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	0018289	A. BUILDING: _____ B. WING _____	R-C 06/04/2024

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 04/24/2024, Surveyors conducted a verification visit and complaint investigation at Hope Stay Memory Care for Statement of Deficiency (SOD) GWCS11 and SOD J0PF11. Data collection continued through 06/04/2024. The complaint was substantiated. Three deficiencies were identified. Three of 3 were repeat deficiencies (see SOD J0PF11, dated 10/06/2023 and SOD 95N711, dated 09/15/2022). Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 24	{N 000}		
{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 record review and interview, the administrator did not supervise the daily	{N 214}		

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

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{N 214}	Continued From page 1	{N 214}		

operations, including: supervision to ensure proper care and services, that the residents' health and safety were protected and promoted, and that residents' rights were respected.

This is a repeat deficiency. See Statement of Deficiency (SOD) J0PF11, dated 10/06/2023.

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 05/02/2024, the department received a complaint related to resident care and treatment and medication administration.

Based on information gathered during this survey, Surveyors discovered the following concerns:

PERSONAL CARE

The provider did not maintain good hygiene for Resident 1 to achieve the highest level of functioning possible when s/he had multiple gaps between showers from February 2024 to April 2024. Resident 1 had 1 incident where it was documented day staff came on shift and found him/her in soiled clothes, with dried stool in his/her groin, and skin breakdown on his/her buttock. There was also documentation in medical notes describing Resident 1 with soiled clothes and hands.

On 05/08/2024, Surveyor reviewed staff progress notes, which indicated the following:

02/26/2024 at 2:45 PM - "Resident went for

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{N 214}	Continued From page 2 catheter change. Foley catheter was changed. Noted that stool was found in vagina, cleaned and new brief placed." On 06/04/2024 at 9:00 AM, Surveyors interviewed Director of Operations (DOO) A, Registered Nurse (RN) B and Licensee C. DOO A indicated there had not been any days where they were short staff. DOO A stated staff were expected to notify RN B and Licensee C with any resident concerns. Licensee C stated the expectation would be for staff to attempt next shift to ask a resident to shower if they had refused during the earlier shift. RN B stated the incident on 02/26/2024 where Resident 1 was found to have stool in the vaginal area at a medical appointment, was common with urinary catheters. RN B conceded the stool should not have been there and Resident 1 should have been cleaned better. RN B stated Resident 1 was always in a seated position which made it hard for staff to keep him/her clean. DOO A and Licensee C did not remember an incident on 02/26/2024 when Resident 1 was found unkempt and did not remember anything about Resident 1's pressure injury on his/her buttock. RIGHTS OF RESIDENTS: RECEIVE MEDICATION The provider did not ensure Resident 1 received his/her prescribed medications when Resident 1's Estradiol Cream and Nystatin Powder were not administered as ordered. Resident 1's Estradiol Cream was scheduled twice weekly, and Nystatin Powder was scheduled twice daily. There was no evidence to demonstrate those medications were administered between December of 2023 and April of 2024.	{N 214}		

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{N 214}	Continued From page 3 DOO A stated the Estradiol Cream was entered into their system as an "as needed" (PRN) medication. DOO A stated the twice weekly order was in Resident 1's discharge paperwork but the pharmacy only indicated it was for 14 days. DOO A stated the provider followed what the pharmacy provided as they do not always obtain the original signed medication order. When asked about the Nystatin Powder, RN B stated the frequent changes made by the doctors made it very easy to be missed as far as how often or how long the medication was to be administered. On 04/24/2024 through 06/04/2024, Surveyor reviewed resident records, employee records and facility documentation. Based on Surveyor's interviews and record reviews, Surveyors substantiated the complaint and identified the following repeat deficiencies: 83.32(3)(h) Rights of Residents: Receive Medication 83.38(1)(a) Personal Care. The provider did not ensure Resident 1 received his/her prescribed medications as ordered and personal cares were done as indicated in the care plan. Cross references: 0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication 0425 DHS 83.38(1)(a) Personal Care	{N 214}		
{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:	{N 352}		

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{N 352}	Continued From page 4 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 1 received his/her prescribed medications as ordered. This is a repeat deficiency. See Statement of Deficiency (SOD) 95N711, dated 09/15/2022 and SOD J0PF11, dated 10/06/2023. Findings include: On 05/02/2024, 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 05/06/2024, Surveyor requested Resident 1's records from the provider via email. On 05/08/2024, Surveyor received an email from Director of Operations (DOO) A with a portion of the records requested. DOO A stated some items were missing because an attachment was too large to send. On 05/09/2024 and 05/10/2024, Surveyor received additional records for Resident 1 via email from DOO A. Resident 1 was admitted to the provider on	{N 352}		

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{N 352}	Continued From page 5 04/05/2023 with the following diagnoses: Pure hypercholesterolemia, Parkinson's disease, restless leg syndrome, dementia with Lewy bodies, chronic pain syndrome, essential hypertension, retention of urine, weakness, history of falling, personal history of transient ischemic attack (TIA), low back pain. Resident 1's individual service plan (ISP), dated 05/06/2024, indicated Resident 1 had the provider manage and administer his/her medications. The "Medication Management - Staff Administer" section did not include instruction on how to administer medication vaginally or who was responsible for doing so. Resident 1 had the following medication orders: -Estradiol Cream 0.01%, insert 1GM into vagina every night at bedtime for 14 days, THEN 1 GM into vagina two times weekly. Haz Meds - Wear Gloves. Start date 07/21/2023. Scheduled at 8:00 PM. -Nystatin Powder 100,000, apply topically twice daily with cares and as needed. Start date 03/29/2023. Scheduled at 8:00 AM and 8:00 PM. The December 2023 Medication Administration Record (MAR) did not have Estradiol Cream or Nystatin Powder listed under scheduled medications. There were no "as needed" medications identified on the December 2023 MAR. The January 2024, February 2024, March 2024, and April 2024 MARs had Estradiol Cream and Nystatin Powder listed under "as needed" medications. The medications were not scheduled as the medication orders indicated. There was no evidence the Estradiol Cream or the Nystatin Powder was signed off or	{N 352}		

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{N 352}	Continued From page 6 administered to Resident 1 between December 2023 and April 2024. Hospital and medical clinic notes, dated between December 2023 and April 2024, contained the following: -A medication list, dated 12/07/2023, indicating Estradiol Cream to be started on 07/21/2023, given for 14 days, then twice weekly. Nystatin Powder was ordered to be applied twice per day to "reddened/yeasty areas during cares." The Estradiol Cream and Nystatin Powder orders appeared on subsequent medical notes dated 01/08/2024, 02/29/2024, 03/25/2024, 04/27/2024, and 05/06/2024. -An office visit progress note, dated 01/08/2024, that read, in part, " ...[s/he] does have quite a bit of irritation in the skin of [his/her] gluteal area. We talked with [Family Member] about using some barrier cream there on a regular basis." -A physicians report form, dated 03/07/2024, stating Resident 1 had an ulcer on his/her left buttock and noted increased skin breakdown. The note encouraged continued use of barrier cream. -An office visit progress note, dated 04/09/2024, that read in part, "Regarding [his/her] estrogen cream, this was prescribed for intervaginal use by Urology on 07/21/2023. This was prescribed to help maintain integrity of the perineal tissues. At the time that this was prescribed, there was comment in the urology note that proper catheter hygiene had not been recently done. Apparently, at the time, the assisted living facility was to do catheter cares 4 times daily, but the facility had not been able to do this. For that reason, a chronic Foley catheter was placed. The estrogen cream had been prescribed to help prevent recurrent urinary tract infection. Talking with [Family Member] today, [s/he] says that the	{N 352}		

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{N 352}	Continued From page 7 Estrace cream is used occasionally. I asked who inserts this into the vagina, and [Family Member] said that [s/he] does sometimes. [S/He] is not aware if anyone else does...On [his/her] med (medication) list, it says estradiol 0.01% vaginal cream that should be used intravaginally 2 times per week. I point that out to family. Healthcare power of attorney had no comment." It was determined through record review, the family member involved in Resident 1's appointments was a paid caregiver and worked for the provider. -A hospital note, dated 04/27/2024, that read, in part, "[Resident 1] was admitted to the hospital with somnolence and decreased oral intake. Medical history pertinent for, TIA (transient ischemic attack), parkinsonism, mild neurocognitive decline with activated POA (power of attorney), urinary retention with chronic indwelling catheter, recurrent urinary tract infection ...Patient was identified as having urinary tract infection and potential cellulitis in [his/her] wrist." On 05/20/2024, at 2:30 PM, Surveyor interviewed a pharmacy representative regarding Resident 1's medications. When asked about Resident 1's Estradiol Cream, the pharmacy representative stated they first received the order for Estradiol Cream in July of 2023. The representative stated the medication was ordered for 1 gram at bedtime for 14 days and then 1 gram twice weekly. The representative stated a new order for Estradiol Cream arrived on 05/17/2024, with twice weekly directions. When asked about the Nystatin Powder, the representative stated there was a prescription dated 03/29/2023, to be applied twice daily topically with cares and as needed. The representative stated the last time they sent that prescription to the provider was July of 2023.	{N 352}		

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{N 352}	Continued From page 8 On 06/04/2024, at 9:00 AM, Surveyor interviewed DOO A, Registered Nurse (RN) B and Licensee C. When asked if the provider was aware the Estradiol Cream was scheduled twice weekly, DOO A stated the Estradiol Cream was scheduled for 14 days and twice weekly thereafter. DOO A stated the twice weekly order was in Resident 1's discharge paperwork but the pharmacy only indicated it was for 14 days. DOO A stated the provider followed what the pharmacy provided as they do not always obtain the original signed medication order. When asked if the provider was aware the Nystatin Powder was scheduled twice daily, RN B stated doctors often do different orders with those types of medications. RN B stated the frequent changes made by the doctors made it very easy to be missed as far as how often or how long the medication was to be administered. When asked if the provider could clarify if the Estradiol Cream or Nystatin Powder was administered to Resident 1 between December of 2023 and April of 2024, Licensee C stated that if the order was identified to be "as needed," there would not be staff initials on the MAR. DOO A stated the Estradiol Cream was entered into their system as an "as needed" medication. The provider did not ensure Resident 1 received his/her prescribed medications as ordered. Resident 1's Estradiol Cream was not included as a scheduled medication on the MAR between December 2023 and April 2024 when it was ordered to be twice weekly. Resident 1's Nystatin Powder was not included as a scheduled medication on the MAR between December 2023 and April 2024 when it was ordered twice daily. There was no evidence to demonstrate either of the medications were administered to Resident 1 between December 2023 and April 2024.	{N 352}		

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{N 352}	Continued From page 9 Cross reference: 0425 DHS 83.38(1)(a) Personal Care	{N 352}		
{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. This Rule is not met as evidenced by: Based on interview and record review, the provider did not provide services adequate to meet Resident 1's needs. This is a repeat deficiency. See Statement of Deficiency (SOD) J0PF11, dated 10/06/2023. Findings include: On 05/02/2024, the department received a complaint alleging residents were not receiving personal cares as indicated in the care plan.	{N 425}		

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

On 04/24/2024 at 10:10 AM, Surveyor interviewed Resident 2. Resident 2 indicated s/he felt the facility was short staffed. Resident 2 stated s/he was to receive 2 showers per week but it would be 1 to 2 weeks between showers.

On 04/24/2024 at 11:50 AM, Surveyor interviewed Resident 3. Resident 3 also indicated s/he felt the facility was short staffed and s/he would have long wait times of up to 30 minutes for staff assistance.

On 04/24/2024 at 11:57 AM, Surveyor interviewed Caregiver D. Caregiver D also indicated s/he felt the facility was short staffed, especially on the weekends. Caregiver D indicated s/he would come in on day shift frequently and find residents soaked in urine but had indicated this was improving. Caregiver D indicated the facility had no hot water for a couple days 2 weeks ago but it had now been fixed.

On 04/24/2024 at approximately 12:00 PM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 04/05/2023. Resident 1 had diagnoses that included Parkinson's disease, dementia with Lewy bodies, history of urinary tract infections, retention of urine, history of transient ischemic attack (TIA), cerebral infarction, and history of falls. Resident 1 had an activated power of attorney for healthcare (POAHC).

An individual service plan (ISP) dated 09/23/2024, indicated Resident 1 needed full

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{N 425}	Continued From page 11 assistance with bathing 3 times per week. An ISP dated 04/05/2023, indicated Resident 1 needed full assistance with bathing 2 times per week. Staff progress notes, dated 02/01/2024 to 05/07/2024, indicated the following: 02/10/2024 at 9:00 PM - "Refused shower ..." 02/13/2024 at 10:00 PM - "Said [s/he] is not feeling well and did not want to shower." 02/16/2024 at 1:30 PM - "Writer gave resident shower." 02/26/2024 at 9:15 AM - "staff went in this morning to find resident in a dirty nightgown that had something crusted all over it, the rest of the nightgown was soaked in a smelly substance, resident also had bottom teeth left in and no cover on [him/her], staff also found old BM (bowel movement) in [his/her] private parts, staff found redness in the groin and bottom and an open sore on [his/her] buttox [sic] cream applied shower sheet filled out and staff assisted in cleaning resident up and getting [his/her] morning cares done ..." 02/26/2024 at 2:45 PM - "Resident went for catheter change. Foley catheter was changed. Noted that stool was found in vagina, cleaned and new brief placed." 03/07/2024 at 11:45 PM - " ...Ulcer to left buttock resolved but increased skin breakdown at gluteal cleft. Encourage continued use of barrier cream and frequent repositioning ..."	{N 425}		

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{N 425}	Continued From page 12 03/07/2024 at 9:17 PM under bathing task - "Staff couldn't shower resident due to maintenance problems." 03/25/2024 at 9:45 AM - "Resident took a shower ...". The skin monitoring form, dated 02/26/2024, indicated staff's initial observation of an open red sore on Resident 1's left buttock and redness in his/her groin. There were no skin monitoring forms for 02/13/2024 and 02/15/2024. The skin monitoring form, dated 03/21/2024, indicated Resident 1 refused to shower. The next dated skin monitoring form was for 04/08/2024. A medical note, dated 01/08/2024, read, in part under the assessment/plan, "I do not see any evidence of ulceration on the buttock, but [s/he] does have quite a bit of irritation in the skin on [his/her] gluteal area." A medical note dated 03/01/2024, indicated Resident 1 had a stage 2 partial thickness pressure injury on his/her left buttock upon admission on 02/29/2024. A medical note, dated 04/09/2024, read, in part under the physical examination, "There is a fair amount of soiling on her clothing ...Hands are somewhat soiled with dark material." Surveyor reviewed the task administration records (TAR) for February 2023 through April 2023. The February 2024 TAR indicated Resident 1 did not receive a shower on 02/24/2024 due to being "short staffed." The March 2024 TAR read on 03/21/2024, "[Resident 1] was very tired and weak [sic] did not want to take shower [sic] we	{N 425}		

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{N 425}	Continued From page 13	{N 425}		

washed up and did catheter care and put on clean clothes." On 03/30/2024, staff noted Resident 1 refused to shower. The April 2024 TAR indicated staff did not chart that a shower was completed for Resident 1 on 04/06/2024. On 04/11/2024, staff noted Resident 1 received a shower "yesterday" on 04/10/2024. On 04/13/2024, staff noted Resident 1 did not receive a shower due to being short staffed.

Surveyor reviewed the care history for bathing, dated 01/01/2024 to 04/30/2024. On 02/15/2024, the care history indicated Resident 1 did not receive a shower. On 03/21/2024, the care history indicated Resident 1 refused a shower.

After reviewing all documentation, Resident 1 had a gap of 7 days between showers, from 02/09/2024 to 02/15/2024. Resident 1 had a gap of 4 days between showers, from 02/23/204 to 02/26/2024. On 02/26/2024, staff made an initial observation of a left buttock open sore. Resident 1 had a gap of 5 days between showers, from 03/20/204 to 03/24/2024. Resident 1 had a gap of 5 days between showers, from 03/28/2024 to 04/01/2024. Resident 1 had a gap of 3 days between showers, from 04/05/2024 to 04/08/2024. Resident 1 had a gap of 6 days between showers, from 04/10/2024 to 04/15/2024.

On 06/04/2024 at 9:00 AM, Surveyors interviewed Director of Operations (DOO) A, Registered Nurse (RN) B and Licensee C. DOO A indicated there had not been any days where they were short staffed. DOO A stated staff were expected to notify RN B and Licensee C with any resident concerns. Licensee C stated the expectation would be for staff to attempt in the next shift to ask a resident to shower if they refused during

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 _____	R-C 06/04/2024

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 14 the previous shift. RN B stated that the incident on 02/26/2024, with Resident 1 having stool in the vaginal area, was common with urinary catheters. RN B conceded the stool should not have been there and Resident 1 should have been cleaned better. RN B stated Resident 1 was always in a seated position which made it hard for staff to keep him/her clean. DOO A and Licensee C did not remember an incident on 02/26/2024 when Resident 1 was found unkempt and did not remember anything about Resident 1's pressure injury on his/her buttock. The provider did not maintain good hygiene for Resident 1 to achieve the highest level of functioning possible when s/he had multiple gaps between showers from February 2024 to April 2024. Resident 1 had 1 incident where it was documentated day staff came on shift and found him/her in soiled clothes, with dried stool in his/her groin, and skin breakdown on his/her buttock. There was also documentation in medical notes decribing Resident 1 with soiled clothes and hands. Cross references: 0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication	{N 425}		