an anti-epileptic medication used to treat and prevent seizures). R4 did not receive clobazam between [DATE] and [DATE] because the pharmacy had not received an order for the medication. R4 did not receive Fycompa from [DATE] through [DATE], [DATE] through [DATE], [DATE] through [DATE], [DATE] through [DATE], and [DATE] through [DATE] due to pharmacy issues. R4 fell from R4's wheelchair during a seizure on [DATE] and incurred a head laceration that required two staples. R3 has a diagnosis of epilepsy and is prescribed Depakote for seizures. R3's bedtime (HS) Depakote order was increased on [DATE], however, the pharmacy did not receive the order. R3 did not receive Depakote on [DATE], [DATE], [DATE], and [DATE] because R3 was out of Depakote and the facility had exhausted their contingency supply. R3 had a seizure on [DATE]. The facility's failure to ensure prescribed medications were available for residents with seizure disorders created a finding of immediate jeopardy that began on [DATE]. Surveyor notified Nursing Home Administrator (NHA)-A of the immediate jeopardy on [DATE] at 2:40 PM. The immediate jeopardy was removed on [DATE], however the deficient practice continues at a scope/severity level D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. Findings include: The facility's Medication Reconciliation policy, revised [DATE], indicates: This facility reconciles medication frequently throughout a resident's stay to ensure the resident is free of any significant medication errors, and that the facility's medication error rate is less than 5 percent .Medication reconciliation refers to the process of verifying the resident's current medication list matches the physician's orders for the purpose of providing the correct medications to the resident .Obtain and transcribe any new orders in accordance with facility procedures. Obtain clarification as needed. New orders should have a second nurse to review the orders for accuracy .Order medications from the pharmacy in accordance with facility procedures for ordering medications . Onfi.com indicates: Clobazam is a prescription medicine used along with other medicines to treat seizures associated with Lennox-Gastaut syndrome in people two years of age or older. Important Safety Information: Clobazam is a benzodiazepine medicine and can cause physical dependence and withdrawal reactions. Stopping or decreasing clobazam suddenly after continued use may cause serious withdrawal reactions, which can be life-threatening, including unusual movements, responses, or expressions, seizures, sudden and severe mental or nervous system changes, depression, seeing or hearing things that others do not, an extreme increase in activity or talking, losing touch with reality, and suicidal thoughts or actions. (continued on next page)

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	525546	A. Building B. Wing	12/10/2024

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Fycompa.com indicates: Fycompa is a prescription medicine used alone or with other medicines to treat partial-onset seizures with or without secondarily generalized seizures in people with epilepsy aged 4 and older and with other medicines to treat primary generalized tonic-clonic seizures in people with epilepsy aged 12 and older. Twelve milligrams (mg) is the highest dose studied . The website indicates: Do not stop Fycompa without first talking with your healthcare provider. Stopping suddenly can cause serious problems and can cause you to have seizures more often .Because of increased likelihood for adverse reactions in elderly patients, dosing titration should proceed slowly in patients aged [AGE] years and older. Fycompa .has the potential to .lead to .withdrawal symptoms including anxiety, nervousness, irritability, fatigue, asthenia, mood swings, and insomnia. According to https://www.depakote.com/epilepsy: Depakote comes in different dosage forms for oral use. Depakote (divalproex sodium) delayed-release tablets, Depakote ER (divalproex sodium) extended-release tablets, and Depakote Sprinkle Capsules (divalproex sodium delayed release capsules) are prescription medicines used: alone or with other medicines to treat: complex partial seizures in adults and children [AGE] years of age and older, simple and complex absence seizures .with other medications to treat: patients with multiple seizure types that include absence seizures .Stopping Depakote suddenly can cause serious problems. Stopping a seizure medicine suddenly in a patient who has epilepsy can cause seizures that will not stop (status epilepticus). 1. From [DATE] to [DATE], Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including epilepsy and dementia. R4's Minimum Data Set (MDS) assessment, dated [DATE], had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R4 was not cognitively impaired. R4 had an activated Power of Attorney for Healthcare ((POAHC)-F). A Neurology note prior to R4's admission, dated [DATE], indicated R4 was seen at an epilepsy clinic for an initial visit and had a long-standing history of epilepsy. R4's seizures were described as a buzz in the head followed by convulsions. R4 underwent invasive evaluation in the 1990s and was told R4 was not a surgical candidate. Since then, R4 was treated medically and reported having seizures on most days. R4 was prescribed Dilantin (an anticonvulsant medication used to treat and prevent seizures), Fycompa, and topiramate (an anticonvulsant medication used to treat and prevent seizures). R4 was also prescribed Klonopin (clonazepam) twice per day. The Neurologist recommended R4 start Onfi with an intention of weaning Klonopin and indicated R4 would be admitted to the epilepsy monitoring unit for characterization and pre-surgical work up. R4 was prescribed clobazam (Onfi) 10 mg take .5 tablet by mouth in the morning and at bedtime for seven days then one tablet (10 mg) in the morning and at bedtime. R4's medical record indicated R4 was prescribed six medications related to seizure activity, including the following: ~One 1 milligram (mg) tablet of clonazepam (a benzodiazepine that is used to treat seizures) given by mouth as needed for seizure activity. ~One 10 mg tablet of clobazam (Onfi) given by mouth two times a day for seizures. ~One 12 mg tablet of Fycompa given by mouth one time a day for seizures. (continued on next page)

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	12/10/2024

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

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:52 PM, Surveyor interviewed R4 who indicated R4 had seizures since R4 was six years old. R4 stated R4 had approximately six seizures per day. R4 indicated R4 recently had a bad seizure, fell out of R4's wheelchair, hit R4's head on the floor, and received two staples to the back of R4's head. R4 stated that was the worst seizure R4 had in a while. R4 stated R4's seizures consist of a buzzing sound in R4's head to severe shaking and tremors. When asked if there were any issues with R4's medications, R4 could not recall and indicated R4 took a lot of medication. On [DATE] at 10:37 AM, Surveyor interviewed POAHC-F who indicated R4 had been on seizure medication most of R4's life. POAHC-F indicated the only time R4 got into trouble was when R4's medications were cut back which caused R4 to have grand mal seizures. POAHC-F indicated the facility called POAHC-F that week because R4 had missed doses of Fycompa. POAHC-F indicated the facility was playing with fire when R4 didn't receive R4's medications. POAHC-F indicated staff stated the pharmacy said the medication was expensive and the pharmacy didn't keep it in stock. POAHC-F wanted to know when a pharmacist gets to decide when a drug is too expensive. POAHC-F indicated POAHC-F needed to follow-up with the facility because it was upsetting that R4 did not receive R4's seizure medication. POAHC-F indicated R4 was seen at an epilepsy clinic earlier in the year for three to four days and they adjusted R4's medications. POAHC-F indicated R4 seemed to be doing okay but was never going to be seizure free despite medication. POAHC-F the facility only contacted POAHC-F one time regarding R4 not receiving medication. R4's June and July (2024) Medication Administration Records (MARs) indicated R4 did not receive clobazam between [DATE] and [DATE]. Multiple progress notes during that time indicated staff attempted to call the pharmacy, left messages for R4's Neurologist, talked to the Neurologist's nurse, and notified the Director of Nursing (DON) and R4's Advanced Practice Nurse Prescriber (APNP). A progress note, dated [DATE] at 5:39 AM, indicated R4 informed a Certified Nursing Assistant (CNA) that R4 had two seizures that morning at 4:48 AM. R4 indicated there was buzzing in R4's head but R4 did not lose consciousness. R4 indicated that was a usual symptom and R4 could tell when a seizure was coming on. A progress note, dated [DATE], indicated staff notified R4's physician that R4 reported two unwitnessed seizures at 4:48 AM. R4 reported the seizure activity included buzzing in R4's head and no loss of consciousness. R4 was prescribed Dilantin and received R4's scheduled dose at 6:00 AM. The physician indicated R4 was on several seizure medications and asked if R4 received all of R4's seizure medications. The note indicated R4 was followed by a physician for seizures and Neurology was updated. A hand-written note indicated staff called the pharmacy on [DATE] and was told the pharmacy did not have a prescription for clobazam. R4's physician was notified. R4 began receiving clobazam on [DATE]. R4's [DATE] MAR indicated R4 did not receive Fycompa from [DATE] through [DATE]. A physician notification, dated [DATE], indicated R4 stated R4 had more seizures this past week than ever before. R4's Fycompa prescription ran out last week and a new script was needed. The note asked the physician to send a prescription to the pharmacy if Fycompa was still part of R4's treatment plan. The physician indicated DON-B would contact Neurology. An order was sent but needed price verification. (continued on next page)

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	525546	A. Building B. Wing	12/10/2024

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R4's September and [DATE] MARs indicated R4 did not receive Fycompa from [DATE] through [DATE] and [DATE] through [DATE]. R4 was administered as needed (PRN) clonazepam for seizures/seizure activity on [DATE], [DATE], [DATE], and [DATE]. A progress note, date [DATE], indicated R4 approached the DON and stated R4 continued to have small seizures every day. A Neurology referral was requested and an appointment was scheduled for February 2025. R4's [DATE] MAR indicated R4 did not receive Fycompa from [DATE] through [DATE]. A progress note, dated [DATE] at 7:39 PM, indicated R4 reported seizure activity. A progress note, dated [DATE] at 5:46 PM, indicated R4 was administered clonazepam for seizure activity. On [DATE], R4 had a seizure in the dining room. R4 fell out of R4's wheelchair and hit R4's head on the floor. R4 had a laceration on the back of the head which required two staples in the emergency room (ER). On [DATE], the facility added an intervention to R4's care plan for anti-roll back bars on the wheelchair. Surveyor did not observe anti-roll back bars on R4's wheelchair until [DATE]. R4's November and [DATE] MARs indicated R4 did not receive Fycompa from [DATE] through [DATE] and had several self-reported seizures during that timeframe. A progress note, dated [DATE] at 5:17 PM, indicated there was no further seizure activity observed by staff, however, R4 reported three seizures that day. A progress note, dated [DATE] at 8:10 AM, indicated R4 had a small unwitnessed seizure with no signs of distress. A progress note, dated [DATE] at 11:55 AM, indicated R4 reported a seizure and requested PRN clonazepam. A progress note, dated [DATE] at 11:00 AM, indicated the writer spoke to the pharmacy regarding R4's Fycompa because R4 hadn't received the medication in two days. The pharmacy stated Fycompa was costly and they would send it that night. POAHC-F was updated that R4 did not receive the medication. R4's Nurse Practitioner (NP) advised staff to monitor for changes. A progress note, dated [DATE] at 10:04 PM, indicated R4 was out of Fycompa and the last dose administered was on [DATE]. R4 reported having seizures, however, there was no change from when R4 had the medication to when R4 did not. R4 mostly reported having seizures when R4 was in the dining room. The pharmacy stated Fycompa would be delivered that night. A progress note, date [DATE] at 10:39 PM, indicated R4 was out of Fycompa. R4 stated R4 had a seizure in the dining room during supper. There was no increase noted in R4's reported seizures. The pharmacy indicated Fycompa would be delivered that night. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor noted R4 received PRN clonazepam and had approximately twenty seven documented seizures. Surveyor noted fifteen of R4's seizures occurred when R4 was not on seizure medication. Twelve of R4's seizures occurred after R4 took all of R4's seizure medication. On [DATE] at 1:03 PM, Surveyor interviewed Director of Nursing (DON)-B. When asked what staff should do if a medication is unavailable, DON-B indicated staff should contact the pharmacy to send the medication, contact the resident's physician and ask what they would like staff to do, contact the resident's decision maker, and inform DON-B. DON-B indicated staff should reorder a medication when there are 5 doses left. DON-B indicated the facility provided staff education on [DATE] due to issues with medications not being available, however, not all staff had received the education yet. DON-B also indicated DON-B reviewed daily reports to ensure medications were not missed. When Surveyor informed DON-B about R4's clobazam and Fycompa, DON-B indicated Fycompa was the drug that helped R4 the most because R4 had tried everything. DON-B indicated Fycompa was a high-cost medication that insurance did not always cover and DON-B had to sign a pre-authorization for the medication each time. DON-B acknowledged it was important to take seizure medications consistently and indicated prescribed medications should be administered. If medications were not administered, DON-B confirmed staff should notify the resident's physician and decision maker and receive instruction from the physician on what to do. On [DATE], Surveyor attempted to call R4's APNP and Case Manager but did not receive return calls. 47248 2. On [DATE], Surveyor reviewed R3's medical record. R3 had diagnoses including seizures, major depression, dementia with behaviors, and anxiety. R3's MDS assessment, dated [DATE], had a BIMS score of 4 out of 15 which indicated R3 had severely impaired cognition. R3 had a court appointed Guardian for healthcare decisions. R3 had physician orders for one 250 mg and one 500 mg tablet of Depakote (for a total of 750 mg) in the AM and two 500 mg tablets of Depakote (for a total of 1000 mg) at bedtime (HS) for seizures. A progress note, dated [DATE] at 12:02 AM, indicated R3 was on follow-up for what could have been a seizure on the AM shift. R3 did not have any seizures that shift and R3's cognition was at baseline. A progress note, dated [DATE] at 2:36 PM, indicated R3 was out of divalproex (Depakote) 500 mg. The pharmacy stated a 30-day supply was sent on [DATE] and were unable to send more at that time. A progress note, dated [DATE] at 9:45 AM, indicated R3 was out of divalproex 500 mg. The computer indicated refills were received on [DATE] but there were no cards. The pharmacy said they would send the medication that night. A progress note, dated [DATE] at 9:15 AM, indicated R3 was out of divalproex 250 mg and a dose was taken from contingency. The pharmacy said fifteen tablets were sent on [DATE] but the card was gone. A progress note, dated [DATE] at 9:16 AM, indicated R3 was out of divalproex 500 mg tablets which were on order since [DATE] and were not sent by the pharmacy. The pharmacy stated a 15-day supply was sent on [DATE] and they could not send a refill until [DATE]. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note, dated [DATE] at 8:53 AM, indicated: Divalproex sodium oral tablet delayed release 250 mg give 1 tablet by mouth one time a day for seizures. Take 1 (250 mg) tablet daily along with 1 (500 mg) tablet to equal an AM dose of 750 mg. Unavailable, contingency empty. A progress note, dated [DATE] at 3:42 PM, indicated the pharmacy was asked about R3's Depakote orders for 750 mg every AM and 1000 mg every PM (dated [DATE]). The pharmacy stated they never received the order for 1000 mg every PM. The facility depleted Depakote in the Nexsys (an automated medication dispensing machine). The NP was notified R3 had not received Depakote and had a small seizure that day. The writer faxed the pharmacy an order clarification. The pharmacy indicated the medication would be sent that night. R3's [DATE] MAR indicated R3's [DATE] HS dose of Depakote was not given. On [DATE] at 1:03 PM, Surveyor interviewed DON-B who confirmed R3 had an order to increase R3's HS dose of Depakote to 1000 mg on [DATE]. DON-B indicated nursing staff did not notify DON-B that the increased Depakote order was not received by the pharmacy or that nursing staff were consistently removing Depakote from the facility's contingency. DON-B verified DON-B was not made aware that R3's HS Depakote order was not received or filled by the pharmacy until R3 had missed doses on [DATE] and [DATE] and had a seizure on [DATE]. DON-B acknowledged it was important to take seizure medications consistently and indicated prescribed medications should be administered. If medications were not administered, DON-B confirmed staff should notify the resident's physician and decision maker and receive instruction from the physician on what to do. On [DATE] at 2:47 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-I who could not recall if R3's Depakote 750 mg AM dose was administered on [DATE]. LPN-I indicated if LPN-I charted that the dose was administered then it would have been administered. LPN-I indicated the facility usually had enough Depakote in contingency to administer the medication as pharmacy would not fill the order. On [DATE] at 9:25 AM, Surveyor contacted R3's Guardian but did not receive a return call. The failure to provide seizure medications for residents with seizure disorders created a reasonable likelihood for serious harm which led to a finding of immediate jeopardy. The facility removed the jeopardy on [DATE] when it had completed the following: 1. Reviewed orders and medications on-hand to ensure medications were in-house and available to administer. 2. Notified physicians, families, and residents of missing doses of medication on or prior to [DATE]. 3. Educated staff on the facility's policy for when medication is unavailable. 4. Initiated audits to ensure medications were administered as ordered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45942 Based on observation, staff interview, and record review, the facility did not ensure drugs and biologicals were stored in accordance with the facility's policy in 2 of 2 medication storage rooms. This practice had the potential to affect more than 4 of the 31 residents residing in the facility. On 12/2/24, Surveyor observed expired syringes and medications in 2 of 2 medication storage rooms. Findings include: The facility's Administering Medication Storage/Storage of Medication policy, dated 1/2024, indicates: Medications and biologicals are stored properly following manufacturers' or provider pharmacy recommendations to keep their integrity and to support safe, effective drug administration .Procedures: 14) Outdated, contaminated, discontinued or deteriorated medications .are immediately removed from stock, disposed of according to procedures for medication disposal .15) Medications awaiting destruction that cannot be disposed of immediately should be recorded on a log to include the name of the individual(s) storing the medication, resident name, the prescription number if applicable, the quantity of the medication, the strength of the medication and date of disposition . On 12/2/24 at 12:27 PM, Surveyor observed two medication storage rooms and noted the following: ~ Four unlabeled, undated open aluminum packages of ipratropium bromide ~ Sixty-nine unlabeled and undated pink sodium chloride saline vials not in their original packaging ~ Nine Once Care 1 milliliter (ml) insulin syringes that expired on 1/31/24 ~ Thirty Assure 1 ml syringes that expired on 1/25/23 ~ One bottle of B-12 vitamin 1000 micrograms that expired on 9/24 ~ One bottle of oyster shell with calcium 250 milligrams and vitamin D that expired on 5/24. Surveyor confirmed with Assistant Director of Nursing (ADON)-D that the medications and supplies were opened, unlabeled, and/or expired. ADON-D indicated medications and supplies should be in their original packaging, labeled, and disposed of appropriately when expired. On 12/2/24 at 12:30 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed the expired medications should have been disposed of in the Drug Buster.

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	525546	A. Building B. Wing	12/10/2024

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 47248 Based on staff interview and record review, the facility did not ensure lab services were provided timely for 1 resident (R) (R18) of 5 sampled residents. The facility did not send a stool sample for testing in a timely manner for R18 who was diagnosed with Clostridium difficile (C. diff). A repeat test was ordered but not completed. Findings include: On 12/4/24, Surveyor reviewed R18's medical record. R18 had diagnoses including cognitive communication deficit, legal blindness, and vascular dementia with mild anxiety. R18's Minimum Data Set (MDS) assessment, dated 8/28/24, had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R18 had moderately impaired cognition. R18 was R18's own decision maker. R18's medical record contained an order, dated 11/1/24, for OVA (parasitology examination) and C. diff testing. On 11/1/24, the results were faxed from the laboratory and indicated C. diff testing would be conducted; however, an OVA test could not be completed because the sample was not sent for testing within the required two-hour time frame. A repeat OVA test was ordered. Surveyor noted an order, dated 11/4/24, from R18's physician to repeat the OVA test and send to the lab for testing within a two-hour time frame. R18's medical record did not contain results from the OVA test ordered on 11/4/24. On 12/4/24 at 12:38 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed R18 had an order, dated 11/4/24, to repeat the OVA test. DON-B indicated DON-B was not aware if a sample was obtained and sent to the lab.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47248 Based on observation, staff interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to help prevent the development and transmission of disease and infection for 4 residents (R) (R18, R2, R11, and R80) of 4 residents. R18 had suspected Clostridium difficile (C. diff) but was not on the facility's infection surveillance line list. R2 was treated for a urinary tract infection (UTI) with antibiotic medication but was not on the facility's infection surveillance line list. R11 had diagnoses including infection and inflammatory reaction due to indwelling urethral catheter and a stage 3 pressure ulcer of the sacral region. R11 was not on enhanced barrier precautions (EBP). R80 was treated for osteomyelitis (bone infection) with intravenous antibiotics administered through a peripherally inserted central catheter (PICC). R80 was not on EBP. Findings include: The facility's Enhanced Barrier Precautions (EBP) policy, revised 8/8/24, indicates: It is the policy of this facility to implement EBP for the prevention of transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high-contact resident care activities .An order for EBP will be initiated for residents with any of the following: Wounds (chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (central lines, peripherally inserted central catheters (PICCs) .urinary catheters .) even if the resident is not known to be infected or colonized with an MDRO .Implementation of EBP: .Make gowns and gloves available immediately near or outside the resident's room .Personal protective equipment (PPE) for EBP is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room .Position a trash can inside the resident's room and near the exit for discarding PPE after removal prior to exit of the room or before providing care for another resident in the same room. The Infection Preventionist (IP) will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Infection Prevention and Control Program policy, revised 3/14/23, indicates: .1. The designated IP is responsible for oversight of the program and serves as a leader to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases .A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infection and communicable disease for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement .The IP serves as the leader in surveillance activities, maintains documentation of incidents, findings and any corrective actions made by the facility .Nursing staff participate in surveillance through assessment of residents and reporting changes in condition to physicians and management staff per protocol .D. Non-licensed staff participate in surveillance through timely communication to licensed staff members regarding notable observations involving residents or staff. 1. On 12/4/24, Surveyor reviewed R18's medical record. R18 had diagnoses including cognitive communication deficit, legal blindness, vascular dementia, and anxiety. R18's Minimum Data Set (MDS) assessment, dated 9/2/24, had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R18 had moderately impaired cognition. R18 made R18's own healthcare decisions. R18's medical record indicated R18 was tested for C. diff ova (a lab test to check for parasites or eggs in the stool) on 11/1/24. Surveyor noted the results were negative on 11/4/24 pending repeat ova testing. On 12/4/24, Surveyor reviewed the facility's infection surveillance line list for November 2024 and noted R18 was not on the list. (See interview under example 2.) 2. On 12/4/24, Surveyor reviewed R2's medical record. R2 had diagnoses including including heart failure and hypertension and was currently being treated for a UTI. R2's MDS assessment, dated 11/20/24, had a BIMS score of 10 out of 15 which indicated R2 had moderately impaired cognition. R2 had an activated decision maker. R2's medical record indicated R2 was diagnosed with a UTI and prescribed ciprofloxacin (an antibiotic) on 11/17/24. On 12/4/24, Surveyor reviewed the facility's infection surveillance line list for November 2024 and noted R2 was not on the list. On 12/4/24 at 10:43 AM, Surveyor interviewed Infection Preventionist (IP)-J who indicated the facility's policy was to investigate the infection and sensitivity when a resident was prescribed an antibiotic. When asked why R2 wasn't on the infection surveillance list, IP-J stated, I must have missed that. IP-J indicated the facility identified a significant amount of UTIs through the infection line list and were working on a plan for prevention. IP-J indicated R18 was not on the infection surveillance line list because R18 was not positive for C. diff when the test results came back. IP-J indicated if a resident is not positive for an infection, staff do not document the infection and initiate surveillance or precautions until a positive result is received. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 12/2/24, Surveyor reviewed R11's medical record. R11 had diagnoses including infection and inflammatory reaction due to indwelling urethral catheter and a stage 3 pressure ulcer of the sacral region. R11's MDS assessment, dated 11/17/24, had a BIMS score of 9 out of 15 which indicated R11 had moderately impaired cognition. R11 had an activated decision maker. On 12/2/24 at 10:38 AM and on 12/3/24 at 8:05 AM, Surveyor noted there was not an EBP sign on or near R11's door or a PPE cart near R11's room. On 12/4/24 at 10:14 AM, Surveyor noted there was an EBP sign and PPE cart provided for R11. R11's medical record contained an order, dated 12/3/24 at 2:00 PM, for EBP related to wounds. On 12/4/24 at 10:16 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-D who was unsure why or when EBP was discontinued for R11 since R11 had wounds and a catheter and was on precautions for a long time due to methicillin-resistant Staphylococcus aureus (MRSA) infection. ADON-B indicated EBP should not have been discontinued for high-contact cares for R11 which were completed daily. ADON-D put on EBP sign on R11's door and PPE equipment in R11's room on 12/4/24. On 12/4/24 at 12:23 PM, Surveyor interviewed IP-J who was unsure why EBP was discontinued for R11. IP-J indicated EBP should have remained for R11 as R11 had chronic wounds and a catheter for an extended period of time. 4. On 12/2/24, Surveyor reviewed R80's medical record. R80 had a diagnosis of osteomyelitis of vertebra, lumbar region upon admission on 11/22/24. R80's MDS assessment, dated 11/25/24, had a BIMS score of 15 out of 15 which indicated R80 was not cognitively impaired. R80 was R80's own decision maker. R80's medical record contained orders for ceftriaxone sodium intravenous solution 2 grams once daily for antibiotic, daily and as needed wound care orders for the right foot, mid-back, and sacrum, and a PICC line dressing change every Monday night. R80's medical record did not contain an order for EBP. On 12/2/24 at 10:40 AM and on 12/3/24 at 8:19 AM, Surveyor noted there was no EBP sign on or near R80's door or PPE cart near R80's room. On 12/4/24 at 10:23 AM, Surveyor noted there was an EBP sign and PPE cart provided for R80. On 12/4/24 at 10:23 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-K who was unsure when EBP was initiated for R80 and had not seen EBP previously for R80. CNA-K indicated CNA-K currently used EBP during high-contact cares but did not use EBP during high-contact cares for R80 prior to 12/4/24. On 12/4/24 at 10:34 AM, Surveyor interviewed IP-J who indicated IP-J noticed R80 was not on EBP on 12/4/24 and initiated EBP for R80. IP-J confirmed R80 should have been on EBP upon admission due to R80's wounds and PICC line.

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	12/10/2024

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

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47248 Based on staff interview and record review, the facility did not ensure the Infection Preventionist (IP) had current certification for specialized infection prevention and control training. This had the potential to affect all 31 residents residing in the facility. IP-J's certification in a specialized infection prevention and control program was expired and no longer valid. Findings include: Centers for Medicare & Medicaid Services (CMS) Memo QSO-,d+[DATE]-NH, revised [DATE], indicates: In 2016, CMS overhauled the Requirements for Participation for Long-Term Care (LTC) facilities which was implemented in three phases: .Phase 3 ([DATE]) .regulations which require nursing homes to have an Infection Preventionist who has specialized training onsite at least part-time to effectively oversee the facility's infection prevention and control program. On [DATE] at 8:15 AM, Surveyor requested IP-J's certificate of completion for specialized training in infection prevention and control from Nursing Home Administrator (NHA)-A. On [DATE] at 1:25 PM, Surveyor interviewed IP-J who indicated IP-J had certificates from modules of the program but could not find IP-J's certificate of completion for infection prevention and control training. IP-J indicated IP-J would obtain the certification and provide it to Surveyor. On [DATE] at 3:13 PM, IP-I approached Surveyor and indicated IP-J found IP-J's certificate of completion for infection prevention and control training, however, the certification had expired. IP-J indicated Director of Nursing (DON)-B was looking for DON-B's certificate because IP-J worked under DON-B. IP-J confirmed IP-J was the facility's designated IP and DON-B did not monitor the infection prevention and control program.

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	12/10/2024

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 48794 Based on staff interview and record review, the facility did not ensure required nurse aid training was completed for 2 of 5 Certified Nursing Assistants (CNAs). CNA-Q was hired on 1/31/22. CNA-Q did not have 12 hours of in-service training during the most recent anniversary of hire year. CNA-R was hired on 7/26/23. CNA-R did not have 12 hours of in-service training during the most recent anniversary of hire year. Findings include: The facility's Facility Assessment, dated 9/3/24, states: .d. Skill competencies are assessed upon hiring and reviewed annually during staff performance evaluations .if any skill deficiencies are identified, the Director of Nursing (DON) or supervisor will provide the necessary training .Required in-service training for Nurse Aides: In-service training must: Be sufficient to ensure the continuing competency of Nurse Aides but must be no less than 12 hours per year. Include dementia management training and resident abuse prevention training. Address areas of weakness as determined in Nurse Aides' performance reviews and Facility Assessment. Address the special needs of residents as determined by facility staff. For Nurse Aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. On 12/10/24, Surveyor reviewed the facility's most recent in-service trainings for 5 sampled CNAs and noted the following concerns: ~ CNA-Q received 2.75 of the required 12 hours of in-service training between 1/31/23 and 1/31/24 with no additional hours worked since 1/31/24. CNA-Q last worked on 8/15/24. ~ CNA-R received 6.83 of the required 12 hours of in-service training between 7/26/23 and 7/26/24 with 2.75 hours completed so far in 2024. CNA-R last worked on 8/15/24. On 12/10/24 at 1:13 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated CNA-Q and CNA-R were both seasonal employees and confirmed both CNAs last worked on 8/15/24. NHA-A stated the facility's business office was responsible for monitoring CNA hours to ensure the 12 hour requirement was met. NHA-A confirmed CNA-Q and CNA-R did not have the 12 hours of required training completed. NHA-A confirmed CNA-Q and CNA-R continued to work in the facility with residents without having 12 hours of training completed.