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 _____	08/13/2025

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

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N 000	Initial Comments From 08/11/2025 through 08/13/2025, Surveyor conducted a complaint investigation and standard survey at Home Instead Living Inc, a CBRF in Waunakee. Eleven deficiencies were identified. One deficiency was a repeat deficiency - See Statement of Deficiency (SOD) XRLL11, dated 06/20/2023 and SOD XRLL12, dated 11/02/2023. The complaint was substantiated. Census: 12	N 000		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure injuries of an unknown sources were investigated for 1 of 1 resident reviewed who had injuries of an unknown source. Resident 1 had documentation of bruises with unknown origin that were not investigated. Findings include: On 08/11/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 1's record, provided by Executive Director A. Resident 1 was admitted	N 161		

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

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N 161	Continued From page 1 to the provider's facility on 06/07/2022 with diagnosis of dementia. Resident 1's record, dated 06/01/2025 to 08/11/2025, documented the following bruises: - 06/12/2025: Large bruise noted to left lower leg. Staff report noting last week. Unaware of any injuries. - 06/26/2025: Wound care to left shin hematoma. - 07/03/2025: New bruising to right inner ankle and left big toe. - 07/30/2025: Small bruises on left elbow. - 08/01/2025: Bruise to left knee and left elbow. - 08/06/2025: Bruise on top of left hand and right forearm. Four small light purple marks on right ankle. - 08/07/2025: New bruise on right ankle/skin. On 08/11/2025 at 1:00 p.m., Surveyor interviewed Executive Director A and Administrator B. Surveyor asked if injuries of an unknown source were investigated at the facility. Executive Director A replied, "That would be a question for the nurse." On 08/11/2025 at 1:25 p.m., Surveyor interviewed Nurse D and asked if s/he had investigated bruises of unknown origin. Surveyor reviewed the bruises noted in Resident 1's record, dated 06/01/2025 through 08/11/2025. Nurse D replied, "No," and explained that s/he updated hospice of the bruises but was unaware that investigations needed to occur.	N 161		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after,	N 219		

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N 219	Continued From page 2 the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a background check was completed every 4 years for 1 of 1 caregivers reviewed that had worked for the employer for greater than 4 years. Caregiver C had not had a background check completed in greater than 4 years. Findings include: According to The Wisconsin Caregiver Program Manual (P-00038), a complete Caregiver Background Check, at minimum, consists of: 1) A completed DHS form F-82064, Background Information Disclosure (BID). 2) A response from the Department of Justice (DOJ). 3) A Governmental Findings Report from DHS that reports the person's status, including administrative finding or licensing restrictions (IBIS). On 08/11/2025 at approximately 12:00 p.m.,	N 219		

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N 219	Continued From page 3 Surveyor reviewed employee records provided by Executive Director A. Records documented Caregiver C was hired on 09/15/2006. Caregiver C's record included a BID, dated 10/13/2019, a DOJ, dated 10/25/2019 and an IBIS, dated 10/13/2019. On 08/11/2025 at approximately 12:35 p.m., Surveyor shared concern with Executive Director A that Caregiver C's record did not include background checks completed in the past 4 years. Executive Director A stated if there wasn't a background check in Caregiver C's record, then an updated background check wasn't done. Executive Director A reviewed Caregiver C's record and was unable to locate an updated record. Executive Director A stated s/he would complete a new background check.	N 219		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the	N 277		

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N 277	Continued From page 4 provider did not ensure 1 of 1 caregivers reviewed received at least 15 hours of continuing education in 2023 and 2024. Caregiver C did not complete continuing education in 2023 or 2024. Findings include: On 08/11/2025 at approximately 12:00 p.m., Surveyor reviewed employee records provided by Executive Director A. Records documented Caregiver C was hired on 09/15/2006. Caregiver C's record did not include documentation to indicate continuing education was completed in 2023 or 2024. On 08/11/2025 at approximately 12:35 p.m., Surveyor shared concern with Executive Director A that Caregiver C did not have documentation of continuing education in 2023 or 2024. Executive Director A reviewed Caregiver C's record and confirmed Surveyor's concern. Executive Director A stated the facility was being overseen by an administrator that "wasn't doing well" and one administrator that probably didn't do the continuing education during 2023 and 2024.	N 277		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, record review and	N 352		

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N 352	Continued From page 5 interview, the provider did not ensure 1 of 3 residents reviewed received all medications as prescribed. Resident 2 did not receive his/her Levetiracetam 100 mg/ml as prescribed. Findings include: From 08/11/2025 to 08/13/2025, Surveyor conducted a complaint investigation alleging a resident did not receive his/her medications as prescribed. On 08/11/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 11/06/2024 with diagnosis of memory deficits and aphasia. Resident 2's physician orders included Levetiracetam 100 mg/ml (Start Date: 01/02/2025) - Take 5 mls 2 times daily. Resident 2's medication administration record (MAR), dated 11/06/2024 through 08/11/2025 documented the following concerns with Levetiracetam 100 mg/ml administration: - Entries for 01/22/2025 AM, 01/23/2025 AM, 01/27/2025 AM, 01/28/2025 AM and 01/29/2025 AM were circled to indicate medications were not given. Notations documented the medication was not available. - Entries for 03/31/2025 AM, 04/01/2025 AM, 04/02/2025 AM and PM, 04/03/2025 AM, 04/05/2025 AM and 04/06/2025 were circled to indicate the medication was not given. Notations on 04/02/2025 PM and 04/03/2025 AM documented the provider had run out of the medication. - Entries for 04/21/2021 AM through 04/23/2025 AM were circled to indicate the medication was not given. Notations documented the medication was unavailable.	N 352		

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N 352	Continued From page 6 - Entry for 06/22/2025 PM was circled to indicate medication was not given. Reason not listed. On 08/11/2025 at approximately 1:25 p.m., Surveyor interviewed Nurse D and asked about Resident 2's Levetiracetam administration. Nurse D confirmed s/he was aware Resident 2 had not received his/her Levetiracetam as prescribed and that s/he did follow up investigations and education regarding the concern. Nurse D stated one investigation concluded caregivers were not accurately measuring Resident 2's Levetiracetam so Resident 2's supply was depleting before insurance would cover a refill and another investigation concluded a caregiver was distracted during medication pass resulting in missed medications. On 08/12/2025 at approximately 5:00 p.m., Surveyor received the following documentation from Nurse D: - "Medication Variance Report," dated 07/07/2025, that concluded Resident 2 had not received his/her PM dose of Levetiracetam 100 mg/ml 5 ml on 06/22/2025, 06/26/2025 and 06/30/2025. The document indicated Resident 2 did have a seizure. - "Medication Variance Report," dated 04/27/2025, that concluded caregivers had not been administering exactly 5 ml of Levetiracetam 100 mg/ml when due, leading to the medication being depleted for the medication was due for refill. On 08/13/2025 at approximately 1:00 p.m., Nurse D followed up with Surveyor to share that the provider had most recently been using 5 mL syringes to ensure Resident 2 received the correct amount of Levetiracetam (rather than	N 352		

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N 352	Continued From page 7 cups for measuring), Nurse D completed re-education with caregivers and had been completing routine audits. Cross Reference: N0415 DHS 83.37(2)(d) Documentation of Medication Administration	N 352		
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 the individual service plan (ISP) of 3 of 3 residents reviewed was reviewed and signed by their legal representative annually or when there was a change in need. Resident 1, Resident 2 and Resident 3's ISPs were not signed by their legal representatives. This is a repeat deficiency. See Statement of Deficiency (SOD) XRLL11, dated 06/20/2023 and SOD XRLL12, dated 11/02/2023.	N 389		

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N 389	Continued From page 8 Findings include: On 08/11/2025 at approximately 11:00 a.m., Surveyor reviewed resident records provided by Executive Director A. The following concerns regarding ISPs were identified: Resident 1: Resident 1 was admitted to the provider's facility on 06/07/2022 with diagnosis of dementia. Resident 1 had an activated Health Care Power of Attorney (HCPOA). Resident 1's ISP, dated 02/05/2025, was not signed by his/her HCPOA. Resident 2: Resident 2 was admitted to the provider's facility on 11/06/2024 with diagnosis of memory deficits and aphasia. Resident 2 had an activated HCPOA. Resident 2's ISP, dated 01/08/2025, was not signed by his/her HCPOA. Resident 3: Resident 3 was admitted to the provider's facility on 04/22/2025 with diagnosis of hemiparesis secondary to stroke. Resident 3 had an activated HCPOA. Resident 3's ISP, dated 04/25/2025, was not signed by his/her HCPOA. On 08/11/2025 at approximately 1:00 p.m., Surveyor interviewed Executive Director A and Administrator B and asked for signed ISPs for Resident 1, Resident 2 and Resident 3. Executive Director A stated Surveyor's request should be directed to Nurse D. On 08/11/2025 at approximately 1:25 p.m., Surveyor interviewed Nurse D and asked if s/he had ISPs signed by Resident 1, Resident 2 and Resident 3's HCPOAs indicating involvement and agreement of the ISPs. Nurse D stated it was not	N 389		

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N 389	Continued From page 9 part of his/her protocol to review and have HCPOAs sign updated ISPs. Nurse D stated s/he typically had HCPOAs sign off on only the initial ISP.	N 389		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential benefits and side effects of the medication. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 residents reviewed had their use of scheduled psychotropic medications reassessed by a pharmacist, practitioner or registered nurse for the desired responses and possible side effects at least quarterly. Resident 1's scheduled psychotropic medication use was not reviewed for nearly 6 months from October 2024 to April 2025. Findings include: On 08/11/2025 at approximately 11:00 a.m., Surveyor reviewed resident records provided by Executive Director A and Administrator B. Resident 1 was admitted to the provider's facility on 06/07/2022 with diagnoses of dementia and	N 407		

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N 407	Continued From page 10 anxiety. Resident 1's physician orders included Citalopram 20 mg (Start Date: 06/22/2022) 1 time daily, Quetiapine 25 mg (Start Date: 05/17/2023) 1 tablet 1 time daily, Quetiapine 25 mg (Start Date: 05/17/2023) 1.5 tablets 2 times daily and Lorazepam .5 mg (Start Date: 04/07/2025) 3 times daily. Resident 1's record did not include a scheduled psychotropic review from 10/05/2024 to 04/01/2025. On 08/11/2025 at approximately 1:25 p.m., Surveyor interviewed Nurse D regarding scheduled psychotropic reviews. Nurse D stated s/he did not have any additional reviews to provide other than what was in a binder provided to Surveyor. Nurse D explained that s/he was relatively new to nursing in assisted living settings and was working on getting to know the regulations. Nurse D stated s/he was recently provided a form by pharmacy to assist with psychotropic reviews.	N 407		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the	N 408		

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N 408	Continued From page 11	N 408		

resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure the rationale for use and detailed description of behaviors which indicated the need for administration of a PRN psychotropic medication were included in the individual service plans (ISP) and that PRN psychotropic use was reviewed at least monthly for 3 of 3 residents reviewed. Resident 3, Resident 2 and Resident 1's ISPs did not include the rational for use of PRN psychotropic medications and their PRN psychotropic use was not reviewed monthly.

Findings include:

On 08/11/2025 at approximately 11:00 a.m., Surveyor reviewed resident records provided by Executive Director A and noted the following concerns with PRN psychotropic medications:

Resident 3:

Resident 3 was admitted to the provider's facility on 04/22/2025 with diagnosis of hemiparesis secondary to stroke. Resident 3's physician orders included Lorazepam .5 mg (Start Date: 04/22/2025) every 4 hours as needed for anxiety or agitation. Resident 3's ISP, dated 04/25/2025, did not include a detailed description of behaviors which indicated the need for administration of the PRN. Resident 3's record did not include monthly psychotropic reviews. Resident 3's MAR, dated

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N 408	Continued From page 12 07/21/2025 to 08/11/2025, documented 5 administrations of PRN Lorazepam. Progress notes, dated 06/11/2025 to 08/11/2025, documented administering PRN Lorazepam prior to showers. Resident 2: Resident 2 was admitted to the provider's facility on 11/06/2024 with diagnosis of memory deficits. Resident 2's physician orders included Lorazepam .5 mg (Start Date: 12/20/2024) every 4 hours as needed for agitation. Resident 2's ISP, dated 01/08/2025, did not include a detailed description of behaviors which indicated the need for administration of the PRN. Resident 2's record included psychotropic reviews on 03/15/2025 and 07/17/2025, but did not include documentation to indicate the PRN psychotropic use was reviewed monthly. Resident 2's Medication Administration Record (MAR), dated 06/17/2025 to 08/11/2025, documented 1 administration of PRN Lorazepam. Resident 1: Resident 1 was admitted to the provider's facility on 06/07/2022 with diagnoses of dementia and anxiety. Resident 1's physician orders included Lorazepam .5 mg (Start Date: 08/26/2024) 1 tablet every 4 hours as needed for anxiety or agitation. Resident 1's ISP, dated 02/05/2025, did not include a detailed description of behaviors which indicated the need for administration of the PRN. Resident 1's record included psychotropic reviews on 10/05/2025, 04/01/2025 and 07/17/2025, but did not include documentation to indicate the PRN psychotropic use was reviewed monthly. On 08/11/2025 at approximately 1:25 p.m.,	N 408		

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N 408	Continued From page 13 Surveyor interviewed Nurse D. Surveyor shared concern that PRN psychotropic use was not included in ISPs and records did not include monthly PRN psychotropic reviews. Nurse D stated s/he was unaware that PRN psychotropic medications should be included in ISPs. Nurse D stated s/he had recently received a form from pharmacy that s/he planned to use for PRN psychotropic reviews monthly.	N 408		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 1 of 3 residents reviewed had their medication administration accurately documented. Resident 2's Levetiracetam 100 mg/ml was documented as administered at times the medication was unavailable for administration. Findings include:	N 415		

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	0012266	A. BUILDING: _____ B. WING _____	08/13/2025

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N 415	Continued From page 14 From 08/11/2025 to 08/13/2025, Surveyor conducted a complaint investigation alleging a resident did not receive his/her medications as prescribed. On 08/11/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 11/06/2024 with diagnosis of memory deficits and aphasia. Resident 2's physician orders included Levetiracetam 100 mg/ml (Start Date: 01/02/2025) - Take 5 mls 2 times daily. Resident 2's medication administration record (MAR), dated 11/06/2024 through 08/11/2025 documented the following concerns with Levetiracetam 100 mg/ml administration: - Entries documented Levetiracetam was unavailable for administration from 01/22/2025 AM through 01/29/2025, yet the medication was documented as administered on 01/22/2035 PM, 01/23/2025 PM, 01/24/2025 AM and PM, 01/25/2025 AM and PM, 01/26/2025 AM and PM, 01/27/2025 PM and 01/28/2025 PM. - Entries documented Levetiracetam was unavailable for administration from 03/31/2025 AM through 04/06/2025 AM, yet the medication was documented as administered on 03/31/2025 PM, 04/01/2025 PM, 04/03/2025 PM, 04/04/2025 AM and PM and 04/05/2025 PM. On 08/13/2025 at approximately 1:00 p.m., Nurse D followed up with Surveyor acknowledging the errors in documentation. Nurse D stated s/he completed 1:1 training with all caregivers regarding documentation and now completed twice weekly audits of the MAR. Cross Reference: N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication	N 415		

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N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire drills were conducted at least quarterly in 2023 and 2024. The provider did not conduct quarterly fire drills in 2023 or 2024. Findings include: On 08/11/2025 at approximately 10:30 a.m., Surveyor reviewed the provider's environmental records provided by Executive Director A. Records, dated 01/01/2023 through 08/11/2025, documented completion of fire drills on the following dates: - Fire Drill 04/16/2025 at 2:30 p.m.	N 525		

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N 525	Continued From page 16 - Fire Drill 03/19/2025 at 10:45 a.m. - Fire Drill 03/10/2023 at 11:45 p.m. On 08/11/2025 at approximately 3:00 p.m., Surveyor reviewed concern with Executive Director A and Administrator B that fire drills were not completed quarterly. Executive Director A acknowledged Surveyor's concern and stated the fire drills were not completed as required when the facility was being managed by a previous administrator.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure other evacuation drills, such as tornado, flooding or other emergency or disaster evacuation drill, were conducted at least semi-annually. The provider conducted 1 evacuation drill in 2023 and 0 evacuation drills in 2024. Findings include: On 08/11/2025 at approximately 10:30 a.m., Surveyor reviewed the provider's environmental records provided by Executive Director A. Records, dated 01/01/2023 through 08/11/2025, documented completion of evacuation drills on the following dates: - Tornado Drill 04/16/2025 at 2:45 p.m. - Tornado Drill 04/04/2023 at 10:00 a.m.	N 526		

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N 526	Continued From page 17 On 08/11/2025 at approximately 3:00 p.m., Surveyor reviewed concern with Executive Director A and Administrator B that evacuation drills were not completed semi-annually. Executive Director A acknowledged Surveyor's concern and stated the evacuation drills did not occur while the facility was being managed by a previous administrator in 2023 and 2024.	N 526		
N 617	83.55(6)(b) Bath and toilet areas: water temperature The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure water fixtures used by residents did not exceed 115 degrees F. The water temperature reached 141.4 degrees F. Findings include: On 08/11/2025 at approximately 12:00 p.m., Surveyor tested the water temperature in the bathroom nearest Executive Director A's office. The bathroom was across from resident rooms and accessible to residents. Surveyor's thermometer reached a temperature of 141.4 degrees F.	N 617		

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N 617	Continued From page 18 Exposure to hot water is a potential environmental danger for clients. Elderly clients and clients with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding, e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability. (DQA publication P-01942, Hot Water Temperatures in Adult Family Homes, 08/2017). On 08/11/2025 at approximately 3:00 p.m., Surveyor shared concern with Executive Director A and Administrator B that the facility's water temperature exceeded 115 degrees F. Executive Director A stated the water heater had been worked on the week prior and the temperature must have been turned up at that time.	N 617		