

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019417	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/23/2026
NAME OF PROVIDER OR SUPPLIER GOOD HOPE II		STREET ADDRESS, CITY, STATE, ZIP CODE 7060 N 124TH ST MILWAUKEE, WI 53224		
(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 04/23/2026, Surveyor concluded three complaint investigations at Good Hope II. Two deficiencies were identified. One complaint was unsubstantiated. Two complaints were substantiated. Census: 8	N 000		
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 interview, the provider did not ensure 1 of 1 resident reviewed (Resident 2) received all prescribed medications in the dosage and at intervals prescribed by a practitioner. This is a repeat deficiency. See Statement of Deficiency (SOD) D0CE11 dated 02/18/2026. Findings include: On 04/17/2026, at 10:10 a.m., Surveyor and House Supervisor (HS) E reviewed the medication cart. Surveyor observed three medication packets for Resident 2 in the locked drawer.	N 352		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019417	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 04/23/2026
NAME OF PROVIDER OR SUPPLIER GOOD HOPE II			STREET ADDRESS, CITY, STATE, ZIP CODE 7060 N 124TH ST MILWAUKEE, WI 53224		
(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 352	Continued From page 1 On 04/17/2026, at 10:11 a.m., HS E identified the following 8:00 a.m. medications for Resident 2, were still in their packets, in the medication cart: - Eliquis 5 milligrams (ml). - Duloxetine delayed release. 20 mg. - Fiber-lax tablet 625 mg. - Multivitamin with minerals 4.5 mg with iron. - Mucinex tablet extended release 600 mg. On 04/17/2026, Resident 2 missed five of his/her 8:00 a.m. medications. Surveyor reviewed Resident 2's medication administration records (MARs), from 04/01/2026 to 04/17/2026, and identified the following: - Eliquis. 5 milligrams (MG). Take 1 tablet by mouth two times a day. 7:00 a.m. (Atrial flutter). - Duloxetine hydrochloride (HCL) 20 (Cymbalta). Take 1 capsule by mouth in the morning. 7:00 a.m. (Major depressive disorder). - Fiber-lax tablet. 625 mg. Take 1 tablet by mouth in the morning. 7:00 a.m. (Irregular bowel movements). - Multivitamin with minerals. 4.5 mg with iron. Take 1 tablet by mouth in the morning. 7:00 a.m. (Malnutrition). - Mucinex 600 mg. Take 1 tablet by mouth every 12 hours. (cough) 8:00 a.m. On 04/17/2026, at 10:24 a.m., Surveyor interviewed HS E, who stated, "I just did a reeducation with [Caregiver I] yesterday for the same thing." HS E showed Surveyor Resident 2's	N 352			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019417	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/23/2026
NAME OF PROVIDER OR SUPPLIER GOOD HOPE II		STREET ADDRESS, CITY, STATE, ZIP CODE 7060 N 124TH ST MILWAUKEE, WI 53224		
(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 352	Continued From page 2 calendar, that had a physical therapy appointment written in on 04/16/2026 7:00 a.m. HS A stated, "I bet this is why s/he didn't get his/her medications.: HS E confirmed Caregiver I did not notify him/her of the medication error.	N 352		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the	N 431		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019417	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/23/2026
NAME OF PROVIDER OR SUPPLIER GOOD HOPE II		STREET ADDRESS, CITY, STATE, ZIP CODE 7060 N 124TH ST MILWAUKEE, WI 53224		
(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 431	Continued From page 3 provider did not ensure health monitoring for 1 of 1 resident. Resident 1 did not have documentation related to health monitoring for tube feeding/consumption monitoring, repositioning in bed/wheelchair and daily irrigation of suprapubic catheter. Findings include: On 04/17/2026, Surveyor reviewed Resident 1's record and identified the following: Resident 1 was admitted to the facility on 10/10/2024, with diagnoses including spastic quadriplegic cerebral palsy, gastronomy tube (G-tube) dependence, suprapubic catheter, neurogenic bowel agitation, seizures, gastroesophageal reflux disease (GERD), and wound infection. Resident 1 had a guardian. Resident 1 was enrolled in services with a managed care organization (MCO) and was assigned case managers. Resident 1 utilized home healthcare services to assist with wound care. Resident 1's move-out date was 04/13/2026. Resident 1's record contained an assessment dated 11/14/2024. Resident 1 did not have any additional assessments on file. On 04/20/2026, Licensee A provided Surveyor with a document titled, "House Supervisors Monthly Report." Licensee A stated Resident 1's hospitalizations were listed on the document. The following was identified: - On 03/04/2026, Resident 1 was admitted for suprapubic catheter dysfunction and discharged on 03/04/2026.	N 431		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019417	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 04/23/2026
NAME OF PROVIDER OR SUPPLIER GOOD HOPE II			STREET ADDRESS, CITY, STATE, ZIP CODE 7060 N 124TH ST MILWAUKEE, WI 53224		
(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 431	Continued From page 4 - On 03/12/2026 Resident 1 was admitted for abdominal pain and discharged on 03/13/2026. - On 03/17/2026 Resident 1 was admitted for urinary tract infection (UTI) and catheter obstruction and discharged on 03/18/2026. - On 03/22/2026 Resident 1 was admitted for influenza B and skin and soft tissue infection. S/He was discharged on 03/26/2026. Resident 1's record did not have documentation related to health monitoring for tube feeding/consumption monitoring, repositioning in bed/wheelchair and daily irrigation of suprapubic catheter. The following was identified: Tube Feeding/Consumption Monitoring On 04/20/2026, Licensee A emailed Surveyor Resident 1's signed individualized service plan (ISP). On 02/13/2026, guardian C, Former House Manager (FHM) B and managed care team representatives signed Resident 1's ISP. Resident 1's ISP identified: "ADLs/Eating. Consumption Monitoring. 3x day. Resident 1 requires staff to monitor food consumption... Resident 1 gets tube feeds [sic] at 6:00 a.m., 12:00 p.m., and 6:00 p.m., daily ... Method for delivering care/who is responsible: Resident 1, his/her activated healthcare power of attorney (AHCPOA) C, and staff at the facility ... Schedule: Daily@ Breakfast, Lunch, Dinner ..." On 04/23/2026, Surveyor received and reviewed Resident 1's March 2026 Medication	N 431			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019417	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/23/2026
NAME OF PROVIDER OR SUPPLIER GOOD HOPE II		STREET ADDRESS, CITY, STATE, ZIP CODE 7060 N 124TH ST MILWAUKEE, WI 53224		
(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 431	Continued From page 5 Administration Record. The following was identified: - Kate Farm 325 milliliters (ml). Mix 1 box of Kate Farm 325 ml with 325ml of water at 6 a.m., and 12 p.m. Give 165ml of Kate Farm with 400 [sic] of water at 6 p.m. - Feed Kate Farm three times per day plus 1 water flush, water flush of 30ml before and after tube feeding. - Water Flush. 100 milliliters (ml) water flush at bedtime. From 03/01/2026 to 03/16/2026, there were no caregiver initials for both the water flush of 30ml before and after tube feeding and the water flush for 100 ml flush at bedtime. Resident 1's March 2026 Task Administration Record identified the following: - Consumption Monitoring. Resident 1 requires staff to monitor food consumption. Resident 1 gets tube feeds at 6:00 a.m., 12:00 p.m., and 6:00 p.m. daily. Surveyor observed the following: Breakfast (6:00 a.m.) - Three days were monitored that Resident 1 consumed 100%. Ten days, Resident 1 was at hospital and 18 days, Resident 1's breakfast was not monitored and/or documented. Lunch (12:00 p.m.) - One day it was monitored that Resident 1 consumed 100%. Ten days, Resident 1 was at the hospital, and 20 days, Resident 1's lunch was not monitored and/or documented. Dinner (6:00 p.m.) - Ten days, Resident 1 was at	N 431		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019417	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/23/2026
NAME OF PROVIDER OR SUPPLIER GOOD HOPE II		STREET ADDRESS, CITY, STATE, ZIP CODE 7060 N 124TH ST MILWAUKEE, WI 53224		
(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 431	Continued From page 6 the hospital, and 21 days, Resident 1's dinner was not monitored and/or documented. Resident 1's Observation Notes from 02/05/2026 through 04/13/2026 identified the following: -On 02/28/2026 at 3:15 p.m., Caregiver F documented, "[Resident 1] does not have feeding schedule in electronic medical records (EMR) D. I did contact manager to update EMR D." Repositioning in Bed/Wheelchair Resident 1's ISP, signed 02/13/2026 identified the following: "ADLs/Mobility and Transferring. Positioning-Staff Assistance. [Resident 1] requires staff assistance with all positioning needs. Staff will assist [Resident 1] with repositioning in bed and in his/her wheelchair. Schedule: Daily@ As Needed. [Resident 1] will like to continue changing position as needed for comfort and to prevent pressure ulcers. Method for delivering care/Who is responsible: [Resident 1], his/her [Guardian C], and staff at the facility." Resident 1's March 2026 Task Administration Record identified the following: - Under Positioning: "Resident 1 requires staff assistance with all positioning needs. Staff will assist Resident 1 with repositioning in bed and his/her wheelchair (Time: As Needed)." Surveyor observed staff documented assisting with Resident 1's positioning needs 1 out of 31 days in the task administration record. Resident 1's Observation Notes from 02/05/2026	N 431		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019417	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/23/2026
NAME OF PROVIDER OR SUPPLIER GOOD HOPE II		STREET ADDRESS, CITY, STATE, ZIP CODE 7060 N 124TH ST MILWAUKEE, WI 53224		
(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 431	Continued From page 7 through 04/13/2026 identified the following: - On 03/01/2026 at 10:30 a.m., Caregiver F documented, "[Resident 1] was transfer [sic] to the recline [sic] so that s/he can sit on something much more softer [sic]." - On 03/16/2026 at 9:45 a.m., Caregiver I checked and changed Resident 1 during his/her shift. - On 03/17/2026 at 4:30 a.m., Caregiver G checked and changed Resident 1 during his/her shift. -On 04/04/2026 at 3:00 p.m., Caregiver H documented Resident 1 was in bed, "due to bottom." Daily Irrigation of Suprapubic Catheter Resident 1's ISP, signed on 02/13/2026, identified the following: "Medication Administration/Medication Management. Resident Needs: [Resident 1] has suprapubic catheter that needs to be irrigated daily to prevent clogging. Staff will assist. Frequency: Catheter change. Once every 2 days and as needed. Resident Desired Outcome: [Resident 1] and [guardian C] will like to continue to have catheter irrigated without complications. Method for delivering care/who is responsible: [Resident 1], his/her [guardian C], and staff at the facility." Resident 1's Observation Notes from 02/05/2026 through 04/13/2026 identified the following: -On 02/15/2026 at 8:33 p.m., House Supervisor	N 431		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019417	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/23/2026
NAME OF PROVIDER OR SUPPLIER GOOD HOPE II		STREET ADDRESS, CITY, STATE, ZIP CODE 7060 N 124TH ST MILWAUKEE, WI 53224		
(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 431	Continued From page 8 (HS) E documented, "Catheter change. No pass. Other-Never was trained." - On 03/04/2026 at 7:30 a.m., Former House Supervisor (FHS) B documented, "[Resident 1] being sent out to hospital due to catheter clogged [sic] Guardian C and social worker both was [sic] notified [sic] will monitor resident return." - On 03/14/2026 at 7:00 p.m., Caregiver F documented, "Concerned that [Resident 1] catheter may be blocked." - On 03/17/2026 at 9:45 p.m., HS E documented that Resident 1 went to hospital for a blocked catheter. At 6:00 p.m., guardian C and wound care nurse were attempting to unblock the catheter. Guardian C questioned if facility was flushing Resident 1's catheter. Hospitalizations From 01/25/2026 to 02/09/2026, Resident 1 was hospitalized. Resident 1's after-visit summary (AVS) stated s/he presented with fever, concerning for acute infection of chronic left ischial wound. Resident 1 had stage 4 sacral wounds and dark, granulation tissue. On 1/26/2026, Resident 1 underwent debridement in general surgery. Resident 1 returned home on 02/10/2026. On 02/11/2026, Resident 1 was seen in the Emergency Department for catheter clogging. The AVS, dated 02/11/2026, provided instruction for suprapubic catheter care at home. The document read, "A suprapubic catheter is a soft tube that is used to drain urine from the bladder into a collection bag outside of the body ... the collection bag must be emptied at least once a	N 431		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019417	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/23/2026
NAME OF PROVIDER OR SUPPLIER GOOD HOPE II		STREET ADDRESS, CITY, STATE, ZIP CODE 7060 N 124TH ST MILWAUKEE, WI 53224		
(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 431	Continued From page 9 day and cleaned at least every other day. The collection bag can be put beside your bed at night and attached to your leg during the day." On 03/04/2026, Resident 1 was seen in the Emergency Department for suprapubic catheter disfunction. Additional instructions read, "Today we were able to replace the catheter, and it seems to be functioning, and it is safe to follow up with your Urologist." On 03/12/2026, Resident 1 was seen in the Emergency Department for fecal impaction. The AVS, dated 03/12/2026, stated reason for visit was for abdominal pain. The diagnosis was fecal impaction and abdominal distension. On 03/17/2026, Resident 1 was seen in the Emergency Department suprapubic catheter disfunction. The discharge summary, dated 03/17/2026, stated reason for visit was listed as suprapubic catheter malfunction, and concerns of urinary tract infection (UTI). From 03/21/2026 to 03/26/2026, Resident 1 was hospitalized at Froedtert Hospital. The AVS, dated 03/26/2026, stated reason for visit was for fever. The hospital course stated Resident 1 presented from facility with acute unset high-grade fever 105 degrees Fahrenheit rigors, tachycardia, and apparent discomfort. Resident was positive for influenza B and had a UTI. Interviews On 04/17/2026 at 9:40 a.m., Surveyor interviewed HS E, who stated Resident 1 was out at the hospital from 01/25/2026 to 02/09/2026. Resident 1 had surgery on his/her wound. When Resident 1 left, his/her wound was the size of a quarter.	N 431		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019417	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/23/2026
NAME OF PROVIDER OR SUPPLIER GOOD HOPE II		STREET ADDRESS, CITY, STATE, ZIP CODE 7060 N 124TH ST MILWAUKEE, WI 53224		
(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 431	Continued From page 10 HM E stated when Resident 1 came home from his/her hospitalization, his/her wound was the size of a dollar coin and much larger. HS E stated, "I was the one who taught the caregivers how to redress the wound if it got wet after a shower." On 04/17/2026 at 9:55 a.m., Surveyor interviewed Licensee A, who stated, "I am the one who monitors paperwork and tracks changes for the residents." Licensee A confirmed the catheter care and catheter flushes were completed by the staff. On 04/17/2026 at 11:00 a.m., Surveyor interviewed HS E, who stated scheduled treatments and tracking are in the EMR D. Surveyor requested documentation for tracking Resident 1's tube feeding/consumption monitoring, repositioning in bed/wheelchair and daily irrigation of suprapubic catheter. On 04/17/2026 at 11:05 a.m., HS E stated, "If the documentation is even done. It may be somewhere in EMR D. The caregivers all document somewhere different and it is all inconsistent." Surveyor asked HS E why wound care would be as needed in Resident 1's ISP. HS E agreed that when Resident 1 had a shower, his/her dressing would need to be changed. HS E reviewed Resident 1's ISP and stated, "I don't even see anything about changing the wound dressing after [Resident 1's] shower." On 04/17/2026 at 12:50 p.m., Surveyor interviewed HS E, who stated when s/he started, the manager had the staff watch videos to learn how to administer Resident 1's tube feeding and daily irrigation of his/her suprapubic catheter. A lot of staff told him/her, and they felt uncomfortable	N 431		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019417	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/23/2026
NAME OF PROVIDER OR SUPPLIER GOOD HOPE II		STREET ADDRESS, CITY, STATE, ZIP CODE 7060 N 124TH ST MILWAUKEE, WI 53224		
(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 431	Continued From page 11 with those tasks. On 04/17/2026 at 4:10 p.m., Surveyor interviewed Licensee A, who stated, when Resident 1 returned home from the hospital, the hospital never gave the facility notice, they just sent him/her home, so the facility could never go and reassess Resident 1's needs. Licensee A stated, "That is why we do not have any other assessments for [Resident 1]." Surveyor reviewed Resident 1's ISP with Licensee A and asked what the methods for monitoring were for tube feeding, repositioning and daily irrigation of his/her suprapubic catheter. Licensee A acknowledged that there were not any methods of monitoring in place for Resident 1's tube feeding, repositioning and daily irrigation of his/her suprapubic catheter. On 04/17/2026 at 4:25 p.m., Surveyor interviewed Licensee A, who stated s/he left the monitoring up to his/her managers. Licensee A stated s/he would handle the updates in the computer and former house supervisor (FHS) B would instruct the caregivers on how to monitor and redress the wound. Licensee A stated, "I don't know what to say. S/He is not here any longer."	N 431		