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	03/10/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a sanitary manner. This practice had the potential to affect all 19 residents residing in the facility.The facility did not cool food with an approved cooling method.The facility did not use sanitizing solution per manufacturer's instructions to ensure proper sanitization of kitchen prep surfaces.Findings include:Cooling Method:The 2022 Food and Drug Administration (FDA) Food Code documents at section 3ˆ501.14 Cooling Methods: .(A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 57 Celsius (C) (135 Fahrenheit (F)) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. (B) Time/temperature control for safety food shall be cooled within 4 hours to 5 degrees C (41 degrees F) or less if prepared from ingredients at ambient temperature, such as reconstituted foods and canned tuna. (C) Except as specified under (D) of this section, a time/temperature control for safety food received in compliance with laws allowing a temperature above 5 degrees C (41 degrees F) during shipment from the supplier as specified in 3-202.11(B), shall be cooled within 4 hours to 5 degrees C (41 degrees F) or less .During a self-guided initial tour of the kitchen that began at 8:32 AM on 3/8/26, Surveyor observed the following pre-cooked items in the walk-in cooler:~ A container labeled fried ham dated 3/7/26~ A container labeled ham dated 3/7/26~ A container labeled chicken dated 3/6/26~ A container labeled baked beans dated 3/6/26~ A container labeled beef gravy dated 3/6/26~ A container labeled chili dated 2/26/26Surveyor observed the following pre-cooked food in the walk-in freezer:~ A container labeled maple mustard pork chops dated 3/5/26Surveyor observed a food cooling log near the walk-in cooler that did not contain any entries.During a continuous kitchen observation that began at 12:17 PM on 3/9/26, Surveyor interviewed Dietary Manager (DM)-H who verified the above items in the walk-in cooler and freezer were cooked, cooled, and saved for future resident consumption. DM-H confirmed the facility did not have a cooling log for foods cooked and cooled for future consumption. DM-D stated the facility previously had a cooling log; however, DM-D was informed by the facility's Registered Dietitian that the cooling log was not necessary since the facility did not save large amounts of food.Sanitizing Solution:During a continuous kitchen observation that began at 12:17 PM on 3/9/26, Surveyor noted the facility used Cleanslate Knoxville Disinfectant-Sanitizer. The sanitizing solution was connected to and used in the third compartment of the three-compartment sink. Surveyor interviewed DM-H who stated the facility used sanitizing solution in buckets to clean kitchen prep surfaces. DM-H stated staff prepare a bucket of sanitizing solution, wipe all countertops with a cloth, and leave the kitchen prep areas to dry. Surveyor noted the manufacturer's directions for Cleanslate Knoxville Disinfectant-Sanitizer indicate a pre-cleaning step is required for visibly soiled areas and a fresh solution should be prepared for each use. To disinfect inanimate, hard, non-porous surfaces, apply solution with a mop, cloth, sponge, low pressure coarse sprayer, or hand pump trigger sprayer and wet all surfaces thoroughly. Allow to remain visibly wet for 10 minutes and remove excess liquid. Surfaces which may contact food must be rinsed thoroughly with potable water after use. The General Disinfection section indicates: To disinfect food processing premises: floors, walls, and storage areas, add 3 ounces of product per 5 gallons of water. For visibly soiled areas, a (continued on next page)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	pre-cleaning step is required. Apply solution with a mop, cloth, sponge, or hand pump trigger sprayer and wet all surfaces thoroughly. Allow to remain visibly wet for 10 minutes and remove excess liquid. Before using the product, food products and packaging materials must be removed from the area or carefully protected. After use, all surfaces in the area must be thoroughly rinsed with potable water. To disinfect food service establishment or restaurant contact surfaces: floors, walls, storage areas, countertops, outside of appliances, and tables, add 3 ounces of product per 5 gallons of water. For visibly soiled areas, a pre-cleaning step is required. Apply solution with a cloth, sponge, or hand pump trigger sprayer and wet all surfaces thoroughly. Allow the surface to remain visibly wet for 10 minutes, remove excess liquid, and rinse the surface with potable water .DM-H verified the sanitizing solution was not left on surfaces for 10 minutes and kitchen prep areas were not rinsed with water following the sanitization process.

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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 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. Based on staff interview and record review, the facility did not implement their abuse policy for 3 (Certified Nursing Assistant (CNA)-J, Registered Nurse (RN)-I, and CNA-K) of 8 employees reviewed for caregiver background checks. This practice had the potential to affect more than 4 of the 19 residents residing in the facility.CNA-J was hired on 12/30/25. CNA-J's background check information did not contain Department of Justice (DOJ) or Government Findings (GF) (formerly known as Integrated Background Information System (IBIS)) reports completed prior to CNA-J working in the facility and caring for residents. RN-I was hired on 1/12/22. RN-I's background check information did not include an updated Background Information Disclosure (BID) form or DOJ and GF reports.CNA-K was scheduled to begin working on 3/9/26. CNA-K's BID form was dated 11/15/24. In addition, CNA-K's background check information did not include DOJ or GF reports.Findings include:The facility's Abuse, Neglect and Exploitation policy, dated 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 .1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property .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 consistently with applicable state law and regulations. Responsibility for performance of compliance checks on contracted temporary staff will be established via contractual agreement. 2. Screenings may be conducted by the facility, a third-party agency, or academic institution. 3. The facility will maintain documentation of proof that the screening occurred .1. On 3/8/26, Surveyor requested background check information for CNA-J who started at the facility on 12/30/25. Surveyor received the background check information on 3/9/26 and noted CNA-J's BID form was completed on 12/21/25. CNA-J's DOJ and GF reports were requested on 2/11/26. Surveyor reviewed CNA-J's timecard which indicated CNA-J worked at the facility as a CNA starting on 12/30/25. 2. On 3/8/26, Surveyor received background check information for agency RN-I and noted RN-I's background check was completed on 1/22/22. RN-I's BID was due to be completed on or before 1/22/26. Surveyor requested the most up-to-date background check information for RN-I. On 3/9/26, Surveyor reviewed RN-I's background check information again and noted RN-I's BID form and DOJ and GF reports were dated 3/9/26.3. On 3/8/26, Surveyor requested background check information for CNA-K who was scheduled to work on 3/9/26. On 3/9/26, [NAME] President of Success (VPS)-C provided CNA-K's BID form and a copy of CNA-K's driver's license, Social Security card, and CNA registration. VPS-C indicated CNA-K's background check was in the process of being completed and CNA-K was no longer scheduled to work that day. Surveyor noted CNA-K's BID form was dated 11/15/24.On 3/9/26 at 2:03 PM, Surveyor interviewed Director of Nursing (DON)-B and VPS-C who stated the facility did not have a Business Office Manager who completed background checks and indicated other individuals in the organization oversaw the completion of background checks. DON-B and VPS-C verified CNA-J worked from 12/30/25 until 2/11/26 without completed DOJ and GF reports. DON-B and VPS-C confirmed RN-I's background check renewal was not completed until Surveyor requested the information. DON-B confirmed CNA-K worked in the facility in 2024, recently returned, and was scheduled to work on 3/9/26 without a completed background check. DON-B and VPS-C were not aware CNA-K's background check was not completed until Surveyor requested the information.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident representative interview and record review, the facility did not ensure written notice or a choice of room/roommate was provided for 1 resident (R) (R8) of 1 sampled resident. R8's belongings were transferred to another room on 1/23/26 against the wishes of R8's Power of Attorney for Healthcare (POAHC). R8's belongings were moved back to R8's room after Ombudsman (OMB)-L contacted the facility. Neither R8 or R8's POAHC received prior written notice of the reason for the room change. In addition, R8 was not given a choice of rooms or potential roommates. Findings include: The facility's Roommates policy, dated 7/2022, indicates: The facility will strive to accommodate the medical and social compatibility of individuals when assigning rooms and roommates. Residents have the right to share a room with whomever they wish, as long as both residents are in agreement .There are some limitations to these rights. Residents do not have the right to demand that a current roommate be displaced in order to accommodate the couple that wishes to room together. In addition, residents are not able to share a room if one of the residents has a different payment source for which the facility is not certified (if the room is in a distinct part of the facility, unless one of the residents pays privately for his/her care) or if one of the individuals is not eligible to reside in a nursing home. A resident's preferences are to be taken into account when considering roommates or making room changes. When a resident is being moved at the request of the facility, the resident, family, and/or responsible party must receive an explanation in writing of why the move is required. The resident should be provided the opportunity to see the new location, meet the new roommate, and ask questions about the move. A resident receiving a new roommate should be given as much advance notice as possible. Notification of the resident and/or responsible party regarding a new roommate is to be documented in the resident's medical record.From 3/8/26 to 3/10/26, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, vascular dementia, anxiety disorder, and major depressive disorder. R8's most recent Minimum Data Set (MDS) assessment, dated 1/30/26, indicated R8's cognition was impaired.On 3/8/26 at 9:59 AM, Surveyor interviewed Family Member (FM)-F who was also R8's activated POAHC. FM-F and R8 were in the common area outside R8's room. FM-F stated in January of 2026, Nursing Home Administrator (NHA)-A and Social Services Director (SSD)-D told FM-F that R8 had to move from R8's current room. FM-F told NHA-A and SDD-D that FM-F did not want R8 to move. When FM-F and R8 returned from breakfast, R8's belongings were being moved. FM-F stopped the move and R8's belongings were moved back to R8's room. The facility then indicated they would add another bed to R8's room and R8 received a roommate approximately one month ago. R8 had not had a roommate since R8 was admitted to the facility.On 3/8/26 at 1:30 PM, Surveyor interviewed FM-G who stated R8 had lived in the facility for two years. R8 was originally on the first floor and was moved to the second floor on 3/12/25. There were no residents on the first floor during the survey. When R8 moved to the second floor, R8 received a south facing room for maximal sun exposure and quiet. The room was located in the corner near a common space that connected to four other rooms. FM-G stated the facility attempted to move R8 into a room with a roommate in January of 2026. The roommate was known to yell and scream which was not a good match for R8 since yelling and screaming upset R8. FM-G wanted to maintain R8's comfort and safety in R8's current room. FM-F called FM-G when the facility began to move R8's belongings. FM-G called OMB-L who called the facility and indicated the facility could not move R8 without R8's consent. The move was stopped and R8 was given a roommate. FM-G stated NHA-A indicated they needed to move R8 to make room for three residents. SSD-D accompanied NHA-A during the interaction.On 3/10/26 at 11:45 AM, Surveyor interviewed SSD-D who verified R8 had not had a roommate in R8's current room which could accommodate two residents. SSD-D stated the facility had potential residents who (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wanted private therapy rooms for short-term rehab. SSD-D stated SSD-D informed FM-F twenty-four hours in advance of the facility's intent to move R8. SSD-D confirmed SSD-D accompanied NHA-A when FM-F was informed that R8 would be moved to a different room. SSD-D stated FM-F expressed FM-F's thoughts and asked about other rooms after being informed of R8's roommate. SSD-D stated many considerations are used to decide roommates, including bathroom placement for shared bathrooms. SSD-D stated FM-F said okay and wait until (FM-G) hears about this. SSD-D did not recall if SSD-D documented FM-F's response but stated SSD-D took FM-F's okay as permission. The move was scheduled for 1/23/26. SSD-D stated FM-G talked with NHA-A on 1/22/26 and stated FM-G did not want R8 to move, however, the facility went ahead with the move because FM-F had given the okay. SSD-D confirmed OMB-L called during a stand-up meeting on the day of R8's move. OMB-L informed the team via speaker phone that R8 was not given choices. SSD-D stated OMB-L made it sound like it was not a well thought out plan. A social services note created on 1/22/26 by SSD-D did not indicate verbal permission was given by FM-F to move R8's room. On 3/10/26 at 12:36 PM, Surveyor interviewed NHA-A who stated the facility reviewed bed availability and was trying to increase the census. They reviewed rooms that were considered semi-private that could have two residents but only had one resident who was not paying for a private room. NHA-A stated SSD-D explained how the facility determines roommates when NHA-A and SSD-D spoke with FM-F the day before the move was scheduled. NHA-A stated both NHA-A and SSD-D heard FM-F say okay to the room change. NHA-A stated the facility ultimately respected that FM-F and FM-G did not want to move R8 and informed FM-F and FM-G that they planned to move a resident in with R8 instead. NHA-A verified FM-G came to the facility on 1/22/26 and informed NHA-A that FM-G did not want R8 to move. NHA-A stated NHA-A would reconsider the move. NHA-A stated OMB-L called DON-B during morning meeting on 1/23/26 and DON-B put OMB-L on speaker phone. OMB-L told staff the move could not occur. NHA-A verified the call occurred while R8's belongings were being moved. NHA-A did not recall who stopped the move and did not think the information was documented unless SSD-D took notes. NHA-A indicated the facility was still looking at how to increase the census. On 3/10/26 at 1:29 PM, Surveyor interviewed OMB-L who confirmed FM-G contacted OMB-L and stated R8 and R8's family felt that they did not have a say in the move. OMB-L called the facility and spoke with NHA-A, DON-B, [NAME] President of Success (VPS)-C, and SSD-D. OMB-L stated the facility did not give proper notice to FM-F and did not consider FM-F and FM-G's input. OMB-L informed staff of the regulation and asked them to stop the move. On 3/10/26 at approximately 4:00 PM, Surveyor interviewed FM-F who confirmed NHA-A and SSD-D spoke to FM-F about the room change on 1/22/26 (the day prior to the attempted move). When Surveyor asked if FM-F gave verbal or written permission to move R8's room, FM-F denied that FM-F said okay or gave verbal consent and did not receive anything in writing about the room change. FM-F verified R8 was not moved but now has a roommate. Surveyor reviewed R8's census history which revealed no change in payor source during the move.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not provide Pre-admission Screening and Resident Review (PASRR) services for 1 resident (R) (R1) of 8 sampled residents.The facility did not contact the state mental health authority to pursue futher PASRR Level I screening after R1's PASRR Level I 30-day exemption expired.Findings include:On [DATE], Surveyor reviewed R1's medical record. R1 had a diagnosis of depression. R1's Minimum Data Set (MDS) assessment, dated [DATE], had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. R1 was R1's own decision maker.R1's medical record contained three PASRR Level I Screens but did not contain a PASRR Level II Screen. Surveyor reviewed R1's PASRR Level I Screens and noted the following:~ R1's date of admission and first PASRR Level I was a 30-day hospital exemption dated [DATE].~ A PASRR Level I Screen, dated [DATE], indicated R1 had a mental health disorder and was prescribed fluoxetine (an antidepresssant medication) and Wellbutrin (an antidepressant medication). A PASRR Level II Screen was not completed.~ A PASRR Level I Screen submitted for R1 on [DATE] indicated R1 had a diagnosis of depression and was prescribed fluoxetine and Wellbutrin. The PASRR Level I indicated R1 had a 30-day hospital exemption. ~ A third PASRR Level I Screen, dated [DATE], indicated R1 had a diagnosis of depression and was prescribed fluoxetine. Wellbutrin was removed. The PASRR Level I indicated R1 had a 30-day hospital exemption. A PASRR Level II Screen was not completed.On [DATE] at 11:57 AM, Surveyor interviewed Social Services Director (SSD)-D who stated SSD-D had worked as the SSD for a little over a year, did not have formal PASRR training, and was self-learning the process. SSD-D was not aware of the requirement to complete another PASRR Level I Screen if a resident remains in the facility after a 30-day exemption expires. SSD-D indicated R1 was originally admitted for rehabilitation and was supposed to transfer to another facility. SSD-D stated a new PASRR Level I Screen should be completed when there is a medication or diagnosis change. SSD-D indicated a PASRR Level I Screen was completed on [DATE] because Wellbutrin was removed. SSD-D verified PASRR Level I Screens were not submitted correctly and a PASRR Level II Screen was not completed for R1 who remained in the facility since admission on [DATE].

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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** Based on staff interview and record review, the facility did not provide care and services to maintain the highest practicable physical well-being for 1 resident (R) (R1) of 2 sampled residents.R1 had a diagnosis of ascites (an abnormal accumulation of fluid within the abdominal (peritoneal) cavity). Staff did not reweigh R1 in accordance with a physician's order or notify the physician after R1 gained 9.7 pounds in less than a month. Findings include:The facility's Weight Monitoring policy, revised 12/21/22, indicates: The Interdisciplinary Team (IDT) will strive to prevent, monitor, and intervene for undesirable weight changes for our residents .6. Any weight change of five pounds or more since the last weight assessment will be retaken for confirmation .10. The nursing staff will notify the individual or responsible party, physician .of any individual with an unintended significant weight change.On 3/10/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including ascites and cirrhosis of the liver. R1's Minimum Data Set (MDS) assessment, dated 1/14/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition.Surveyor reviewed R1's physician orders and noted an order to obtain R1's weight monthly one time a day every four weeks on Saturday and obtain a re-weight if there is a change of 5 pounds since R1's last weight.Surveyor reviewed R1's weights and noted the following:~ On 1/3/26, R1 weighed 285.8 pounds.~ On 2/1/26, R1 weighed 295.5 pounds which was an increase of 9.7 pounds in less than a month. R1's medical record did not indicate R1 was reweighed.On 3/10/26 at 11:36 AM and 12:51 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who confirmed R1 gained 9.7 pounds as of 2/1/26. When asked if R1 should have been reweighed and if the physician should have been notified, LPN-E stated LPN-E had asked a Certified Nursing Assistant (CNA) to reweigh R1. LPN-E verified R1's medical record did not contain a documented re-weight and did not indicate the physician was notified.On 3/10/26 at 1:16 PM, Surveyor interviewed [NAME] President of Success (VPS)-C who confirmed R1 should have been reweighed and the physician should have been notified. VPS-C indicated obtaining a resident's weight is the nurse's responsibility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program to prevent the transmission of communicable disease and infection for 1 resident (R) (R14) of 8 sampled residents.Certified Nursing Assistant (CNA)-M did not appropriately change gloves and cleanse hands during incontinence care for R14. Findings include: The facility's Hand Hygiene policy, revised 11/2/22, indicates: 1. All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations in the facility.2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached Hand Hygiene Table. The Hand Hygiene Table includes the following regarding when to perform hand hygiene: After handling contaminated objects; When moving from a contaminated body site to a clean body site during resident care; After assistance with personal body functions (e.g., elimination, hair grooming, smoking). From 3/8/26 to 3/10/26, Surveyor reviewed R14's medical record. R14 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia, and diabetes mellitus type 2. R14's most recent Minimum Data Set (MDS) assessment, dated 2/3/26, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R14 had moderately impaired cognition. On 3/8/26 at 12:59 PM, Surveyor observed CNA-M and CNA-O complete incontinence care for R14. While R14 was in bed, CNA-M and CNA-O positioned R14 to change R14's brief. CNA-M removed R14's wet brief and used wipes to clean R14's perineal area. Without changing gloves and cleansing hands, CNA-M retrieved a tube of barrier cream from the night stand drawer, applied cream to R14's groin, and put the cream back in the drawer. With the same same soiled gloves, CNA-M put a clean brief underneath R14. CNA-M and CNA-O assisted R14 onto the left side and secured the brief. CNA-M put the package of wipes in the night stand drawer, put a pillow under R14's legs, and provided R14 with blankets. CNA-M then removed gloves. Without cleansing hands, CNA-M removed and replaced the garbage bag. CNA-M then sanitized hands. Immediately after the observation, Surveyor interviewed CNA-M. When asked when CNA-M should change gloves and complete hand hygiene during incontinence care, CNA-M stated after a resident's brief is changed and a new brief is applied. On 3/8/26 at 3:51 PM, Surveyor interviewed Director of Nursing (DON)-B and Infection Preventionist (IP)-N who stated staff should change gloves and complete hand hygiene after gloves are soiled during incontinence care.