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 02/04/2026

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 01/07/2026, Surveyors conducted a standard survey, verification visit, and 5 complaint investigations at Hope Stay Memory Care. Data collection continued through 02/04/2026. Two of 5 complaints were substantiated. Ten deficiencies were identified. Five deficiencies were repeat violations. See Statement of Deficiency (SOD) 8WZX12, dated 07/23/2021, SOD H7LH11, dated 04/07/2022, and SOD J0PF11, dated 10/06/2023. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 48	{N 000}		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12.	N 219		

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
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HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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N 219	Continued From page 1	N 219		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not complete a caregiver background check (CBC) for 1 of 5 staff sampled (Caregiver D).

This is a repeat deficiency. See Statement of Deficiency (SOD) 8WZX12, dated 07/23/2021.

Findings include:

On 01/07/2026, Surveyor reviewed employee records. A complete CBC consists of 3 components:

1. A background disclosure (BID) filled out by the employee,
2. A criminal history record search from the Department of Justice (DOJ),
3. The Governmental Findings Report (GRF) letter to alert the employers to findings, restrictions and licenses from the Department of Health Services (DHS).

Caregiver D was hired on 08/31/2023 and rehired on 06/02/2025. Caregiver D's most recent BID form was dated 06/05/2025. The DOJ report was dated 01/15/2026, after our onsite visit, and records request. Caregiver D's file did not contain a GFR letter.

On 02/04/2026, at approximately 10:45 AM, Surveyors interviewed Director of Operations (DOO) A and Administrator B via Microsoft Teams meeting. When asked about background checks, DOO A stated Administrator B and Administrator Assistant (AA) C typically conducted them. Administrator B stated s/he did not recall if s/he did one for Caregiver D and if they did not run one upon Caregiver D's hire, it must have gotten

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	0018289	A. BUILDING: _____ B. WING _____	R-C 02/04/2026

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HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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N 219	Continued From page 2 missed.	N 219		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 5 employees reviewed had obtained documentation from a physician, physician assistant, clinical nurse practitioner, or a licensed registered nurse, indicating they had been screened within 90 days before the start of employment for clinically apparent communicable disease, including tuberculosis (TB). Findings include: On 01/07/2026, Surveyor conducted a review of 5 employee records. Surveyor requested communicable disease screenings and TB tests from Administrator Assistant (AA) C.	N 220		

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HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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N 220	Continued From page 3 Caregiver D was hired on 06/02/2025. Caregiver D's record did not contain evidence from a physician, physician assistant, clinical nurse practitioner, or a licensed registered nurse, indicating s/he had been screened within 90 days before the start of employment for clinically apparent communicable disease. Caregiver F was hired on 12/22/2025. Caregiver F's record did not contain evidence from a physician, physician assistant, clinical nurse practitioner, or a licensed registered nurse, indicating s/he had been screened within 90 days before the start of employment for clinically apparent communicable disease. Caregiver G was hired on 07/03/2023. Caregiver G's record did not contain evidence from a physician, physician assistant, clinical nurse practitioner, or a licensed registered nurse, indicating s/he had been screened within 90 days before the start of employment for clinically apparent communicable disease. On 01/07/2026 at approximately 3:00 PM, Surveyor interviewed Caregiver F and Caregiver G and asked if they had received a TB test and communicable disease screen 90 days prior to employment. Caregiver F and Caregiver G both stated they did not receive a TB test and were not screened for communicable diseases upon employment and asked Surveyor if it was required.	N 220		
{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	{N 239}		

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HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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{N 239}	Continued From page 4 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 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 3 of 5 employees obtained all department approved training as required. Administrator Assistant (AA) C did not have training in first aid and choking and fire safety within 90 days after starting employment. Caregiver G did not have training in first aid and choking within 90 days after starting employment. Registered Nurse (RN) F did not have training in fire safety within 90 days after starting	{N 239}		

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	0018289	A. BUILDING: _____ B. WING _____	R-C 02/04/2026

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 5 employment. This is a repeat deficiency. See Statement of Deficiency (SOD) 8WZX12, dated 07/23/2021, SOD J0PF11, dated 10/06/2023, and SOD J0PF14, dated 05/07/2025. Findings include: The facility is licensed as a class CNA (non-ambulatory) facility with a capacity to care for 55 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 01/07/2026, Surveyor reviewed 5 employee files. Fire Safety The record for AA C, hired on 09/30/2024, showed AA C completed Fire Safety training on 06/12/2025, approximately 9 months after hire according to the Community-Based Care and Treatment training registry for fire safety. The record for RN F, hired on 10/13/2025, did not contain evidence of training or evidence of meeting an exemption for fire safety. On 01/27/2026, Surveyors interviewed Director of Operations (DOO) A and Administrator B via phone. DOO A stated they did not do any Community Based Residential Facility (CBRF) training for the nurses. DOO A stated it was his/her understand the nurse was exempt from those. First Aid and Choking	{N 239}		

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HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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{N 239}	Continued From page 6 The record for AA C, hired on 09/30/2024, showed AA C completed First Aid and Choking training on 07/29/2025, approximately 10 months after hire according to the Community-Based Care and Treatment training registry for fire safety. The record for Caregiver G, hired on 07/03/2023, did not contain evidence of training or evidence of meeting an exemption for first aid and choking. On 01/28/2026, Surveyor verified Caregiver G was not on the Community-Based Care and Treatment training registry for first aid and choking. The provider did not ensure 3 employees obtained all department approved training as required.	{N 239}		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid.	N 277		

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HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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N 277	Continued From page 7 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 staff sampled, completed at least 15 hours of continuing education requirements in 2024 and 2025. Findings include: The provider is licensed to care for 55 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, and physically disabled. On 01/07/2026, Surveyors obtained an employee roster indicating Caregiver E was hired on 11/06/2023 and Caregiver H was hired on 07/31/2023. On 01/08/2026, Surveyor requested records for Caregiver E and Caregiver H via email from Director of Operations (DOO) A and Administrator B. On 01/13/2026, Surveyors made a second request via email for the employee records. On 01/15/2026, Surveyors received an email from Administrator B that read, in part, "As far as [Caregiver E] and [Caregiver H's] files, I couldn't find [Caregiver H]. I think it must got [sic] misfiled somewhere in [DOO A's] office. I will continue to look for it. I have no continuing education for [Caregiver E.]"	N 277		
{N 386}	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the	{N 386}		

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	0018289	A. BUILDING: _____ B. WING _____	R-C 02/04/2026

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HOPE STAY MEMORY CARE	3908 CIRCLE DRIVE HOLMEN, WI 54636

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{N 386}	Continued From page 8 assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 had a comprehensive individualized service plan (ISP) that identified Resident 1's needs and desired outcomes related to his/her communication methods. Resident 1's primary language was Hmong. The ISP did not include clear directions for non-Hmong speaking staff regarding effective communication methods. This is a repeat deficiency. See Statement of Deficiency (SOD) J0PF14, dated 05/07/2025 and SOD H7LH11, dated 04/07/2022. Findings include: On 11/25/2025, the department received a complaint regarding resident care and treatment. On 01/07/2026, at approximately 10:00 AM, Surveyors interviewed Administrator Assistant (AA) C. AA C stated Resident 1 had been	{N 386}		

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 386}	Continued From page 9	{N 386}		

discharged recently after his/her family requested Resident 1 be sent to the hospital for evaluation. Resident 1 passed away in the hospital a few days later. AA C stated Resident 1's primary language was Hmong and staff had access to flash cards to use with Resident 1. AA C stated Resident 1 was good at expressing his/her feelings in the Hmong language.

At approximately 12:30 PM, Surveyors interviewed Registered Nurse (RN) F. RN F stated s/he had minimal interaction with Resident 1 and there had been a language barrier. RN F stated Resident 1 was very paranoid and would wander in the lobby of the facility. RN F stated s/he was not part of developing Resident 1's care plan.

At 4:03 PM, Director of Operations (DOO) A emailed Surveyors with the company log in information for Surveyors to access the provider's electronic records system.

Resident 1 was admitted on 02/05/2025 with multiple diagnoses including major depressive disorder. Resident 1 had an activated power of attorney for healthcare (POAHC). Resident 1's "14-30 Day Assessment," dated 02/24/2025, identified the following: Under a "Verbal Skills" section, with a subsection titled, "Resident's Needs/Preferences," it read, "Displays effective verbal skills. Can speak and sound out words." Under "Service Provider Responsibilities" it read, "Staff to use sign language for communication. Resident is a [sic] non-English speaking." The "Measurable Goals, Outcomes and Review" section was blank. Under a "Communication" section, with a subsection titled, "Resident's Needs/Preferences," it read, [Resident 1] speaks in Hmong language. Family interprets for

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	0018289	A. BUILDING: _____ B. WING _____	R-C 02/04/2026

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 386}	Continued From page 10 [him/her] or other staff." The "Service Provider Responsibilities" and "Measurable Goals, Outcomes and Review" sections were blank. Resident 1's "Matrix Care Plan," dated 03/05/2025, included a section titled, "Communication Skills." It stated Resident 1 spoke in Hmong and family would interpret for him/her or other staff. Under the "Resident's Desired Goals & Outcomes" section it read, "To effectively communicate needs and wants." The "Frequency of Service and Service Performed," "Service Provider Responsibilities," and "Measurable Goals, Outcomes and Review" sections were all blank. On 01/26/2026, at approximately 4:00 PM, Surveyors interviewed Care Coordinator (CC) I via phone. CC I stated s/he had multiple job responsibilities over the course of his/her employment with the provider and s/he was now in charge of the 30-day assessments and making updates to the resident care plan. When asked if Resident 1 was involved in his/her care plan meetings, CC I stated because of the language barrier, they liked to call Resident 1's family. CC I stated if they had no one available, Resident 1 would not be a part of the meetings. CC I stated family would often come in and sometimes DOO A, Administrator B and AA C would assist as they all speak Hmong. CC I stated if nobody was immediately available they would have a hard time with Resident 1. CC I stated they used to have flash cards but those did not work well. CC I stated Resident 1 would want to talk to someone that understood him/her.	{N 386}		
N 410	83.37(1)(k) Medication error or adverse reaction.	N 410		

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 02/04/2026

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 410	Continued From page 11 Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. This Rule is not met as evidenced by: Based on interview and record review, the provider did not report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after 1 of 1 (Resident 1) residents reviewed refused a medication for 2 consecutive days. Resident 1 refused his/her Insulin medication for 18 consecutive days. The provider did not notify Resident 1's medical provider until 11/25/2025. Findings Include: On 11/25/2025, the department received a complaint regarding resident care and treatment. On 01/07/2026, at approximately 12:30 PM, Surveyors interviewed Registered Nurse (RN) F. RN F stated s/he had minimal interaction with Resident 1 and there had been a language barrier. RN F stated Resident 1 was sent in for	N 410		

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 02/04/2026

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 410	Continued From page 12	N 410		

medical evaluation after Resident 1's power of attorney for healthcare (POAHC) came to visit one weekend. Resident 1 seemed different and had been refusing meals, medications, and insulin. RN F stated Resident 1 passed away in the hospital a few days later. RN F stated if a resident refused medications 2 times in a row, s/he would notify the resident's medical provider via fax. RN F stated s/he kept copies of the faxes in a communication binder. Surveyors requested to review the binder.

At 4:03 PM, Director of Operations (DOO) A emailed Surveyors with the company log-in information for Surveyors to access the provider's electronic records system.

Resident 1 was admitted on 02/05/2025 with multiple diagnoses including Type 2 diabetes mellitus with hyperglycemia. Resident 1 had an order for Lantus Solostar 100 Unit/ML SOL. Inject 18 Units Sub-Q Every Evening plus 2 units to Prime (max daily dose 20 units.) Resident 1's November MAR (Medication Administration Record) indicated Resident 1 refused the medication from 11/04/2025 through 11/21/2025. Resident 1's record did not contain documentation Resident 1's physician, supervising nurse or a pharmacist was notified Resident 1 had refused the medication 18 consecutive days.

Surveyor reviewed a physician communication fax, dated 11/25/2025. The fax was sent to Resident 1's' physician for notification of the following missed medications:

-Lantus 18u (units) QD (once a day) for dates 11/04/2025-11/21/2025
-Gabapentin 100mg BID (twice daily) for dates

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 02/04/2026

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 410	Continued From page 13 11/08/2025-11/22/2025 -Gabapentin 300mg QD for dates 11/09/2025-11/14/2025, 11/16/2025-11/22/2025 -Farxiga 10mg QD for dates 11/09/2025-11/14/2025, 11/16/2025-11/22/2025 -Quetiapine 50mg QD for dates 11/09/2025-11/14/2025, 11/16/2025-11/22/2025 On 02/04/2026, at approximately 10:40 AM, Surveyors interviewed DOO A, Administrator B, and Care Coordinator (CC) I via Microsoft Teams meeting. When asked who was responsible for notifying physicians of a resident's missed or refused medications, DOO A stated the nurse was responsible for alerting medical providers after 2 consecutive medication refusals. Surveyors shared concerns it did not appear Resident 1's medical provider was notified of his/her multiple missed medications until after Resident 1 had left the facility. CC I stated if the notification was not sent earlier it was because the nurse did not do it. DOO A stated the lack of notification fell on the nurse and they would need to tackle that with the nurse.	N 410		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based on record review and interview, the	N 416		

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 02/04/2026

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 416	Continued From page 14	N 416		

provider did not ensure 2 of 2 employees responsible for the administration of injectables were delegated by a registered nurse. Medication administration described under sub. (2)(e) was not delegated to non-licensed employees pursuant to s.N6.03(3).

This is a repeat deficiency. See Statement of Deficiency (SOD) 8WZX12, dated 07/23/2021.

Findings include:

On 01/07/2026, at approximately 12:15 PM, Surveyor interviewed Registered Nurse (RN) F. RN F stated s/he had been employed approximately 3 months and his/her responsibilities included: medications, assessments (pre-admission), coordinating care and equipment/supply requests. Surveyor asked if s/he provided nurse delegation for staff passing medications including injectables, nebulizers, stomal and enteral medications, treatments or preparations. RN F informed Surveyor s/he had delegated appropriate tasks to all staff responsible for passing medications.

On 01/07/2026, at approximately 3:05 PM, Surveyor interviewed Caregiver J and Caregiver K. Caregiver J and Caregiver K confirmed they were both scheduled to pass medications on the date of survey. Surveyor asked Caregiver J and Caregiver K if they were responsible for injectables or other enteral medications. Caregiver J and Caregiver K confirmed they were responsible for injectables such as insulin and blood sugar checks, eye drops and nebulizers. Surveyor asked Caregiver J and Caregiver K if RN F had delegated tasks pursuant to s.N6.03(3). Caregiver J and Caregiver K both stated RN F had not completed delegation per

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 02/04/2026

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 416	Continued From page 15 s.N6.03(3) and they did not receive any training, or demonstration from RN F. Caregiver J stated s/he received minimal training for medications after the facility was made aware s/he had previous experience administering medications. Surveyor reviewed Caregiver J's employee record. Caregiver J had a hire date of 11/03/2025. Surveyor reviewed Caregiver K's employee record. Caregiver K had a hire date of 07/28/2025. On 01/07/2026, at approximately 4:50 PM, Surveyor interviewed RN F and asked if s/he was aware of the standards of practice for registered nurses for delegation tasks. RN F stated s/he was aware and described the delegation process as training, observing and watching return demonstration for competency. When asked by Surveyor to see delegation documentation for Caregiver J and Caregiver K, RN F stated s/he had the delegation forms and pulled a file from the file cabinet in his/her office. The forms were not completed or signed. RN F informed Surveyor the completed forms may be in the training room. When asked to see them, RN F continued to rummage through the file cabinet and did not lead Surveyor to retrieve records from the training room. RN F explained that s/he may have missed some staff if they did not have a delegation form signed by the previous nurse on file. Surveyor asked RN F if s/he was creating delegation sheets based off the previous nurse's delegation. RN F did not answer the question. RN F provided Caregiver J and Caregiver K's delegation sheets, containing their name and hire date with instructions "Nurse to date and initial when delegation is complete." The sheets contained a section "MED PASSERS ONLY"	N 416		

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 02/04/2026

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 416	Continued From page 16 listing nebulizers, injectables and eye drops, however, the items were not initialed by RN F as completed. The delegation sheets did not have an employee signature and date, and were not signed and dated off by RN F. Surveyor informed RN F that it appeared s/he had not completed nurse delegations as s/he described above. RN F stated, "the process needs to be cleaned up and will get better." RN F further stated s/he would review the delegation requirements outlined in N6.03(3). The provider did not ensure staff were delegated tasks by a licensed nurse pursuant to s. N 6.03(3).	N 416		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and	N 431		

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 02/04/2026

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 431	Continued From page 17	N 431		

fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not monitor the health of 2 of 3 residents and/or make arrangements for physical health services when a change of condition occurred.

The provider did not adequately document monitoring and assessments of Resident 2's skin changes in his/her record.

The provider did not notify or communicate changes to Resident 3's physician when Resident 3 had a significant change in condition on 11/23/2025; staff noted a change in physical and mental status, and deviations from normal food and fluid intake patterns.

This is a repeat deficiency. See Statement of Deficiency (SOD) Y23911, dated 06/02/2022 and SOD 8WZX13, dated 11/11/2021.

Findings include:
On 12/14/2025, the Department received a complaint regarding resident care.

RESIDENT 2

01/07/2026, at approximately 10:45 AM, Surveyor interviewed Resident 2. Resident 2 stated s/he was going to be starting wound care treatments

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 02/04/2026

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 431	Continued From page 18	N 431		

for cellulitis on both of his/her legs. Resident 2 stated s/he had previously received wound care services, but those services ended when the previous wounds healed. When asked when s/he expected those services to begin, Resident 2 stated s/he did not know but suggested "tomorrow maybe."

At approximately 12:30 PM, Surveyors interviewed Registered Nurse (RN) F. When asked about Resident 2's statements regarding wound care, RN F stated Resident 2 needed bilateral lower leg wound care and that wound care, "should be getting set up." RN F stated that a couple of weeks ago staff had reported an open area on Resident 2's leg. RN F stated s/he contacted Resident 2's previous wound care agency about restarting wound care services. RN F stated s/he was told they needed a new order for wound care services. RN F stated s/he contacted Resident 2's managed care organization (MCO) and they had to determine if it was covered because they set up the funding. RN F stated s/he did have a new order for wound care but there was MCO pushback, and s/he was waiting to hear back from them. RN F stated Resident 2 did have open areas currently on his/her skin. RN F stated s/he was not sure if Resident 2 was receiving any topical treatments on the wounds. RN F stated s/he did a skin assessment when s/he was first notified by staff and checked on the wounds a couple of times since then. RN F stated those checks should be in staff observation notes.

At 4:03 PM, Director of Operations (DOO) A emailed Surveyors with the company log-in information for Surveyors to access the provider's electronic records system.

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 02/04/2026

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 431	Continued From page 19 Resident 2 was admitted on 02/28/2025 and had multiple diagnoses including bacterial infection, unspecified, hemiplegia, other specified soft tissue disorders and localized edema. Resident 2 had an activated power of attorney for healthcare (POAHC.) A needs assessment dated 12/14/2025, indicated Resident 2 required full assistance with bathing/showering, dressing and toileting. The assessment did not identify any skin issues. Staff observation notes dated 11/28/2025 through 01/08/2026 included the following: -11/28/2025 at 1:30 PM, "This RN was asked to assess resident's bilateral lower legs. Resident's lower legs are edematous- right more than the left. Resident has one pea-sized open are [sic] to [his/her] left lateral leg and multiple blistered areas to bilateral lower legs. Email sent to [MCO] team and guardian regarding wound care for bilateral lower legs and getting a power lift chair for [his/her] room." -12/04/2025 at 8:00 AM, a call was placed to Resident 2's home health agency for wound care. There were no observation notes dated 12/05/2025 - 12/09/2025. -12/10/2025 at 12:45 PM, "Call placed to [Home Health Agency] to see if services are set up for resident. [Home Health Agency] needs a referral sent and have not received one as of yet. Email sent to care team with [MCO] to have them send the referral." There were 3 subsequent observation notes between 12/11/2025 and 01/08/2026. The notes did not reference Resident 2's wound care or status of wounds that resulted in wound care referral request. There was no charting to indicate the wounds were monitored or assessed.	N 431		

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 02/04/2026

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 431	Continued From page 20 On 01/26/2026, at approximately 5:30 PM, Surveyors interviewed Care Coordinator (CC) I via phone. When asked if Resident 2 was receiving wound care, CC I stated Resident 2 had wound care in place. CC I stated, "They told me they can get it restarted anytime." Surveyors asked when Resident 2 was last seen by a wound care agency. CC I stated those dates were usually scheduled on the calendar. CC I could not verify the information and asked 2 additional staff if they knew when Resident 2 last received wound care services. CC I later stated s/he could not find anything to indicate a wound care agency had met with Resident 2 recently. When asked if CC I was aware when Resident 2 last had any wound care service needs, CC I stated s/he would have to check and did not want to misquote but "for the last 3 weeks, for sure nothing." The provider did not provide adequate health monitoring related to changes in Resident 2's skin and document changes in their records. RESIDENT 3 On 01/07/2026 at approximately 9:30 AM, Surveyor interviewed Administrator Assistant (AA) C and asked for a list of residents recently discharged. AA C identified Resident 3 had passed away after s/he was sent out to the hospital. AA C confirmed Resident 3 was not enrolled in hospice and had passed of natural causes. When asked what cares Resident 3 needed, AA C informed Surveyor Resident 3 was initially independent with eating and needed total assistance from staff for toileting. AA C further stated Resident 3 had a diagnosis of dementia. On 01/07/2026 at approximately 10:45 AM,	N 431		

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 02/04/2026

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 431	Continued From page 21	N 431		

Surveyor interviewed Caregiver D and asked about Resident 3's care needs and discharge. Caregiver D stated Resident 3 was "hardly drinking or eating at the end. [S/he] got sent in and passed away at the hospital...Refused care and was picky about what [s/he] ate. [S/he] was taking [his/her] meds okay towards the end though."

On 01/07/2026 at approximately 2:25 PM, Surveyor interviewed Caregiver L about Resident 3's care needs and decline. Caregiver L stated Resident 3 had a sudden decline with falls and had alarms, 30-minute checks and at the end was hallucinating as s/he was at end of life. Caregiver L confirmed Resident 3 was not enrolled in hospice services. Caregiver L stated Resident 3's son/daughter (not APOA) eventually came in on 11/28/2025, was very upset and demanded s/he be sent in based on the condition s/he observed Resident 3 in. Surveyor asked Caregiver L why Resident 3 was not sent out for 5 days after a decline was noted. Caregiver L stated, "I don't know, you'll have to ask management or [RN F]."

At 4:03 PM, Director of Operations (DOO) A emailed Surveyors with the company log-in information for Surveyors to access the provider's electronic records system.

Surveyor reviewed staff charting notes, including the following entries:

-11/23/25 at 3:45 PM: "Staff report progressive decline in resident's condition. Resident is unable to eat independently and requires staff assistance. When provided fluids, resident struggles to drink from a straw. Resident presents as less alert and appears disengaged or "out of

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 02/04/2026

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 431	Continued From page 22	N 431		

it." Continued monitoring and follow-up are recommended."

-11/23/25 at 5:45 PM: "delusional [sic], refusing to eat or get up. POA contacted"

-11/23/25 at 6:45 PM: "Staff entered Room (#) to perform scheduled checks. Resident expressed spiritual beliefs, stating [s/he] is waiting for God because [S/he] is going to take [him/her] home. Staff remained present and continued monitoring resident's condition and emotional state."

-11/23/25 at 8:45 PM: "staff [sic] assisted resident with fluids all throughout the shift, and residents brief remained dry"

-11/24/25 at 9:15 AM: "Staff came to writer in concerns of resident. resident [sic] was not wanting to get out of bed and did not want to eat. Writer got residents [sic] vitals, and they were as follows BP-112/72 P-69 O2-96 T-90.6 R-16. resident sounded very dry when trying to talk. resident was not able to take a sip of water, writer found a mouth sponge and applied water, and resident got some that way, resident asked for cranberry juice. resident seemed to wake up more and writer attempted a straw with resident and resident was able to drink 8 oz of cranberry juice and about 4oz of water. writer will let staff know to keep monitoring resident and offering drinks. writer repositioned resident and got tv turned on."

-11/28/25 at 9:15 AM: "Call placed to PCP office regarding Losartan and missed appointment."

-11/28/25 at 10:00 AM: "Call received from PCP RN Nancy with order to D/C Losartan and would like resident to reschedule appointment that 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 _____	R-C 02/04/2026

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 431	Continued From page 23	N 431		

missed on 11/25/25. Will have receptionist call to get this scheduled."

-11/29/25 at 4:00 AM: "resident [sic] has been restless throughout the night, rca constantly have to check [him/her] every 30 minutes due to the fact that resident is constantly trying to get out of bed. resident need something for [his/her] restless"

-11/29/25 at 9:00 AM: "refused breakfast"

-12/01/25 at 8:15 AM: Call received from [name] at [hospice agency]. [Name] states [s/he] will try contacting family at [hospital name] to follow up with family as resident is currently hospitalized."

On 01/26/2026 at approximately 4:30 PM, Surveyor interviewed Care Coordinator (CC) I via phone and asked what his/her job responsibilities were. CC I stated s/he had been employed for approximately 3 to 4 years and has held many different responsibilities since s/he began employment. CC I stated [his/her] current job was focused on resident and care coordination. CC I provided the following job tasks: ensuring reports are turned in on time, ensuring residents have what they need or locating what they may need, and gathering information. CC I stated s/he did not have a specific job description because s/he has been responsible for several different roles. CC I stated s/he was not responsible for health monitoring and coordinating physician communications, and informed Surveyor Registered Nurse (RN) F was responsible for that.

When asked to describe Resident 3's care needs, CC I stated Resident 3 was losing weight and stopped eating the things s/he liked. CC I

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 02/04/2026

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 431	Continued From page 24	N 431		

described Resident 3's decline as "slow, over time." CC I stated Resident 3 had a history of falls and had a change in condition with mobility and walking between 08/18/2025 and 08/28/2025 and had a change in condition on 05/05/2025 after a fall on 05/03/2025. CC I confirmed Resident 3 had falls on 11/28/2025 (found on floor, unable to communicate), 09/23/2025 (self-transfer to couch), 07/12/2025, 07/04/2025 (slipped off toilet), 05/18/2025 (slipped out of wheelchair), and 04/13/2025 (observed on the floor). Surveyor asked CC I if interventions had been implemented after the fall on 05/03/2025. CC I stated Resident 3 had scheduled toileting every two hours and required full assistance with 2 staff using the walker and gait belt but was unable to determine if it was a new intervention. CC I was confused why the system showed one person was required for the transferring task but then stated assist of two in the general description area of the task. CC I stated "somewhere in between those falls alarms were requested. If I request alarms I may have it in an email." CC I stated s/he was not aware the physician needed to be notified of incidents, and was instructed to notify managed care organization (MCO), power of attorney (POA)/guardians and facility administration within 24 hours.

Surveyor asked CC I if a follow-up appointment had been re-scheduled per the charting note on 11/28/2025 and if any evidence was available for physician notification after Resident 3's significant decline charted on 11/23/2025. CC I did not see any follow-up appointments scheduled for Resident 3 and acknowledged the lack of charting and follow-up between 11/23/2025 and 11/28/2025 when Resident 3 was sent out after his/her fall. CC I was unable to determine why it took five days to send Resident 3 out after it 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 _____	R-C 02/04/2026

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 431	Continued From page 25	N 431		

charted s/he was not eating or drinking and experienced hallucinations.

On 02/04/2026 at 10:30 AM, Surveyor interviewed DOO A, Administrator B, AA C and CC I via phone about Resident 3. CC I stated s/he had spoken to staff as there had been no documentation for 5 days in response to Resident 3's change in condition. CC I stated s/he told staff to document more. CC I further stated staff reported the POA was notified and told staff it was up to Resident 3 whether s/he wanted to go to the hospital or not. Staff reported they felt s/he should've sought medical treatment. CC I acknowledged Resident 3 could not speak or communicate needs.

DOO A stated s/he respects resident rights and POA said "no," so they involved Resident 3's [son/daughter] who said "yes" so they eventually sent Resident 3 in for medical evaluation. DOO A's response did not match CC I response at the time of interview.

Surveyor then asked if an assessment would have been completed for a noted change in condition. CC I stated s/he did not do an assessment if it was not located in the electronic charting system. Surveyor then asked if RN F was responsible for completing and documenting assessments for changes in condition. DOO A stated there was not a specific assessment form, but CC I would update the change on the ISP. The record did not contain an assessment when Resident 3 had a change in condition on 11/23/2025.

Surveyor asked the provider if the physician was consulted after Resident 3 declined, or if a hospice referral was made or discussed with

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 02/04/2026

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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 431	Continued From page 26 Resident 3's family. CC I stated staff may have discussed it verbally as documentation was not available in Resident 3's record.	N 431		
N 504	83.46(1)(c) Heating system maintenance. Heating. The CBRF shall maintain the heating system in a safe and properly functioning condition. The CBRF shall ensure that a heating contractor or local utility company completes all of the following maintenance and makes available to the facility documentation of the maintenance performed: 1. An oil furnace shall be serviced at least once each year. 2. A gas furnace shall be serviced at least once every 3 years. 3. The CBRF shall have a chimney inspected at intervals corresponding with the heating system service under subd. 1. or 2. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a heating contractor or local utility company completed maintenance service on the gas furnace at least every 3 years. Findings include: The provider is licensed to care for 55 residents in the client groups of advanced aged, physically disabled, and irreversible dementia/Alzheimer's disease. On 01/07/2026, Surveyor reviewed the provider's safety binder. Surveyor did not locate a furnace inspection.	N 504		

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 02/04/2026

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N 504	Continued From page 27 On 01/08/2026 and 01/13/2026, Surveyor requested the most recent furnace inspection from Director of Operations (DOA) A and Administrator B via email. On 01/15/2026, Surveyors received an email from Administrator B that read, in part, "Regarding the furnace, I thought we had [Furnace Agency] do our furnace inspections, but when I followed up with them, they stated they did not do our furnace inspections. So I am lose [sic] and don't remember who else would be doing the inspection beside them. I had set up a quarterly furnace inspection with [Furnace Agency] already." On 01/27/2026, at approximately 12:00 PM, Surveyors interviewed DOA A and Administrator B via phone. Surveyor discussed the requirement for gas furnaces to be inspected at least every 3 years. Administrator B stated they reached out to the company that installed the furnaces and would be setting up an inspection. As of 01/28/2026, Surveyors had not received any additional documentation related to the furnace inspections.	N 504		
N 538	83.48(3)(a) Fire detection systems inspected annually. After the first year following installation, fire detection systems shall be inspected, cleaned and tested annually by certified or trained and qualified personnel in accordance with the specifications in NFPA 72 and the manufacturer ' s specifications and procedures. This Rule is not met as evidenced by:	N 538		

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N 538	Continued From page 28 Based on record review and interview, the provider did not ensure the fire detection system (smoke and heat detectors) was tested annually by certified and qualified personnel in accordance with the specifications in NFPA 72 and the manufacture's specifications and procedures. Findings include: The provider is licensed to care for up to 55 residents in the client groups of advanced age, physically disabled, and irreversible dementia/Alzheimer's. On 01/07/2026, at approximately 3:30PM, Surveyor requested the provider's annual smoke and heat detection inspection report from Director of Operations (DOA) A. On 01/08/2026 and 01/13/2026, Surveyors made additional attempts to request the smoke and heat detection inspection reports from DOA A and Administrator B via email. On 01/15/2026, Surveyors received an email from Administrator B with records attached and information within the body of the email. It did not include information related to the request for smoke and heat detection inspection reports. As of 01/28/2026, Surveyors had not received any additional records related to smoke and heat detection inspections. The provider did not ensure the fire detection system (smoke and heat detectors) was tested annually by certified and qualified personnel in accordance with the specifications in NFPA 72 and the manufacture's specifications and procedures.	N 538		

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