STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012266	A. BUILDING: _____ B. WING _____	R 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD LIVING INC	1040 QUINN DRIVE WAUNAKEE, WI 53597

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 11/02/2023, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit at Homestead Living Inc, a community-based residential facility (CBRF) located in Waunakee, WI. As a result of the survey, 2 deficiencies were identified. Two of two deficiencies were repeat deficiencies from Statement of Deficiency (SOD) XRLL11, dated 06/20/2023. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 13	N 000		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 2 of 2 employees	N 230		

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

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N 230	Continued From page 1	N 230		

reviewed were provided with orientation training in all the required topics before performing their job duties.

Caregiver G did not have training in emergency and disaster plan and evacuation procedures, recognizing and responding to resident changes of condition, or information regarding the assessed needs and individual services for each resident for whom s/he was responsible.

Caregiver H did not have training in emergency and disaster plan and evacuation procedures, recognizing and responding to resident changes of condition, or information regarding the assessed needs and individual services for each resident for whom s/he was responsible.

This is a repeat deficiency. See Statement of Deficiency (SOD) XRLL11, dated 06/20/2023.

Findings include:

On 11/02/2023, Surveyor conducted a review of 2 employees to verify compliance with orientation training requirements. Surveyor requested from Administrator A all training records since the times of hire for Caregivers G and H.

The record for Caregiver G, hired 04/29/2023, did not contain evidence of training in emergency and disaster plan and evacuation procedures, recognizing and responding to resident changes of condition, or information regarding the assessed needs and individual services for each resident for whom s/he was responsible.

The record for Caregiver H, hired 04/10/2023, did not contain evidence of training in emergency and disaster plan and evacuation procedures,

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N 230	Continued From page 2 recognizing and responding to resident changes of condition, or information regarding the assessed needs and individual services for each resident for whom s/he was responsible. At approximately 12:00 p.m., Surveyor interviewed Administrator A. Administrator A confirmed s/he was unable to find any other training records for Caregivers G and H.	N 230		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the individual service plans (ISPs) for 1 of 2 residents reviewed were updated when there was a change in his/her needs and physical condition. Resident 1's ISP was not updated to reflect fall prevention efforts that the provider was utilizing.	N 389		

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N 389	Continued From page 3	N 389		

This is a repeat deficiency. See Statement of Deficiency (SOD) XRLL11, dated 06/20/2023.

Findings include:

On 11/02/2023, at approximately 9:52 a.m., Surveyor toured the facility. Surveyor observed the room identified as belonging to Resident 1. Surveyor observed a blue mat that appeared to be a fall mat, folded up and placed against the wall near the foot of Resident 1's bed.

On 11/02/2023, at approximately 10:00 a.m., Surveyor interviewed Administrator A regarding hospice resident ISPs. Administrator A confirmed that for residents receiving hospice services, staff follow the provider's own ISPs to direct resident cares.

On 11/02/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 11/22/2022 with diagnoses including Alzheimer's disease. Surveyor reviewed an incident report, dated 10/13/2023, which described an incident in which staff had heard Resident 1's bed alarm and entered his/her room to find that s/he had fallen out of bed. Surveyor reviewed Resident 1's current ISP, dated 10/01/2023, and observed the following:

- Under the "Falling" heading: "[Resident 1] is non ambulatory and is a low fall risk...All HLI staff Team will monitor as needed when [Resident 1] wants to walk or move throughout the building..."

Surveyor did not observe any information about Resident 1's bed alarm or fall mat use.

At approximately 12:25 p.m., Surveyor interviewed Administrator A. Administrator A

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N 389	Continued From page 4 confirmed that the blue mat observed by Surveyor was a fall mat. Administrator A reported that the fall mat and bed alarm were used nightly ever since Resident 1 began hospice services. Administrator A reported that Resident 1 began hospice services on 04/07/2023. Administrator A reported that the fall mat and bed alarm were provided by his/her hospice team, and that Resident 1 was also using a scoop mattress as a means to prevent falling out of his/her bed. Administrator A confirmed s/he did not find any fall prevention efforts in Resident 1's ISP and reported that s/he forgot to add them.	N 389		