STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 09/06/2023, Surveyors conducted a licensure survey, 2 self-report investigations, and 5 complaint investigations at Hope Stay Memory Care. Data collection continued through 10/06/2023. Three of 5 complaints were substantiated. Nineteen deficiencies were identified. Two of the 18 deficiencies were repeat violations. See SOD 95N711, dated 09/15/2022 and SOD 8WZX12, dated 07/23/2021. Census: 25	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure a written report was submitted to the Department within 3 working days of when law enforcement was called to the facility as a result of an incident that jeopardized the health, safety, or welfare of Resident 2 and employees of the facility.	N 164		

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
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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N 164	Continued From page 1 On 07/27/2023, law enforcement personnel were called to the facility for Resident 2's behaviors and elopement. The findings include: The provider is licensed to care for 26 residents within the client groups of advanced aged, physical disabilities and irreversible dementia/Alzheimer's disease. At approximately 1:15 PM, Surveyor requested the incident reports for Resident 2's elopements. The reports indicated Resident 2 was found outside of the facility, unknown to staff on 09/26/2023. Resident 2 was also found outside of the facility, unknown to staff, on 07/27/2023. This was Resident 2's second elopement from the provider. Law enforcement was called to help find Resident 2. Resident 2 was discharged from the provider on 07/27/2023 due to behaviors and elopement concerns. Surveyor did not locate evidence the provider reported to the Department that law enforcement was called to the provider. At approximately 3:00 PM, Surveyor interviewed Assistant Administrator H. Assistant Administrator H stated s/he did not report to the Department that law enforcement was at the facility on 09/27/2023 due to Resident 2's behaviors and second elopement in 48 hours. Assistant Administrator H stated s/he was not prepared for the behaviors Resident 2 displayed once Resident 2 was admitted to the facility and was not aware Resident 2 was an elopement risk. At approximately 4:45 PM, Surveyor interviewed Director Of Operations (DOO) A. DOO A stated Assistant Administrator H was not fully aware of	N 164		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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N 164	Continued From page 2 the behaviors Resident 2 displayed upon admission to the provider and was not aware that Resident 2 was an elopement risk. DOO A stated the facility staff was not able to handle Resident 2's behaviors and had to call law enforcement to assist with Resident 2's behaviors and elopement concerns.	N 164		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written report was sent to the Department within 3 working days for incidents resulting in injury requiring hospital admission or emergency room (ER) treatment of residents. The provider is licensed to care for 26 residents within the client groups of advanced aged, physical disabilities and irreversible dementia/Alzheimer's disease. Findings include: On 09/06/2023 at approximately 1:10 PM, Surveyors requested Resident 3's incident reports for the past 3 months. Surveyor received multiple incident reports. One unwitnessed fall incident report, dated 08/26/2023, indicated Resident 3	N 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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N 165	Continued From page 3 was sent in to be medically evaluated. The medical notes, dated 08/26/2023, indicated Resident 3 had an unwitnessed fall and hit the back of his/her head on the wall and was diagnosed with a scalp contusion. Resident 3 was prescribed acetaminophen for pain management and to apply cold compresses to his/her head injury. The medical notes indicated Resident 3 was on an anticoagulant medication and staff were to monitor Resident 3 for a severe headache and/or change in status. Surveyor reviewed the Department's facility file and did not find a self-report sent by the provider for the incident on 08/26/2023. On 10/04/2023, Surveyor asked the provider if they reported the above incident to the Department via email. Assistant Administrator (AA) H replied via email on 10/04/2023 and indicated the incident for Resident 3 on 08/26/2023 was not reported to the Department. AA H stated, "We deeply regret not getting that in and are working on a system to get things in on time and on the proper forms...I am unsure how I missed the one on 8-26-2023." On 10/04/2023 at 4:33 PM, the Department received a self-report from AA H for the incident on 08/26/2023. The self-report indicated Resident 3 had an unwitnessed fall in his/her bathroom and hit his/her head while trying to self-transfer. The self-report indicated Resident 3 was diagnosed with a closed head injury and contusion of the scalp. The Individual Service Plan indicated staff were to monitor Resident 3 for 72 hours and do vitals once per shift.	N 165		

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	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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N 214	Continued From page 4	N 214		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure an administrator provided the supervision necessary to ensure residents received proper care and treatment, residents health and safety were protected and promoted and resident rights were respected. Findings include: The facility is licensed as a class CAN (non-ambulatory) facility with a capacity to care for 26 residents. The facility is licensed to serve residents within one the following client groups: advanced aged, irreversible dementia/Alzheimer's disease, and physically disabled. The Department received 5 complaints related to resident care and treatment, elopement and personal cares not conducted as needed. Three of the 5 complaints were substantiated.	N 214		

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	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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N 214	Continued From page 5 Based on information gathered during this survey, Surveyors discovered the following concerns: STAFF TRAINING The provider did not ensure three of 4 staff received all training. Caregiver F and L did not have documented evidence of training in resident rights, challenging behaviors, provision of personal care, and dietary training. Caregiver F and L also did not have department approved training in fire safety and first aid with choking. Caregiver C did not have client group training. SUPERVISION The provider did not provide supervision appropriate to meet resident needs. Resident 2 eloped with whereabouts unknown twice in a 48-hour period. Resident 3 had at least 27 unwitnessed falls since his/her admission on 01/22/2021, with no improvement from interventions. PERSONAL CARE The provider did not ensure Resident 4 received the personal care services needed promptly to maintain good hygiene and to achieve the highest level of functioning possible when on one occasion s/he went hours without having his/her clothes changed after an incontinence episode. On 09/06/2023 at 4:25 PM, Surveyors interviewed Director of Operations (DO) A, Licensee B, and Assistant Administrator (AA) HO. Surveyors discussed survey findings with the group. DO A stated they keep replacing staff with the high turnover and each time there is a learning curve	N 214		

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	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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N 214	Continued From page 6 with the new staff. DO A stated AA HO and Registered Nurse (RN) D were both newer to their roles and run the more day-to-day operations of the facility. The provider did not ensure an administrator provided the supervision necessary to ensure residents received proper care and treatment, residents health and safety were protected and promoted and resident rights were respected. Cross references: 0239 DSS 83.20(2)(a)-(d) Department-Approved Training Courses 0243 DSS 83.21(1)-(3) All Employee Training 0247 DSS 83.22(1)-(4) Task Specific Training 0426 DSS 83.38(1)(B) Supervision 0425 DSS 83.38(1)(a) Personal Care	N 214		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any	N 239		

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	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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N 239	Continued From page 7 employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 employees obtained all department approved training as required. Caregiver F and Caregiver L did not have training in fire safety within 90 days after starting employment. Caregiver F and Caregiver L did not have training in first aid and choking within 90 days after starting employment. This is a repeat deficiency. See Statement of Deficiency (SOD) 8WZX12, dated 07/23/2021. Findings include: The facility is licensed as a class CNA (non-ambulatory) facility with a capacity to care for 26 residents. The facility is licensed to serve residents within one the following client groups: advanced aged, irreversible dementia/Alzheimer's disease, and physically disabled. On 09/06/2023, Surveyor reviewed 4 employee files. Surveyor requested training records from Human Resources (HR) M for Caregiver C, Caregiver F, Caregiver L and Caregiver N.	N 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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N 239	Continued From page 8 Fire Safety The record for Caregiver F, hired on 10/04/2022, did not contain evidence of training or evidence of meeting an exemption for fire safety. On 09/06/2023 at approximately 2:00 PM, Surveyor interviewed HR M. HR M confirmed the provider did not have evidence Caregiver F completed or met an exemption for fire safety training. On 10/05/2023, Surveyor verified Caregiver F was not on the Community-Based Care and Treatment training registry for fire safety. The record for Caregiver L, hired on 09/13/2022, did not contain evidence of training or evidence of meeting an exemption for fire safety. On 09/06/2023 at approximately 2:00 PM, Surveyor interviewed HR M. HR M confirmed the provider did not have evidence Caregiver L completed or met an exemption for fire safety training. On 10/05/2023, Surveyor verified Caregiver L was not on the Community-Based Care and Treatment training registry for fire safety. First Aid and Choking The record for Caregiver F, hired on 10/04/2022, did not contain evidence of training or evidence of meeting an exemption for first aid and choking. On 09/06/2023 at approximately 2:00 PM, Surveyor interviewed HR M. HR M confirmed the provider did not have evidence Caregiver F completed or met an exemption for first aid and choking. On 10/05/2023, Surveyor verified Caregiver F was not on the Community-Based Care and Treatment training registry for first aid and	N 239		

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	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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N 239	Continued From page 9 choking. The record for Caregiver L, hired on 09/13/2022, did not contain evidence of training or evidence of meeting an exemption for first aid and choking. On 09/06/2023 at approximately 2:00 PM, Surveyor interviewed HR M. HR M confirmed the provider did not have evidence Caregiver L completed or met an exemption for first aid and choking. On 10/05/2023, Surveyor verified Caregiver L was not on the Community-Based Care and Treatment training registry for first aid and choking. The provider did not ensure Caregiver F and Caregiver L obtained all department approved training as required for fire safety and first aid/choking.	N 239		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment.	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 243	Continued From page 10 Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 4 employees reviewed, obtained all training as required within 90 days after starting employment. Caregiver F and Caregiver L did not have training in resident rights within 90 days after starting employment. Caregiver F and Caregiver L did not have training in recognizing, preventing, managing and	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 243	Continued From page 11	N 243		

responding to challenging behaviors within 90 days after starting employment.

Caregiver C, Caregiver F and Caregiver L did not have training in required client groups within 90 days after starting employment.

Findings include:

The facility is licensed as a class CNA (non-ambulatory) facility with a capacity to care for 26 residents. The facility is licensed to serve residents within one the following client groups: advanced aged, irreversible dementia/Alzheimer's disease, and physically disabled.

On 09/06/2023, Surveyor conducted a review of 4 employees to verify compliance with all employee training requirements. Surveyor requested training records from Human Resources (HR) M for Caregiver C, Caregiver F, Caregiver L and Caregiver N.

Resident Rights

The record for Caregiver F, hired 10/04/2022, did not contain evidence of training or evidence of meeting an exemption for resident rights.

The record for Caregiver L, hired on 09/13/22, did not contain evidence of training or evidence of meeting an exemption for resident rights.

On 09/06/2023, at approximately 2:00 PM, Surveyor interviewed HR M. HR M confirmed the provider did not have evidence Caregiver F and Caregiver L completed or met an exemption for resident rights training.

Recognizing, Preventing, Managing and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 243	Continued From page 12 Responding to Challenging Behaviors The record for Caregiver F, hired 10/04/2022, did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. The record for Caregiver L, hired 09/13/2022, did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. On 09/06/2023, at approximately insert time 2:00 PM, Surveyor interviewed HR M. HR M confirmed the provider did not have evidence Caregiver F and Caregiver L completed or met an exemption for challenging behaviors training. Client Group The record for Caregiver C, hired 11/11/2021, did not contain evidence of training or evidence of meeting an exemption for client group training. The record for Caregiver F, hired 10/04/2022, did not contain evidence of training or evidence of meeting an exemption for client group training. The record for Caregiver L, hired 09/13/2022, did not contain evidence of training or evidence of meeting an exemption for client group training. On 09/06/2023, at approximately 2:00 PM, Surveyor interviewed HR M. HR M confirmed the provider did not have evidence Caregiver C, Caregiver F, and Caregiver L completed or met an exemption for client group training.	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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N 247	Continued From page 13	N 247		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation.	N 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 247	Continued From page 14	N 247		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 employees obtained all task specific training.

Caregiver F and Caregiver L, who had responsibilities for providing assistance with activities of daily living, did not have training in the provision of personal care prior to assuming these duties.

Caregiver F and Caregiver L, who perform dietary duties, did not have training in dietary services within 90 days after assuming these job duties.

Findings include:

This provider is licensed as a class CNA (non-ambulatory) facility with a capacity to care for 26 residents. The facility is licensed to serve residents within one of the following client groups: advanced aged, irreversible dementia/Alzheimer's disease, and physically disabled.

On 09/06/2023, Surveyor conducted a review of 4 employees to verify compliance with task specific training requirements. Surveyor requested training records from Human Resources (HR) M for Caregiver C, Caregiver F, Caregiver L and Caregiver N.

Provision of Personal Care

The record for Caregiver F, hired on 10/04/2022, did not contain evidence of training or evidence of meeting an exemption for personal care training.
On 09/06/2023 at approximately 2:00 PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 247	Continued From page 15 Surveyor interviewed HR M. HR M confirmed Caregiver F is responsible for providing personal cares. HR M confirmed the provider did not have evidence Caregiver F completed or met an exemption for provision of personal care training prior to assuming these job duties. The record for Caregiver L, hired on 09/13/2022, did not contain evidence of training or evidence of meeting an exemption for personal care training. On 09/06/2023 at approximately 2:00 PM, Surveyor interviewed HR M. HR M confirmed Caregiver L was responsible for providing personal cares. HR M confirmed the provider did not have evidence Caregiver L completed or met an exemption for provision of personal care training prior to assuming these job duties. Dietary Training The record for Caregiver F, hired on 10/04/2022, did not contain evidence of training or evidence of meeting an exemption for dietary training. On 09/06/2023, at approximately 2:00 PM, Surveyor interviewed HR M. HR M confirmed Caregiver F had performed dietary tasks. HR M confirmed the provider did not have evidence Caregiver F completed or met an exemption for dietary training within 90 days after assuming these job duties. The record for Caregiver L, hired on 09/13/2022, did not contain evidence of training or evidence of meeting an exemption for dietary training. On 09/06/2023 at approximately 2:00 PM, Surveyor interviewed HR M. HR M confirmed Caregiver L had performed dietary tasks. HR M confirmed the provider did not have evidence Caregiver F completed or met an exemption for dietary training within 90 days after assuming these job	N 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 247	Continued From page 16 duties.	N 247		
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 record review and interview, the provider did not ensure Resident 4 received his/her prescribed medications as ordered. This is a repeat deficiency. See Statement of Deficiency (SOD) 95N711, dated 09/15/2022. Findings include: On 08/30/2023, the department received a complaint alleging residents were missing doses of medication. The provider is licensed to care for 26 residents within the client groups of advanced aged, physical disabilities and irreversible dementia/Alzheimer's disease. On 09/06/2023 at 2:45 PM, Surveyor interviewed Resident 4. Resident 4 stated s/he had to switch pharmacies upon admission to the facility and did not like the pharmacy the provider wanted him/her to use. Resident 4 stated the pharmacy was sometimes late delivering medications and s/he had missed doses of medications.	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 17 Resident 4 was admitted to the provider on 01/06/2023 with the following diagnoses: adjustment disorder with mixed disturbance of emotions and conduct; type 2 diabetes; chronic atrial fibrillation; heart failure; hemiplegia and hemiparesis following unspecified cerebral vascular disease; chronic kidney disease stage 3; transient ischemic attack; cerebral infarction; and bilateral below the knee amputation. Resident 4 was his/her own decision-maker. Resident 1's individual service plan (ISP), dated 03/30/2023, indicated Resident 4 had the provider manage and administer his/her medications. The ISP indicated Resident 4 received both short and long-acting insulin to manage his/her type 2 diabetes. Surveyors came upon a staff corrective action, dated 03/31/2023, during employee record review. The corrective action stated, "[Resident 4] was running low on insulin that is only given on second shift. [Caregiver C] did not reorder the medication and this resulted in [Resident 4] not receiving insulin for two days and having high blood sugar in the 300 and 400 range. This also resulted in family member coming in and [managed care organization (MCO)] nurse being notified. We may be cited and fined from state down the road." The corrective action indicated the effect of the incident was Resident 4 had high blood sugars for two days, Resident 4's family member did not trust the provider and took over reordering medications for Resident 4, and "the state" would potentially be involved and cite for the infraction. The corrective action stated Caregiver C's comments were, "Told 3rd shift to fax on 03/25/2023 and they should have given to 1st. [S/he] thought it was on cycle fill to reorder."	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 18 Resident 4's medication administration record (MAR) for March 2023 indicated Resident 4 did not receive Levemir 12 units subcutaneous injection every evening at 8:00 PM on 03/26/2023 and 03/27/2023. The MAR indicated the reason Levemir was not given on those two dates was the medication had been reordered. The June 2023 MAR indicated that on 06/102023, Resident 4 only received 10 units of Levemir insulin. The staff note indicated that was the amount of insulin left in the injection and there were no refills in the facility. The staff note indicated an emergency refill from the pharmacy was requested. Resident 4 did not receive Levemir insulin on 06/11/2023 and 06/12/2023 due to the pharmacy not delivering it until 06/13/2023. The July 2023 MAR indicated Resident 4 did not receive Eliquis 5 milligram (mg) tablet, Metoprolol Tartrate 100 mg tablet, Topiramate 50 mg tablet, and Potassium Chloride 20 milliequivalents (meq) on 07/27/2023 due to medication arriving late from the pharmacy. On 07/25/2023, Levemir insulin was not charted as given by staff on the MAR and there was no staff note about the missed dose. The August 2023 MAR indicated Resident 4 did not receive his/her weekly Trulicity injection 4.5/0.5 on 08/04/2023 due to the pharmacy not delivering the medication yet. The MAR indicated Resident 4 did not receive a Potassium Chloride tablet on 08/19/2023 and 08/21/2023 due to the medication not being available in the facility. Staff observation notes from 03/23/2023 through 09/12/2023 indicated the following:	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 19 03/27/2023 at 8:00 PM - Staff called pharmacy and was told the medication needed a new order from the physician. A message was left at the physician's office. 06/11/2023 at 8:29 PM - Levemir insulin injection not administered due to waiting for arrival from pharmacy. 07/27/2023 at 11:47 AM - Metoprolol Tartrate, Potassium Chloride, Topiramate, and Eliquis arrived late from the pharmacy. The medication administration policy and procedure, read in part, "The Administrator or designee will coordinate with the pharmacy to send refills in a timely manner." On 09/06/2023 at 4:25 PM, Surveyors interviewed Director Of Operations (DOO) A and Licensee B. DOO A stated they had issues with switching to their pharmacy getting the medications for Resident 4 when first admitted. DOO A stated Family Member (FM) K went back to Resident 4's previous pharmacy to pick up medication, which created more confusion. Licensee B stated there were issues with Resident 4's insulin, diabetic supplies, and potassium chloride related to the hospital order. Licensee B stated they used their house supply of medication and glucometer until the issue was resolved. DOO A stated that since they had changed to their current pharmacy, there were no issues with Resident 4's medications. On 09/12/2023 at 2:45 PM, Surveyor interviewed Registered Nurse (RN) D. RN D stated s/he started about 3 months ago in his/her role. RN D stated s/he was still learning the electronic medication charting system. RN D stated medications come from the pharmacy and the	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 20	N 352		

pharmacy puts the orders in the electronic system. RN D stated staff can accept the medications upon arrival and make edits in the electronic system. RN D stated there had been issues with Resident 4's diabetic supplies and which pharmacy would cover them. RN D stated that for Resident 4's Trulicity injection, staff were to take the tag off the medication when close to the last injection and fax to the pharmacy. RN D stated sometimes their pharmacy did not have the medication available and/or delivered it a day late. RN D stated staff thought Resident 4's Potassium Chloride had not been delivered by the pharmacy but it had slipped underneath in the cart and was found later. RN D stated they were currently working on their medication systems and currently had "too many hands in the medication cart."

On 10/04/2023 at 10:13 AM, Surveyor interviewed Family Member (FM) K. FM K stated Resident 4 would run out a lot of medications since his/her admission on 01/06/2023. FM K stated that recently, Resident 4 was hospitalized due to missing his/her Potassium Chloride. FM K stated Resident 4 had also been out of insulin twice and diabetic supplies.

On 10/04/2024 at 10:51 AM, Surveyor interviewed Case Manager (CM) O. CM O confirmed Resident 4 on multiple occasions did not have many of his/her medications. CM O stated the provider had to give Resident 4 their house supply of Potassium Chloride and Vitamin D. CM O stated that on one occasion, the provider did not have Resident 4's insulin available and had to give another resident's insulin to him/her.

The provider did not ensure Resident 4 received

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 21 his/her prescribed medications as ordered. Resident 4 did not receive his/her insulin on 03/26/2023, 06/11/2023, 06/12/2023, and 07/25/2023. Resident 4 did not receive his/her full dose of insulin on 06/10/2023. Resident 4 did not receive his/her Eliquis, Metoprolol Tartrate, Topiramate, and Potassium Chloride on 07/27/2023. Resident 4 also did not receive Potassium Chloride on 08/19/2023 and 08/21/2023. Resident 4 did not receive his/her weekly Trulicity injection on 08/04/2023.	N 352		
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 2 of 6 residents were reassessed by a pharmacist, practitioner, or registered nurse as needed, but at least quarterly, for the desired response and possible side effects of scheduled psychotropic medications. Findings include:	N 407		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 407	Continued From page 22 The provider is licensed to care for 26 residents within the client groups of advanced aged, physical disabilities and irreversible dementia/Alzheimer's disease. On 09/06/2023, Surveyors requested scheduled psychotropic medication reviews for Resident 3 and Resident 4. Surveyors did not receive documentation before leaving the facility. On 09/12/2023 at 1:00 PM, Surveyors again requested scheduled psychotropic medication reviews for Resident 3 and Resident 4 via email. On 09/13/2023 at 5:13 PM, Surveyors received an undated typed document titled, "Psychotropic Medication for [Resident 3]." The document indicated Resident 3 was on 5 different scheduled psychotropic medications. Resident 3 Resident 3 was admitted on 1/22/2021 with diagnoses that included vascular dementia with behavioral disturbance, unspecified psychosis, major depressive disorder, panic disorder, generalized anxiety disorder, adjustment disorder, psychophysiologic insomnia, and personality disorder. Resident 3 had a healthcare power of attorney (HCPOA) that made decisions on his/her behalf. Resident 3's medication administration record (MAR) indicated Resident 3 was currently taking the following scheduled psychotropic medications: - Buspirone 20 milligrams (mg) tablet three times per day for anxiety. - Diazepam 2 mg tablet given once daily for anxiety.	N 407		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 407	Continued From page 23	N 407		

- Mirtazapine 45 mg tablet given once daily for unknown indication.
- Olanzapine 5 mg tablet given once daily for hallucinations.
- Venlafaxine 300 mg extended-release capsule given once daily for unknown indication.
- Hydroxyzine HCL 50 mg given one tablet twice daily for unknown indication.

Resident 3's record did not contain a scheduled psychotropic medication review.

Resident 4

Resident 4 was admitted to the provider on 01/06/2023 with a diagnosis that included adjustment disorder with mixed disturbance of emotions and conduct.. Resident 4 was his/her own decision-maker.

Resident 4's MAR indicated Resident 4 was currently taking the following scheduled psychotropic medication:
- Duloxetine 30 mg capsule given once daily for unknown indication.

Resident 4's record did not contain a psychotropic medication review.

The Psychotropic Medication Monitoring policy and procedure stated, "The Administrator will have a Registered Pharmacist or Registered Nurse review the medication regimen quarterly and with any change in resident condition...The review and recommendations will be documented in the medical record and communicated to the practitioner."

On 09/12/2023 at 2:45 PM, Surveyor interviewed Registered Nurse (RN) D about the quarterly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 407	Continued From page 24 scheduled psychotropic medication reviews for 2022 and 2023. RN D stated s/he had no knowledge of a pharmacist or physician completing the psychotropic medication reviews. RN D stated s/he had only recently become an employee starting on 6/8/2023 and the provider did not have a full-time nurse prior to this. RN D stated s/he had not reviewed the psychotropic medications for any residents since s/he started and there was no documentation. RN D stated s/he had not been shown or told by the provider what a psychotropic medication review was or how to do one.	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 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.	N 408		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 408	Continued From page 25 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that each resident prescribed a psychotropic medication on an as needed (PRN)basis had, at least monthly, a review to determine if the individual service plan (ISP) had a detailed description of why and when to give the medication. The review is to determine if the drug was given contrary to its intended use and review any negative side effects. This information is to be documented. This was discovered for 1 of 1 sampled residents that were given PRN psychotropic medications. Findings include: The provider is licensed to care for 26 residents within the client groups of advanced aged, physical disabilities and irreversible dementia/Alzheimer's disease. On 09/06/2023 at 9:50 AM, Surveyors conducted a standard survey, self-report investigation and complaint investigation. Surveyor asked to review the records of Resident 3. On 09/06/2023, Surveyors requested PRN psychotropic medication reviews for Resident 3. Surveyors did not receive documentation before leaving the facility at 5:35 PM. On 09/12/2023 at 1:00 PM, Surveyors again requested PRN psychotropic medication reviews for Resident 3 via email. On 09/13/2023 at 5:13 PM, Surveyors received an undated typed document titled, "Psychotropic Medication for [Resident 3]." The document indicated Resident 3 was on 1 PRN psychotropic medication.	N 408		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 408	Continued From page 26 Resident 3 was admitted on 1/22/2021 with diagnoses that included vascular dementia with behavioral disturbance, unspecified psychosis, major depressive disorder, panic disorder, generalized anxiety disorder, adjustment disorder, psychophysiological insomnia, and personality disorder. Resident 3 had a healthcare power of attorney (HCPOA) that made decisions on his/her behalf. The ISP, dated 06/29/2023, indicated Resident 3 received diazepam PRN for visual hallucinations. Resident 3's medication administration record (MAR) indicated Resident 3 was currently taking the following PRN psychotropic medications: -Diazepam 2 milligrams (mg) given one tablet PRN once daily. This medication was given 7 times in August 2023, 12 times in July 2023, and 5 times in June 2023. -Hydroxyzine HCL 25 mg given 1 to 2 tablets every 6 hours as needed. This medication was given 5 times in July 2023. The Psychotropic Medication Monitoring policy and procedure did not include any reference to monthly PRN psychotropic medication reviews. On 09/06/2023 at 12:01 PM, Surveyors interviewed Caregiver F. Surveyors asked Caregiver F how they would determine which PRN medication for anxiety to administer to Resident 3. Caregiver F stated it would depend upon how much anxiety Resident 3 was having. Caregiver F stated s/he would administer the PRN medication with the lowest dose. Caregiver F confirmed that the MAR did not indicate to staff when to give which PRN medication for anxiety.	N 408		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 408	Continued From page 27 On 09/12/2023 at 2:45 PM, Surveyor interviewed Registered Nurse (RN) D about the monthly PRN psychotropic medication reviews for 2022 and 2023. RN D stated s/he was not aware the PRN psychotropic medications needed to be reviewed monthly. RN D stated s/he had no knowledge of a pharmacist or physician completing the PRN psychotropic medication reviews. RN D stated s/he had only recently become an employee, starting on 6/8/2023, and the provider did not have a full-time nurse prior to this. RN D stated s/he had not reviewed the PRN psychotropic medications for any residents since s/he started and there was no documentation. RN D stated s/he had not been shown or told by the provider what a PRN psychotropic medication review was or how to do one. The provider did not monitor at least monthly for the inappropriate use of PRN psychotropic medication for Resident 3.	N 408		
N 425	83.38(1)(a) Personal care. 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: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence.	N 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 425	Continued From page 28	N 425		

This Rule is not met as evidenced by:
Based on interview and record review, the provider did not provide services adequate to meet Resident 4's needs.

Findings include:

The provider is licensed to care for 26 residents in the client groups of advanced aged, physical disabilities and irreversible dementia/Alzheimer's disease.

On 09/06/2023 at 2:45 PM, Surveyor interviewed Resident 4. Resident 4 stated the facility is short staffed, especially on the weekend. Resident 4 stated that within the last 2 weeks, s/he was not helped by staff on the overnight shift to go to the bathroom and by morning was soaked in urine up to his/her shoulders. Resident 4 stated that sometimes s/he must wait a long time for staff to respond to his/her call light. Resident 4 stated the longest s/he had to wait for staff was 45 minutes and s/he was not the only resident with long call light wait times.

Resident 4 was admitted to the provider on 01/06/2023 with diagnoses that included adjustment disorder with mixed disturbance of emotions and conduct, type 2 diabetes, chronic atrial fibrillation, heart failure, hemiplegia and hemiparesis following unspecified cerebral vascular disease, chronic kidney disease stage 3, transient ischemic attack, cerebral infarction and bilateral below the knee amputation. Resident 4 was his/her own decision-maker.

Resident 4's individual service plan (ISP), dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 425	Continued From page 29	N 425		

03/30/2023, indicated the following: Resident 4 needed full assistance getting on and off the toilet with an EZ-stand or bed pan. Resident 4 was sometimes incontinent. Resident 4 needed full assistance of 1 staff for all transfers and was pivoted to and from his/her wheelchair. Resident 4 required hands-on assistance with helping to stand up, using walking devices, and helping to sit and/or lay down. Resident 4 required 2 staff to assist with a gait belt and walker to ambulate. Resident 4 was very unsteady and learning to walk again after bilateral amputation of both legs.

The staff observation notes for August 2023 did not indicate this incident occurred.

The call light log for Resident 4, dated 08/01/2023 through 08/31/2023, indicated the total number of call lights answered by staff was 160. The log indicated the call light elapsed time ranged from 28 minutes to almost 4 hours, which occurred on 08/03/2023.

On 09/06/2023 at 4:25 PM, Surveyors interviewed Director of Operations (DOO) A and Licensee B. DOO A stated they were short staffed and had high staff turnover.

On 09/12/2023 at 2:45 PM, Surveyor interviewed Registered Nurse (RN) D about call light response time. RN D stated that sometimes there just was not enough staff to respond to resident needs.

On 10/04/2023 at 9:35 AM, Surveyor interviewed Case Manager (CM) I about call light response time. CM I stated the call light system at the facility was not always working. CM I stated s/he had tried the call once when visiting a resident and staff never came to assist. CM I stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 425	Continued From page 30	N 425		

batteries to the call lights were constantly going dead and staff did not always replace them right away.

On 10/04/2023 at 10:13 AM, Surveyor interviewed Family Member (FM) K. FM K stated s/he had overheard a resident upset one day due to waiting 45 minutes for staff to help him/her to the bathroom. FM K stated Assistant Administrator (AA) H tried the resident's call light and it was working.

On 10/04/2023 at 10:55 AM, Surveyor interviewed Power of Attorney (POA) J about call light response time. POA J stated the facility had issues with the call light system and staff were not always prompt answering call lights.

On 10/06/2023 at 1:44 PM, Surveyor interviewed Assistant Administrator (AA) H. AA H stated the call light system was a wireless system that connected to cell phones staff carried on them. AA H stated staff also had walkie talkies to communicate with each other. AA H stated s/he tests the system twice weekly. AA H stated the cell phones did not always pick up when call light alarms were going off due to the phone app going out, the screen going black, the phone needing to be refreshed, and/or the phone did not pick up the signal in staff's pockets. AA H stated the call light issue had been documented and brought to management's attention. AA H stated s/he was told the call light system would not be upgraded until the new addition was completed in March 2024. AA H stated there had been plenty of outcomes due to this system failure. AA H stated there had been a lot of complaints from residents' families. AA H stated there was one incident where day shift staff found Resident 4 soaked in his/her bed up to his/her waistline and write-ups

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 425	Continued From page 31 were done on staff involved. AA H stated s/he had implemented 2-hour checks for each resident and staff were to document in the electronic system and go into each resident's room to sign a sheet. AA H stated there had been issues with staff signing off on resident cares but not actually completing them. AA H stated the system was not perfect and s/he was doing the best s/he could with the current system they had. AA H stated that when the facility is at full capacity, it is not feasible for staff to check on residents more frequently and staff would not have time to get other resident cares completed. AA H stated Resident 4's wait time of about 4 hours was the longest s/he was aware of. The provider did not maintain good hygiene for Resident 4 to achieve the highest level of functioning possible when on one occasion s/he went hours without having his/her clothes changed after an incontinence episode.	N 425		
N 426	83.38(1)(b) Supervision. 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: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by:	N 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 426	Continued From page 32	N 426		

Based on record review and interview, the provider did not ensure supervision to meet resident needs. Resident 2 eloped twice in a 48-hour period. Resident 3 had at least 10 unwitnessed falls in the past 3 months.

Findings include:

The provider is licensed to care for 26 residents within the client groups of advanced aged, physical disabilities and irreversible dementia/Alzheimer's disease.

RESIDENT 2

On 09/06/2023 at approximately 12:30 PM, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 07/26/2023 and discharged on 07/27/2023. Resident 2's initial assessment was done virtually. Surveyor did not locate evidence the provider had a waiver to conduct virtual initial assessments. According to Resident 2's record, Resident 2 was combative, struck staff, and eloped from the facility twice in 48 hours. Resident 2's file indicated Resident 2 was placed on 15 minute checks after the first elopement.

At approximately 1:15 PM, Surveyor requested the incident reports regarding Resident 2's elopements. The reports indicated Resident 2 eloped from the provider on 07/26/2023 and 07/27/23. The elopement on 07/27/2023 was after the facility started 15-minute checks on Resident 2. Law enforcement was called to help find Resident 2. Resident 2 was discharged from the facility on 07/27/2023 due to behaviors and elopement concerns.

At approximately 3:00 PM, Surveyor interviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 426	Continued From page 33	N 426		

Assistant Administrator (AA) H. AA H stated s/he did conduct the initial assessment for Resident 2. Surveyor asked where the interview was conducted. AA H stated it was done virtually while Resident 2 was a patient at the hospital. AA H stated Resident 2 slept through the entire assessment and that s/he was not prepared for the behaviors Resident 2 displayed once Resident 2 entered the facility. Surveyor asked AA H if Resident 2 was put on any checks after the first elopement. AA H stated Resident 2 was put on 15-minute checks after the first elopement but somehow managed to exit the facility without staff knowing. Surveyor asked to see documentation the checks were completed. AA H stated there was no documentation regarding the checks being completed and staff were told to keep Resident 2 in line of site.

At approximately 4:45 PM Surveyor interviewed Director Of Operations (DOO) A. DOO A acknowledged Resident 2 was not assessed in person and the assessment was completed by AA H. DOO A stated Resident 2 was sleeping through the entire assessment and AA H was not fully aware of the behaviors Resident 2 displayed upon admission to the facility. Surveyor asked if DOO A had a waiver from the department to conduct an assessment virtually. DOO A said no. DOO A stated that the facility was not staffed to handle Resident 2's behaviors and did not know Resident 2 was an elopement risk.

RESIDENT 3

On 08/30/2023, the department received a self-report indicating Resident 3 had a fall. The report indicated Resident 3 was found by staff sitting on the floor in his/her room. The report indicated Resident 3 was trying to pick a towel up

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 426	Continued From page 34	N 426		

off the floor at the foot of his/her bed when s/he fell. The report indicated Resident 3 did not wait for staff to come help him/her. The report indicated Resident 3's wheelchair was in his/her bathroom and Resident 3 told staff when found that s/he needed to go to the bathroom. The report indicated Resident 3 had hit his/her head. The report indicated Resident 3 had unwitnessed falls on 08/14/2023, 07/28/2023, 06/28/2023, and 06/24/2023.

On 09/06/2023, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the facility on 01/22/2021 with diagnoses that included vascular dementia with behavioral disturbance, unspecified psychosis, major depressive disorder, panic disorder, generalized anxiety disorder, adjustment disorder, psychophysiology insomnia, personality disorder, anemia, chronic pain, bilateral macular degeneration, orthostatic hypertension, spinal stenosis, left knee osteoarthritis, bowel and bladder incontinence, and dizziness. Resident 3 had a healthcare power of attorney (HCPOA) that made decisions on his/her behalf.

Resident 3's individual service plan (ISP), dated 06/29/2023, indicated Resident 3 needed full assistance with toileting. The ISP, for toileting, read, "[Resident 3] wears briefs and is able to toilet [him/herself] using the grab bars to transfer - but really should not. [S/he] is safer with assistance. [S/he] has been increasing the frequency of self toileting [sic]. Staff have been monitoring [him/her] to make sure [s/he] is safe ...When [s/he] uses the call light, time is of the essence. [S/he] needs to get to the bathroom quickly ...[S/he] is to be encouraged to wait for staff to help [him/her] with toilet transfers. [S/he] has had multiple falls in [his/her] prior facility from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 426	Continued From page 35	N 426		

self transfers [sic] resulting in a fractured pelvis and fractured humerus ...[S/he] is up to the bathroom frequently during the night."

The ISP indicated Resident 3 needed 1 staff assistance for ambulation with a walker, gait belt, and wheelchair following behind Resident 3. The ISP read for transferring, "Requires monitoring and cues while transferring. Needs stand by assistance for safe transfers. Resident can transfer [him/herself], but staff really need to monitor and assist with transfers for safety. [S/he] is a fall risk and [s/he] needs to make sure [his/her] wheel chair [sic] brake is on when [s/he] transfers." The ISP indicated Resident 3 was on an anticoagulant medication. The ISP indicated Resident 3 had a right-sided stroke and his/her left side was weaker. The ISP indicated Resident 3 could have dizziness upon rising from sitting. The ISP indicated Resident 3 can have difficulty expressing him/herself due to his/her dementia and s/he needed staff to anticipate his/her needs.

On 09/06/2023 at approximately 1:10 PM, Surveyors requested Resident 3's incident reports and medical notes related to falls in the past 3 months. Surveyor received ten unwitnessed fall incident reports and medical notes for 4 different dates.

The incident report dated 06/12/2023 indicated Resident 3 had an unwitnessed fall at 10:10 PM while trying to self-transfer. It stated Resident 3 should have asked staff for help before self-transferring out of bed.

The incident report dated 06/15/2023 indicated Resident 3 had an unwitnessed fall at 11:12 PM while trying to self-transfer from wheelchair to the toilet. It stated Resident 3 should have asked staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 426	Continued From page 36	N 426		

for help before self-transferring. The incident report indicated Resident 3 had 14 falls prior to this incident in 2022 and 2023.

The incident report dated 06/17/2023 indicated Resident 3 had an unwitnessed fall at 8:00 AM while trying to self-transfer from toilet to wheelchair. It stated Resident 3 had no visible injury but was complaining of pain. The incident report indicated Resident 3 should have asked staff for help before self-transferring.

The incident report dated 06/24/2023 indicated Resident 3 had an unwitnessed fall at 8:50 AM while trying to self-transfer in the bathroom. It stated Resident 3 had hit his/her head against the wall and left a mark on the wall. It stated Resident 3 should have asked staff for help before self-transferring due to feeling unstable. The incident report indicated Resident 3 had 18 falls prior to this incident in 2022 and 2023.

The incident report dated 07/02/2023 indicated Resident 3 had an unwitnessed fall at 5:30 PM while trying to self-transfer in the bathroom. It stated Resident 3 had hit his/her head when s/he fell and s/he had a received a medical evaluation. The incident report indicated Resident 3 should have asked staff for help before self-transferring before staff could respond to his/her call light.

The incident report dated 07/20/2023 indicated Resident 3 had an unwitnessed fall at 7:05 AM while trying to self-transfer. Resident 3 was found by staff on the floor next to his/her bed and unaware s/he had been incontinent. The incident report indicated Resident 3 should have asked staff for help before self-transferring.

The incident report, dated 07/31/2023, indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 426	Continued From page 37	N 426		

Resident 3 had an unwitnessed fall at 5:19 AM while trying to self-transfer in his/her room. It stated Resident 3 should have asked staff for help before self-transferring.

The incident report dated 08/26/2023 indicated Resident 3 had an unwitnessed fall at 9:45 AM while trying to self-transfer in the bathroom. Resident 3 had hit his/her head with no visible injury. The incident report indicated Resident 3 was sent in to be medically evaluated. It stated Resident 3 should try to remember to push the call light and ask for help transferring. The incident report indicated staff would check on Resident 3 more frequently.

The incident report dated 08/30/2023 indicated Resident 3 had an unwitnessed fall at 5:51 PM while trying to pick up a towel off the floor by the foot of his/her bed. Resident 3's wheelchair was in his/her bathroom, and s/he had hit his/her head. The incident report stated Resident 3 should have asked staff for help with his/her needs.

The incident report dated 09/05/2023 indicated Resident 3 had an unwitnessed fall at 6:05 AM while trying to self-transfer in the bathroom. Resident 3's legs gave out on him/her while trying to self-transfer from the wheelchair to the toilet. It stated Resident 3 should have asked staff for help prior to self-transferring. The incident report indicated staff were to remind Resident 3 about using his/her call light and encourage not to transfer without staff assistance.

A medical note dated 06/24/2023 indicated Resident 3 was medically evaluated for a fall and had a CT (computed tomography) scan of his/her head and cervical spine. The medical note

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 426	Continued From page 38	N 426		

indicated Resident 3 had no new orders from this visit.

A medical note dated 07/02/2023 indicated Resident 3 was medically evaluated for a fall which resulted in an abrasion to his/her head. The medical note indicated general wound care was prescribed for the head abrasion.

A medical note dated 08/26/2023 indicated Resident 3 was medically evaluated for a fall which resulted in a scalp contusion. Resident 3 was prescribed acetaminophen for pain management and to apply cold compresses to his/her head injury. The medical note indicated Resident 3 was on an anticoagulant medication and staff were to monitor Resident 3 for a severe headache and/or change in status.

A medical note dated 08/30/2023 indicated Resident 3 was medically evaluated for a fall which resulted in subarachnoid hemorrhage in the right parietal lobe. It was recommended Resident 3 discontinue his/her anticoagulant medication indefinitely and should follow-up with his/her primary care provider regarding risks versus benefits of continuing blood thinners in the future given his/her increasing falls. The medical note indicated staff should continue to monitor Resident 3's neurological status for the next few days.

A fall risk mitigation discussion with the managed care organization (MCO), dated 07/18/2023, indicated Resident 3 had 21 falls in 2022 and 2023. The document indicated the MCO was sporadically receiving fall incident reports from the provider for Resident 3. Resident 3 only used his/her call light 50% of the time and the falls were unwitnessed. The MCO had a concern for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 426	Continued From page 39	N 426		

Resident 3's risk of having a great physical injury. The provider's call light system was not always working 100% of the time and Resident 3 also had a doorbell system to push by his/her bed and in the bathroom. The document read, in part, "[Resident 3] has memory loss & is impatient. [S/he] has been educated on call light system many times. 8/29/22 IDT (interdisciplinary team) funded bed & chair alarm but [Resident 3] would remove alarms, so they were removed. 10/26/22 IDT funded anti slip strips to put by [his/her] bed & toilet to prevent slipping, [Resident 3] did not like them & they were removed by staff. [The provider] currently states that staff will respond 'immediately' to call light, they will ask [him/her] to wait until they come back. [Resident 3] will just try to self-transfer [him/herself] & falls. [Resident 3] states that they do not come back & check on [him/her]. IDT has been at [the facility] several times & pushed call light & did not have staff report to us immediately or at all. Family has same [Provider] & alarm system. [Provider] states that they believe [Resident 3] has cognitive capacity to wait if needed." The document addressed options to minimize the potential harm from the falls and indicated Assistant Administrator (AA) H stated s/he wanted to try bed and chair alarms and staff were to respond immediately to Resident 3's call light and would ask him/her to wait. The document indicated Resident 3 had tried alarms in the past at his/her previous facility but Resident 3 would remove them. Resident 3 did not routinely wait for staff to respond to his/her call light. The document stated, "IDT will continue to monitor & discuss fall issues with [Provider] staff every 6 months or before if needed. I do not believe [Resident 3] can wait when asked as evidenced by [his/her] frequent falls, repeated behaviors & cognition. I have asked [Provider] for solutions or what was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 426	Continued From page 40	N 426		

tried & they respond that they keep telling [Resident 3] to wait if [s/he] is told staff cannot assist at that moment. But that is the moment [Resident 3] must get up."

On 09/12/2023 at 2:45 PM, Surveyor interviewed Registered Nurse (RN) D. RN D stated s/he started working at the facility 3 months ago. RN D stated s/he did not understand why Resident 3 was having frequent falls. RN D confirmed Resident 3 would try to self-transfer and most of his/her falls occurred in the bathroom. RN D stated Resident 3 had a cushion on the bathroom wall and laser alarms by the bed and going into bathroom. RN D stated staff were all busy and they could not get into Resident 3's room on time. RN D stated there are times when there are not enough staff at the facility on a shift. RN D stated Resident 3 would almost be considered 1:1 with staff watching him/her but Resident 3 did not get up to the bathroom that often. Surveyor asked RN D how many times Resident 3 had been medically evaluated for a fall. RN D stated about 5 to 6 times, including the last fall on 09/10/2023.

On 10/04/2023 at 9:35 AM, Surveyor interviewed Case Manager (CM) I. CM I stated Resident 3 had a fall on average every 11 days since the beginning of 2023 and had 27 falls in total since admission. CM I stated the provider's only intervention to prevent Resident 3's falls was to tell Resident 3, who had Alzheimer's disease, to use his/her call light. CM I stated the provider's call light system did not always work and staff had told him/her that if the call light system alarms for Resident 3, it was probably an accident. CM I stated staff were mostly only answering Resident 3's doorbell system alarm. CM I stated the provider told him/her it was CM I's job to prevent Resident 3's falls. CM I stated Resident 3 did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

(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 426	Continued From page 41 have safety awareness with transfers. On 10/04/2023 at 9:43 AM, Surveyor interviewed Power of Attorney (POA) J. POA J stated Resident 3 was losing his/her balance and falling at least weekly due to his/her weak legs. POA J stated Resident 3 did not like to be hurried in the bathroom and staff would tell him/her they would "be right back" after helping Resident 3 on the toilet. POA J stated staff would not come back so Resident 3 would grow impatient and/or forget to put his/her call light on and try to self-transfer. POA J stated they had been working with the care team to come up with other interventions and s/he was currently looking into a wireless beam system to alert staff when Resident 3 was moving around on his/her own. Surveyor asked POA J why staff would not just stay with Resident 3 until s/he was done in the bathroom. POA J stated staff did not have time to stay with Resident 3 and sometimes the facility was short staff. The provider did not ensure supervision appropriate to meet resident needs. Resident 2 eloped with whereabouts unknown twice in a 48-hour period. Resident 3 had at least 27 unwitnessed falls since his/her admission on 01/22/2021, with no improvement from interventions.	N 426		
N 435	83.38(1)(k) Transportation. 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:	N 435		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 435	Continued From page 42 Transportation. The CBRF shall provide or arrange for transportation when needed for medical appointments, work, educational or training programs, religious services and for a reasonable number of community activities of interest. CBRFs that transport residents shall develop and implement written policies addressing the safe and secure transportation of residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure transportation was provided or arranged for when needed for medical appointments or for a reasonable number of community activities of interest. Findings include: The provider is licensed to care for 26 residents in the client groups of advanced aged, physical disabilities and irreversible dementia/Alzheimer's disease. On 08/30/2023, the Department received a complaint alleging residents were missing medical appointments due to the provider not providing transportation. On 09/06/2023 at 1:17 PM, Surveyors interviewed Caregiver F. Caregiver F stated that most residents used the licensee-owned transportation company for medical appointments and personal community outings. Caregiver F stated the transportation drivers had been late on multiple occasions and/or had not been scheduled at all over the last several months.	N 435		

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HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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N 435	Continued From page 43 At 2:45 PM, Surveyors interviewed Resident 4. Resident 4 stated s/he had missed multiple medical and personal appointments through the licensee-owned transportation company over the last several months. Resident 4 stated that on 08/14/2023, s/he missed a dental appointment due to transportation not being scheduled. The transportation services policy and procedure stated, "Staff will provide or arrange for resident transportation when needed for medical appointments, work, educational or training programs, religious services, and for a reasonable number of community services." Resident 4 was admitted to the provider on 01/06/2023 with diagnoses that included adjustment disorder with mixed disturbance of emotions and conduct, type 2 diabetes, chronic atrial fibrillation, heart failure, hemiplegia and hemiparesis following unspecified cerebral vascular disease, chronic kidney disease stage 3, transient ischemic attack, cerebral infarction and bilateral below the knee amputation. Resident 4 was his/her own decision-maker. The Individual Service Plan (ISP), dated 03/30/2023, indicated Resident 4 was totally dependent for all transportation needs and was to receive transportation coordination by staff. Resident 4's admission agreement, dated 01/06/2023, and the provider's program statement, indicated the provider offered the services of scheduling appointments and transportation. At 4:25 PM, Surveyors interviewed Director Of Operations (DOO) A and Licensee B. DOO A stated transportation had been a problem with	N 435		

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HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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N 435	Continued From page 44	N 435		

Resident 4. DOO A stated Resident 4 and Family Member G both try to manage Resident 4's appointments. The provider received inconsistent requests for appointments and who was responsible for transportation. DOO A stated they recently changed from all staff helping to manage transportation to assigning one staff member to coordinate transportation.

On 09/12/2023 at 2:45 PM, Surveyors interviewed Registered Nurse (RN) D. RN D stated the transportation coordination process was not clear in terms of who was responsible to coordinate transportation for appointments. RN D stated they were currently trying to implement a more efficient transportation coordination process. RN D stated residents were getting upset when transportation issues caused missed appointments.

On 10/04/2023 at 10:13 AM, Surveyor interviewed Family Member (FM) K. FM K stated Resident 4 had missed at least 5 medical appointments and numerous personal outings since admission in January 2023. FM K stated two appointments were for Resident 4's leg prosthetics, one appointment for his/her CPAP (continuous positive airway pressure) machine, and one appointment for the dentist. FM K stated they had been working for over 1 year to get a dental appointment for Resident 4. FM K stated that due to Resident 4 missing the prosthetic appointments, Resident 4 had a hard time standing and walking since the bilateral leg prosthetics had not been adjusted. FM K stated Resident 4 had also missed numerous "fun" outings since admission. FM K stated Resident 4 just recently missed his/her primary care provider appointment for his/her annual wellness check and lab work-up. FM K stated poor

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	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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N 435	Continued From page 45 communication, staff turnover, and poor staff direction have caused the transportation issues. FM K stated Resident 4 had discharged from the facility on 09/19/2023. On 10/04/2023 at 10:51 AM, Surveyor interviewed Case Manager (CM) O. CM O stated the provider indicated they did not provide transportation as a service to residents, but residents could go through their transportation company. CM O stated s/he had to authorize transportation through the licensee owned transportation company. CM O stated Resident 4 never got to appointments on time and missed at least 2 appointments, if not more. CM O stated Resident 4 was still trying to get in for those previously missed appointments. The provider did not ensure transportation was provided or arranged when needed for medical appointments and for a reasonable number of community activities of interest. Resident 4 missed at least 5 medical appointments and numerous personal outings due to transportation coordination issues.	N 435		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider	N 481		

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	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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N 481	Continued From page 46 did not provide a living environment that was clean and homelike. Findings include: The provider is licensed to care for 26 residents within the client groups of advanced aged, physical disabilities and irreversible dementia/Alzheimer's disease. On 09/06/2023, between 10:00 AM and 10:45 AM, while touring the facility, Surveyor observed the following: 1) Laundry room and public bathrooms had dust covered ceiling vents. 2) Laundry room vent not secured to ceiling. 3) Laundry room sprinkler was covered in dust and lint. 4) Hole in the wall near south side exit door with visible wires. 5) Dining room chairs had visible stains on the upholstery. At approximately 10:35 AM, Surveyor interviewed Housekeeper A. Housekeeper A stated they do have a full-time housekeeper to tend to deep cleaning duties. Housekeeper A reported caregivers assist in areas of basic housekeeping. Housekeeper A stated training could use improvement in this area. At approximately 5:10 PM, Surveyors interviewed Director Of Operations (DOO) A and shared findings observed during the environmental tour. DOO A acknowledged the findings and stated s/he would ensure they were addressed accordingly.	N 481		

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	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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N 499	Continued From page 47	N 499		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure toxic substances were stored securely. Findings include: The provider is licensed to care for 26 residents within the client groups of advanced aged, physical disabilities and irreversible dementia/Alzheimer's disease. On 09/06/2023, between 10:00 AM and 10:45 AM, Surveyor observed the following toxic substances unsecured in the facility. The laundry room door was unlocked with the below substances visibly sitting out on shelves and appliances. Laundry Room -Bleach -Shout laundry stain remover -Raid bug killer -Lysol Dining Area -Raid South Side Hallway -Lysol At approximately 5:00 PM, Surveyor interviewed	N 499		

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	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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N 499	Continued From page 48 Director Of Operations (DOO) A and shared concerns regarding the unlocked laundry room door and the unsecured toxic substances in the laundry room, dining area and hallway. DOO A stated s/he did not know about the unsecured toxic substances and would get the toxic substances secured immediately.	N 499		
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 observation and interview, the provider did not ensure emergency evacuations (other than fire) were conducted in 2022 and 2023. Findings include: The provider is licensed to care for 26 residents within the client groups of advanced aged, physical disabilities and irreversible dementia/Alzheimer's disease. On 09/06/2023 at approximately 11 AM, Surveyor requested other emergency evacuations, such as tornado drills, for 2022 and 2023. Surveyor did receive fire drills but did not receive other emergency evacuation drills. Surveyor made two more attempts to retrieve evidence of other emergency drill records. On 09/12/2023, Surveyor requested additional documentation from the provider. Licensee B acknowledged the request and stated the documents would be provided.	N 526		

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	0018289	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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N 526	Continued From page 49 On 09/15/2023, at approximately 10:00 AM, Licensee B stated the following in an e-mail to Surveyor, "Can you be more specific on this? (other emergency evacuations). I don't know what you are looking for, is it for a specific resident, etc.? Otherwise we haven't [sic] had no [sic]emergency evacuations since we opened the facility." As of 10/04/2023 no records of conducted other emergency evacuation drills were received by the Department.	N 526		
N 531	83.47(4)(a) Fire extinguishers: type and inspection. At least one portable dry chemical fire extinguisher with a minimum 2A, 10-B-C rating shall be provided on each floor of the CBRF. All fire extinguishers shall be maintained in readily usable condition. Inspections of the fire extinguisher shall be done by a qualified professional one year after initial purchase and annually thereafter. Each fire extinguisher shall be provided with a tag documenting the date of inspection. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure an inspection of fire extinguishers was done by a qualified professional one year after initial purchase and annually thereafter. All facility fire extinguishers were dated July of 2022, approximately 30 days past due. Findings include: The facility serves up to 26 residents in the client	N 531		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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N 531	Continued From page 50 groups of advanced aged, physically disabled, irreversible dementia and Alzheimer's disease. On 09/06/2023, between 10:00 AM and 10:45 AM, Surveyor observed fire extinguishers with inspection tags date stamped July 2022. At approximately 5:15 PM, Surveyor interviewed Director Of Operations (DOO) A and shared concerns regarding the extinguisher dates of inspection. Surveyor stated the date on tag was approximately 30 days past due. DOOA stated s/he was aware of the date on the tags. S/he stated the extinguishers would be inspected and re-tagged.	N 531		
N 636	83.59(1)(f) Exit passageways, stairways: width maintained All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Exit passageways and stairways to outside exits shall be at least 36 inches in width and maintained clear and unobstructed at all times. Exit passageways and stairways to outside exits shall be at least 32 inches in width in facilities licensed on or before the effective date of this section. In existing large facilities, the minimum corridor width shall be at least 4 feet. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the facility had 2 exits that provided unobstructed travel to the outside. One of 2 exits was blocked by a recliner and window covering that was adhered to the glass portion of	N 636		

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N 636	Continued From page 51 the door. Findings include: The provider is licensed to care for 26 residents within the client groups of advanced aged, physical disabilities and irreversible dementia/Alzheimer's disease. On 09/06/2023, between 10:00 AM and 10:45 AM, while touring the facility, Surveyor observed the facility's exits. The corridor of the south side emergency exit had a recliner placed in front of it, reducing the pathway for travel to the outside. Residents would need to exit single file to avoid the recliner. Surveyor also observed the exit door was covered with a window covering, presenting as a bookshelf that disguised the outside. Surveyor also observed the hallways leading to the emergency exits were cluttered with a sit-to-stand, wheelchair, organizing bins, desk, and a resident lift device. At approximately 5:00 PM, Surveyor interviewed Director Of Operations (DOO) A. S/he stated the window covering was placed on the door in attempt to trick the residents from attempting to elope. DOO A stated s/he understood the hallways leading to the emergency exits need to be clutter free. DOO A stated s/he planned to have the door window covering removed and the recliner moved.	N 636		
N 650	83.59(4)(b) Delayed egress: locking device sign posted Delayed egress door locks are permitted with department approval only in facilities with a supervised automatic fire sprinkler system and a	N 650		

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N 650	Continued From page 52 supervised interconnected automatic fire detection system and shall comply with all of the following: A sign shall be posted adjacent to the locking device indicating how the door may be opened. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure facility exits with delayed egress door locks included a sign posted adjacent to the locking device indicating how the doors may be opened. Findings include: The provider is licensed to care for 26 residents within the client groups of advanced aged, physical disabilities and irreversible dementia/Alzheimer's disease. On 09/06/2023 at approximately 10:00 AM, Surveyor conducted a tour of the facility, including two exits leading to the outside. Surveyor observed two exits on the west side of the facility with delayed egress door locks. The doors did not have a sign posted adjacent to the locking device indicating how the door may be opened. At approximately 5:00 PM, Surveyor interviewed Director Of Operations (DOO) A. Surveyor shared observations and concerns about the lack of posted signs adjacent to egress doors. DOO A indicated one of the doors had a sign but the writing was small and hard to read. S/he stated the sign was not posted adjacent to the locking device. S/he stated the other door was new and did not have a sign. DOO A acknowledged the need to update signs so that they are visible and	N 650		

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N 650	Continued From page 53 properly posted.	N 650		