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 04/04/2024

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 04/04/2024, 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, 1 deficiency was identified. This deficiency was a repeat deficiency from Statement of Deficiency (SOD) XRLL11, dated 06/20/2023, and SOD XRLL12, dated 11/02/2023. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 15	{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

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 04/04/2024

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 230}	Continued From page 1 reviewed were provided with orientation training in all the required topics before performing their job duties. Caregiver G did not have training in recognizing and responding to resident changes of condition. Caregiver I did not have training in recognizing and responding to resident changes of condition, the prevention and reporting of abuse, neglect, and misappropriation of resident property, 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, and SOD XRLL12, dated 11/02/2023. Findings include: On 11/02/2023, Surveyor conducted a review of 2 employees to verify compliance with orientation training requirements. Surveyor requested from Licensee J and Staff Coordinator K training records for Caregivers G and I. The record for Caregiver G, hired 04/08/2023, did not contain evidence of training in recognizing and responding to resident changes of condition. The record for Caregiver I, hired 11/13/2023, did not contain evidence of training in recognizing and responding to resident changes of condition, the prevention and reporting of abuse, neglect, and misappropriation of resident property, or information regarding the assessed needs and individual services for each resident for whom s/he was responsible.	{N 230}		

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 04/04/2024

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 230}	Continued From page 2 At approximately 10:48 a.m., Surveyor interviewed Licensee J. Licensee J reported that Administrator A, who was typically responsible for training, had passed away in January, and s/he wasn't sure if s/he would have gotten around to updating the necessary training for staff since the last SOD. Licensee J was observed to look in a box that s/he reported contained staff training records, but after a few minutes reported the most recent records s/he found were from October 2023. Licensee J reported s/he could ask Caregivers G and I if they had completed the above training, but confirmed s/he did not have any documented evidence that they completed it.	{N 230}		