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	0018289	A. BUILDING: _____ B. WING _____	C 05/20/2026

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(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 04/28/2026, Surveyors conducted 10 complaint investigations at Hope Stay Memory Care. Data collection continued through 05/12/2026. On 05/15/2026, an additional complaint was received and investigated. Data collection continued through 05/20/2026. Ten of 11 complaints were substantiated. Fifteen deficiencies were identified. Six of the 15 violations were repeat deficiencies. See Statement of Deficiency (SOD) J0PF11, dated 10/06/2023, SOD J0PF12, dated 06/04/2024, SOD J0PF13, dated 08/29/2024, SOD J0PF14, dated 05/07/2025, SOD H7LH11, dated 04/07/2022, SOD Y23911, dated 06/02/2022, SOD 95N711, dated 09/15/2022, and SOD 8WZX13, dated 11/11/2021. Census: 46	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition	N 158		

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

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N 158	Continued From page 1	N 158		

of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not investigate alleged caregiver misconduct and did not take immediate steps to ensure the safety of all residents.

Staff reported concerns related to registered nurse (RN) I and his/her management of resident's morphine. An investigation was not immediately conducted and was dismissed as a non-legitimate concern. RN I was later terminated and reported to law enforcement for medication diversion.

Resident 4 was missing an iPad charger. The provider did not investigate the potential for misappropriation of resident property.

Caregiver C was reported to have screamed at Resident 11 after pushing Resident 11's wheelchair into a wall with Resident 11 seated in the wheelchair.

Findings include:

On 03/17/2026 and 05/15/2026, the department received complaints regarding caregiver misconduct.

Example 1

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N 158	Continued From page 2 On 04/28/2026, at approximately 9:45 AM, Surveyors interviewed Administrator A and Director B. When asked about any recently identified staff misconduct, Administrator A stated RN I "did drug diversions" with medications belonging to hospice residents. Administrator A stated RN I was terminated right away after staff reported concerns to Administrator A. Administrator A stated s/he investigated and identified RN I did not follow proper medication disposal protocols and did not keep an accurate record of morphine disposals. RN I did not ensure 2 staff members were present during medication disposals. At 4:09 PM, Surveyors interviewed Administrator A, Director B, and RN K. When discussing RN I's misconduct, Director B stated Caregiver L knew it was happening but there was no proof and it was not filed right away because they did not catch RN I. Administrator A stated the medication passers were not comfortable with what RN I was doing. At approximately 4:15 PM, Caregiver L joined the discussion with Administrator A, Director B, and RN K. Caregiver L described an incident where s/he observed a bag of morphine syringes with the seals all broken. The syringes had different amounts of liquid in them and appeared to be a different color than what Caregiver L knew as typical for morphine medication. Caregiver L stated s/he first reported concerns to Supervisor M. At approximately 4:20 PM, Administrator Assistant (AA) N joined the discussion with Administrator A, Director B, RN K, and Caregiver L. AA N stated Supervisor M did come to AA N	N 158		

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N 158	Continued From page 3 with the concerns originally reported by Caregiver L. AA N stated s/he discussed the concerns with Care Coordinator (CC) H. AA N stated CC H did not think RN I would do something like that. AA N stated Supervisor M first reported concerns related to RN I's conduct to him/her sometime before the big holidays, between October and November 2025. AA N stated s/he and CC H did not document an investigation because they did not think it was a legitimate concern, and they could not second guess the RN. Director B stated AA N and CC H should have brought the concerns to Administrator A and Director B so they could make a determination on how to handle the allegations. Example 2 On 04/28/2026 at 12:20 p.m., Surveyor observed a note written in black marker hanging on the door outside of Resident 4's room. The note read: "Whomever took [Resident 4's] Ipad charger out of [his/her] bathroom, please return it Thanks" (Photo 2). Surveyor interviewed Resident 4 and his/her spouse, Person X. Person X identified him/herself as Resident 4's power of attorney. Surveyor asked about the note on Resident 4's door. Person X told Surveyor Resident 4's charger had been missing since about Thanksgiving time. Surveyor asked if Administrator A was aware. Person X said, "[S/he] should be aware of it." Person X explained Administrator A did work the floor administering medications and came into Resident 4's room many times. Person X said Administrator A should have seen the note that's been hanging on the door since around Thanksgiving. Surveyor asked if anyone offered to replace the charger. Person X said, "No."	N 158		

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N 158	Continued From page 4 On 04/29/2026, Surveyor emailed Administrator A and Director B to request additional information including: All investigations into caregiver misconduct from 01/01/2026 to current, except the ones they already provided. On 05/04/2026, Administrator A replied, via email, which read, in part: "No other than what I already provided to you." Surveyor did not receive an investigation into Resident 3's and Resident 4's missing chargers. Example 3 Under Wisconsin DQA regulations in Chapter DHS 13, Publication (P-00976, dated 07/2024) titled, "Misconduct Definitions" (https://www.dhs.wisconsin.gov/publications/p00976.pdf), "Neglect" is defined as an intentional omission or intentional course of conduct by a caregiver or a non-client resident, including but not limited to restraint, isolation or confinement, that is contrary to the entity's policies and procedures, is not part of the client's treatment plan and, through substantial carelessness or negligence. "Verbal Abuse" could be identified as threats of harm and saying things to intentionally frighten a client. "Mental Abuse" could be identified as humiliation, harassment, and intimidation. On 05/19/2026, Surveyor emailed Administrator A and Director B to request Resident 11's records including any incident reports, skin assessments, staff observation notes, and ISP. Surveyor asked if the provider was aware of any misconduct allegations involving Resident 11. At 2:15 PM, Surveyor received an email from	N 158		

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Administrator A that read, "Yes, I was aware of this situation. On April 16th, 3rd shift staff [Caregiver Y] reported to me that on April 15th around 4:00am [Resident 11] was getting placed back to [his/her] room by another staff member [Caregiver C]. and [sic] [s/he] wheeled [him/her] into the room turning into the bathroom resulting in [Resident 11] banged [sic] [his/her] leg on the wall. I looked at both of [Resident 11's] legs in the morning when I got into the office and there was [sic] no bruises. I asked [Resident 11] if [s/he] has [sic] any pain in [his/her] legs and [s/he] said no. I even monitor [his/her] legs for 2 days and there was [sic] no bruises nor [s/he] has pain. I did not fill out any skin assessment because there was [sic] no bruises. I couldn't talk to [Caregiver C] because [s/he] quit on the 15th, [s/he] didn't return to work the next day. I felt this is not a misconduct so I did not take further investigation because it was not intentional. Sometimes staff accidentally bumped resident's leg/foot on the door while turning into their room or the bathroom and it wasn't a bad hit or anything. [Caregiver Y] was also terminated 2 days after on the 18th. I think these two employees has something against each other and trying to make accusations to get one fired. So I believed it was just a bump in this situation. But I can send you the requested information below."

At 3:28 PM, Surveyor emailed Administrator A and asked how Administrator A became aware of the allegations.

At 4:33 PM, Surveyor received an email from Administrator A that read, "[S/he] reported to me via text message and told me in person the next day too."

Surveyor requested to review the text messages

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N 158	Continued From page 6 related to the incident. On 05/20/2026, Surveyor received an email from Administrator A with screenshots of text messages reported to be from Caregiver Y. The text messages read, in part, "Around 4am [Resident 11] was getting placed back to [his/her] room by [Caregiver C] and [s/he] wheeled [him/her] in the room to [sic] fast turning into the bathroom resulting in [Resident 11] banging [his/her] leg on the wall. [S/he] blamed [Resident 11] and started screaming at [him/her.] So I screamed at [him/her] that it was [his/her] fault not [Resident 11.]" A text message response from Administrator A read, "Well it's good thing we got rid of [him/her.]" The provider did not investigate alleged caregiver misconduct and did not take immediate steps to ensure the safety of residents when staff reported concerns regarding RN I's management of morphine, and Resident 4 had a personal item allegedly taken by staff. The provider did not adequately investigate and document misconduct allegations when Caregiver Y reported Caregiver C pushed Resident 11's leg into the wall and screamed at Resident 11.	N 158		
N 160	83.12(2)(c) Report to law enforcement and coroner Investigating and reporting abuse, neglect, or misappropriation of property. Other reporting. Filing a report under sub. (1) or (2) does not relieve the licensee or other person of any obligation to report an incident to any other authority, including law enforcement and the coroner.	N 160		

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N 160	Continued From page 7	N 160		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure law enforcement was notified when the provider was made aware of allegations of misappropriation of resident funds.

On 01/14/2026, Resident 8 reported s/he was missing $400 from his/her wallet.

Findings include:

On 04/30/2026, Surveyor reviewed Resident 8's record. Resident 8 was admitted to the facility on 07/15/2025. S/he did not have a legal representative. On 01/14/2026, staff documented: "resident [sic] stated [s/he] was upset claiming staff stole money from [him/her]. did [sic] inform higher ups of conversation."

On 05/11/2026, at approximately 11:30 AM, Surveyors interviewed Administrator A and Administrator Assistant (AA) N via Teams meeting. When asked about Resident 8's allegation of missing money, Administrator A stated the provider interviewed staff and nobody admitted to taking the money. AA N stated part of their admission agreement was to advise residents to only keep $20 in their possession otherwise it should be put into petty cash. Administrator A stated they were not responsible for valuables or money kept in Resident 8's room. Surveyors requested to review the investigation summary.

On 05/12/2026, Surveyors received an email from Administrator A with an attachment of Resident 8's investigation into missing money.

At 1:39 PM, Surveyor responded via email and asked if the provider reported the allegation of

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N 160	Continued From page 8 misappropriation to the division of quality assurance (DQA) or any outside agencies such as law enforcement. At 2:11 PM, Surveyor received an email from Administrator A that read, "[AA N] did not submit a self-report to DQA nor contact law enforcement. Sorry, this was [his/her] first investigation that [s/he] did and [s/he] forgot to do those two things."	N 160		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not investigate an injury of unknown source when Resident 6 was noted to have bruising to his/her hand. Findings Include: On 04/23/2026, the Department received a complaint alleging staff were physically rough with residents during cares. On 04/29/2026, Surveyor reviewed Resident 6's record. Resident 6 was admitted on 02/04/2022. S/he	N 161		

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had a legal representative. Resident 6's diagnoses included: Wernicke's encephalopathy, alcohol dependence with other alcohol-induced disorder, and mild cognitive impairment.

On 02/24/2026, staff noted: "Staff noticed a large bruise on residents [sic] right wrist and on the right side of [his/her] palm and on [his/her] thumb. Staff also noticed right thumb looks like it could be possibly dislocated when comparing to [his/her] other hand. Resident [sic] states [s/he] did not run into anything and did not fall. Resident [sic] says there is slight pain when [s/he] tries to fully straighten [his/her] thumb out."

Resident 6's record did not contain documentation to indicate an investigation into injury of unknown source was completed.

On 05/11/2026 at approximately 10:00 a.m., Surveyor interviewed Administrator A and Director B. Surveyor asked if they did an investigation into injury of unknown source when staff discovered Resident 6 had bruises to his/her right hand, wrist, and thumb. Administrator A said s/he did not remember that and would look to see if an investigation was completed. Surveyor asked if Resident 6 would have been able to recall the night prior if staff were rough with cares. Administrator A told surveyor, "I don't think [s/he] would remember the night before." Administrator A told Surveyor if s/he would have been aware of Resident 6's bruises s/he would have done an investigation.

On 05/11/2026, Administrator A emailed Surveyor. The email read, in part: "It looked like staff reported the bruise to the former 1st shift supervisor [Supervisor M] and [s/he] took it upon [him/herself] to call [Resident 6's] POA (power of

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N 161	Continued From page 10 attorney) to take [him/her] to the doctor. I was not informed of this incident so I did not do an investigation of unknown injury." The provider did not ensure all injuries of unknown source were investigated.	N 161		
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 report to the Department when Resident 7 fell and sustained fractures to his/her lumbar transverse processes, which required pain relief interventions. This is a repeat deficiency. See Statement of Deficiency (SOD) J0PF11, dated 10/06/2023. Findings include: On 04/24/2026, the Department received a complaint alleging the provider was not documenting and reporting falls appropriately. On 04/29/2026, Surveyor reviewed Resident 7's record. Resident 7 was admitted on 12/11/2025. S/he had multiple diagnoses including: diabetes with	N 165		

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neuropathy, morbid obesity, lymph edema, acquired absence of left toes, history of falling, and intellectual disability. Resident 7 had a legal representative.

An incident report, dated 02/08/2026, read, in part: "While transferring resident to [his/her] bathroom, resident lost balance with walker and fell backwards on butt." The report indicated Resident 7 had pain in his/her lower back and s/he was sent to the emergency department via emergency medical services.

The after visit summary (AVS) from the emergency department, dated 02/08/2026, read, in part: "You have broken they [sic] bony handles on your 3 upper low back spine bones, which are going to cause pain whenever you try to move ...A small prescription of medication has been provided today, however you may have pain for a month or 2 ..." The AVS indicated Resident 7 had a diagnosis of lumbar transverse process fracture, closed, initial encounter.

On 05/11/2026 from approximately 10:00 a.m. until 12:15 p.m., Surveyor interviewed Administrator A and Director B. Surveyor asked if Resident 7's fall was reported to the Department. Administrator A told Surveyor s/he would check and let Surveyor know.

On 05/11/2026, Administrator A emailed Surveyor which read, in part: "I looked and there is no self-report for the 2/8. [Care Coordinator H] did not send one in because [s/he] did not hit [his/her] head at the time. We found out about the tail bone fracture afterwards and I don't think it crossed [his/her] thought to send in the self-report."

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N 165	Continued From page 12 On 05/11/2026, Surveyor reviewed the department's electronic file of Self-reports from the Department and did not locate a self-report for Resident 7's fall with fracture, which required pain medication.	N 165		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on interview and record review, the provider did not immediately notify the resident's legal representative and the resident's physician when there was an incident or injury to the resident or a significant change in the resident's physical or mental condition for 1 of 9 (Resident 1) residents reviewed. Resident 1 was found with a bruise on his/her wrist. Resident 1's legal representative and physician were not made immediately notified of the injury. This is a repeat deficiency. See Statement of Deficiency (SOD) H7LH11, dated 04/07/2022. Findings Include:	N 169		

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N 169	Continued From page 13 On 04/06/2026, the department received a complaint regarding injuries of unknown origin. On 04/28/2026, at approximately 10:05 AM, Surveyors interviewed Administrator A and Director B. When asked about any recently identified staff misconduct, Administrator A stated a misconduct incident report (MIR) was submitted related to Resident 1's injury. Administrator A stated Resident 1 was found with a bruise on his/her arm. Administrator A stated Resident 1 had a history of combative behavior and it was possible someone grabbed Resident 1's wrist to protect themselves. Director B stated they suspected it was Caregiver C based on the timeline of events, but they could not prove it. Administrator A stated Resident 1's guardian initiated a discharge because Resident 1's guardian did not feel Resident 1 was safe. Resident 1 no longer resided at the facility. Surveyors requested a closed record review of Resident 1's records. Resident 1 was admitted on 10/20/2023 and had a legal guardian. Resident 1's discharge date was 04/06/2026. The MIR included an incident summary that read, in part, "It was reported to the Administrator on Sunday night by 2nd shift supervisor [Caregiver D] that staff noticed resident has a large bruise on [his/her] wrist. Staff noticed on Sunday, 3/29/26 at 7:30pm when they put [him/her] down in bed. On Monday, 3/29 the Administrator checked observation note and saw an observation note by 1st shift staff [Caregiver E] that [s/he] noticed resident's wrist was very swollen on 3/28/26 [sic] Saturday morning when staff brought breakfast in	N 169		

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for [him/her] ..." Surveyor noted discrepancy in dates, as 03/30/2026 fell on a Monday. It appeared the bruise was first observed on 03/28/2026 and an investigation was started 03/30/2026.

A document titled, "Investigation Form," dated 03/29/2026. It summarized details included in the MIR and included a section titled, "Response to Incident." Under a subsection titled, "Physician Notified?" it read, "No." Under a subsection titled, "Family or Representative Notified?" it read, "No."

On 04/29/2026, at 1:45 PM, Surveyor interviewed Resident 1's guardian via phone. Guardian F confirmed s/he was Resident 1's legal guardian. Guardian F stated s/he was notified by Resident 1's hospice provider via email of Resident 1's injury. Guardian F stated the provider did not contact him/her to notify him/her of Resident 1's injury. Guardian F stated communication with the provider was not great.

At 5:58 PM, Surveyor received an email from Guardian F including the original email from Resident 1's hospice provider notifying Guardian F of the bruises. The email was dated 04/01/2026, at 10:03 AM, and read, in part, "Want to update [Resident 1's] team. [S/he] has significant bruising that our aid discovered yesterday that were [sic] not there Friday. We ate [sic] following up with facility again today but we were not notified of anything that could have caused these these..."

On 05/11/2026, at approximately 11:30 AM, Surveyors interviewed Administrator A via Teams meeting. When asked if the provider immediately notified Resident 1's guardian regarding the injury, Administrator A stated s/he thought they

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N 169	Continued From page 15 were notified via email. Surveyor requested a copy of the email. At 5:02 PM, Surveyor received an email from Administrator A with 2 attachments. The body of the email read, in part, "Attachments [sic] is the emailed [sic] I notified care team and Guardian..." An attachment included an email sent by the provider to what appeared to be an agent at Resident 1's guardian agency. The contact did not match the name of Resident 1's assigned guardian. The email was dated 04/01/2026, at 6:49 PM. The email read, in part, "It was reported to me on Sunday night by 2nd shift staff that they noticed bruises in [Resident 1's] left wrist and right hand. Sorry it took me a bit to get this email out to you all because I was trying to catch and get a hold of staff. I finally completed my investigation today and sounded [sic] like 3rd shift staff noticed the bruises on Friday night and doesn't know what happened....[His/her] bruises looks like someone grab [sic] [him/her]. I wonder if [s/he] was agitated and trying to hit staff and they grab [sic] [his/her] wrist..."	N 169		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure the community based residential facility (CBRF) and its operation complied with all laws governing the CBRF.	N 196		

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As a result of this 11-complaint survey, a total of 15 violations were issued and 10 of 11 complaints were substantiated. Six of the 15 violations were repeat deficiencies.

Findings include:

The provider is licensed to care for 55 residents in the client groups irreversible dementia/Alzheimer's disease, physically disabled, and advanced age.

On 04/28/2026, Surveyor reviewed department records for Hope Stay Memory Care, licensed on 01/01/2022.

Since initial licensure on 01/01/2022, the facility has had 23 substantiated complaints, resulting in 69 deficiencies, and 22 recites issued. The provider was issued a No New Admit Order on 04/29/2022. The order was extended on 07/11/2022 and 12/12/2022. The provider was issued a No New Admit Order on 03/13/2026. The following information was reviewed:

SOD 8WZX11 was issued on 04/15/2021. One deficiency was identified:
1. 83.35(5)(a) Initial Evaluation Of Evacuation Limitations

SOD 8WZX12 was issued on 07/23/2021. One of 3 complaints was substantiated, and 12 deficiencies were identified:
1. 83.17(1) Licensee Conduct Caregiver Background Check
2. 83.17(2)(a) Employees Screened For Communicable Disease
3. 83.20(2)(a)-(d) Department-Approved Training Courses
4. 83.37(2)(e) Other Administration Given Or

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N 196	Continued From page 17 Delegated By RN 5. 83.38(1)(c) Leisure Time Activities 6. 83.38(1)(h) Medication Administration 7. 83.39(1) Infection Control Program 8. 83.41(1)(c) Dishwashing 9. 83.41(2)(a) Nutrition: Diet 10. 83.41(2)(c) Nutrition: Menus 11. 83.47(2)(d) Fire Drills 12. 441.301(c)(4)(vi)(B)(1) Residential Setting: Living Unit Locks SOD 8WZX13 was issued on 11/11/2021. Three of 4 complaints were substantiated, and there were 2 repeat violations (see SOD 8WZX12, dated 07/23/2021). Five deficiencies were identified: 1. 83.32(3)(i) Rights of Residents: Adequate Treatment 2. 83.37(3)(f) Medication Storage: Internals and Externals 3. 83.38(1)(g) Health Monitoring 4. 83.38(1)(h) Medication Administration 5. 83.39(1) Infection Control Program On 11/16/2021, the provider was sent a Notice and Order letter with SOD 8WZX13 which contained special orders. The special orders read, in part, "The licensee will correct all violations identified in SOD # 8WZX13 and will achieve substantial compliance with all laws and administrative rules governing the facility and its operation prior to expiration of the facility's Probationary License ..." SOD H7LH11 was issued on 04/07/2022. One complaint was substantiated, and 4 deficiencies were identified: 1. 83.12(5)(a) Notification: Incident, Injury, Changes 2. 83.14(2)(j) Not Permit A Condition of	N 196		

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N 196	Continued From page 18 Substantial Risk 3. 83.29(2)(a) Admission Agreement Includes Services, Charges 4. 83.35(3)(a) Comprehensive Individualized Service Plan On 04/29/2022, the provider was sent a Notice and Order letter with SOD H7LH11 which contained an order not to admit new or additional residents and special orders. The orders read, in part, "Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b)7., EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Hope Stay Memory Care NOT ADMIT ANY NEW OR ADDITIONAL RESIDENTS until all violations in SOD # H7LH11 are corrected, compliance is verified by the Department, and this Order is rescinded in writing ...Pursuant to Wis. Stat. § 50.03(5g)(b)6., effective immediately, the licensee shall develop and implement corrective measures to resolve each deficiency in SOD H7LH911. The corrective measures shall include, at a minimum, the development (or review/revision) of written procedures to address: Behavior Management. The procedure shall include, but is not limited to: (a) identifying specific behavior patterns that are or may be harmful to the resident or others, (b) assessing and documenting contributing factors to the behaviors, (c) developing and implementing the Individualized Service Plan (ISP) with specific individualized interventions to reduce incidences of these behaviors, (d) staff response when the identified interventions are not effective, (e) monitoring the effectiveness of any behavioral intervention including the use of PRN psychotropic medications, and (f) notifying the resident's legal representative and physician	N 196		

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N 196	Continued From page 19 when there is a significant change in a resident's mental condition. Recognizing, preventing, investigating, and reporting caregiver and non-caregiver misconduct. The procedure shall include, but is not limited to: (a) how the facility will investigate and respond to incidents or reports of inappropriate sexual contact involving residents, such as sexual contact involving an incompetent resident, (b) what steps the licensee will take immediately to protect the safety of residents when the CBRF receives a report of an allegation of abuse or neglect of a resident, (c) how the licensee will ensure timely medical care (to address physical and mental health), notify legal representatives, and involve law enforcement, if relevant, and (d) when applicable, the licensee shall follow the abuse reporting requirements under s. 46.90 Stats., or the adult at risk requirements under s. 55.043, Stats. In addition, the CBRF will follow the reporting requirements under Wis. Admin. Codes DHS 83 and 13. Additionally: All managers and resident care staff, as appropriate, shall receive training on the procedures required by Order #1. The training will be documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content." SOD Y23911 was issued on 06/02/2022. One of 2 complaints was substantiated, and there were 2 repeat violations (see SOD 8WZX12, dated 07/23/2021 and SOD 8WZX13, dated 11/11/2021). Two deficiencies were identified: 1. 83.38(1)(g) Health Monitoring 2. 83.38(1)(h) Medication Administration On 07/11/2022, the provider was sent a Notice and Order letter with SOD Y23911 extending the order to not admit new or additional residents.	N 196		

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The letter also included special orders that read, in part, "The licensee will develop (or review and revise) procedures and staff training to address: Medication Management, including how the facility will: (a) document medication orders, medication administration, missed/refused doses; (b) ensure residents receive medications at the intervals and dosages prescribed; (c) prevent medication errors; (d) respond to medication errors if they occur; (e) obtain prescriptions and refills timely; (f) securely store medications including schedule II narcotics and ensuring timely system review; (g) monitor or adverse side effects; (h) discontinue and dispose of medications; and (i) document and maintain proof of use record for schedule II drugs ...All managers and caregivers (as appropriate) will receive in-service training regarding the facility's written procedures required by Order #1. Training will be documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content."

SOD 95N711 was issued on 09/15/2022. Five of 5 complaints were substantiated, and there were 2 repeat violations (see SOD 8WZX12, dated 07/23/2021, SOD 8WZX13, dated 11/11/2021 and SOD H7LH11, dated 04/07/2022). Five deficiencies were identified:
1. 83.14(2)(j) Not Permit A Condition of Substantial Risk
2. 83.16(2) Resident Care Staff At Least 18 Years Old
3. 83.32(3)(h) Rights Of Residents: Receive Medication
4. 83.37(1)(j) Proof Of Use Record
5. 83.39(1) Infection Control Program

On 12/12/2022, the provider was sent a Notice

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N 196	Continued From page 21 and Order letter with SOD 95N711 extending the order to not admit new or additional residents. The letter also included special orders that read, in part, "The licensee shall development (or review/revise) a written procedure and conduct staff training to address: Infection Control, including how the provider will implement an infection control program based on current standards of practice to prevent the development and transmission of communicable disease and infections. The infection control program will include, at a minimum, current guidance for the prevention, identification, and monitoring of respiratory infections, including COVID-19 and influenza, along with Transmission-Based Precautions to be used when caring for residents." SOD J0PF11 was issued on 10/06/2023. Three of 5 complaints were substantiated, and there were 2 repeat violations (see SOD 95N711, dated 09/15/2022 and SOD 8WZX12, dated 07/23/2021.) Eighteen deficiencies were identified: 1. 83.12(4)(b) Reporting When Law Enforcement Is Called 2. 83.12(4)(c) Reporting Incidents With Serious Injury 3. 83.15(3)(a) Administrator Shall Supervise Daily Operation 4. 83.20(2)(a)-(d) Department-Approved Training Courses 5. 83.21(1)-(3) All Employee Training 6. 83.22(1)-)4) Task Specific Training 7. 83.32(3)(h) Rights Of Residents: Receive Medication 8. 83.37(1)(h) Scheduled Psychotropic Medications 9. 83.37(1)(i) Prn Psychotropic Medication 10. 83.38(1)(a) Personal Care	N 196		

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N 196	Continued From page 22 11. 83.38(1)(b) Supervision 12. 83.38(1)(k) Transportation 13. 83.43(1) Environment Safe, Clean, And Comfortable 14. 83.45(3) Toxic Substances 15. 83.47(2)(e) Other Evacuation Drills 16. 83.47(4)(a) Fire Extinguishers: Type and Inspection 17. 83.59(1)(f) Exit Passageways, Stairways: Width Maintained 18. 83.59(4)(b) Delayed Egress: Locking Device Sign Posted On 01/05/2024, the provider was sent a Notice and Order letter with SOD J0PF11 which included special orders. The special orders read, in part, "That is, the licensee shall ensure the administrator supervises the daily operation of the CBRF, including but not limited to, resident care and services, personnel and physical plant. The licensee shall develop and implement corrective measures to resolve each deficiency identified in Statement of Deficiency J0PF11." SOD GWCS11 was issued on 01/11/2024. One complaint was substantiated. One deficiency was identified: 1. 83.32(3)(b) Rights of Residents: Confidentiality SOD J0PF12 was issued on 06/04/2024. One complaint was substantiated, and there were 3 repeat violations (see SOD GWCS11, dated 01/11/2024 and SOD J0PF11, dated 10/06/2023). Three deficiencies were identified: 1. 83.15(3)(a) Administrator Shall Supervise Daily Operation 2. 83.32(3)(h) Rights Of Residents: Receive Medication 3. 83.38(1)(a) Personal Care	N 196		

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N 196	Continued From page 23 On 07/01/2024, the provider was sent a Notice and Order letter with SOD J0PF12 which included special orders. The special orders read, in part, "The licensee shall ensure the administrator supervises the daily operation of the CBRF, including but not limited to, resident care and services, personnel, and physical plant." SOD J0PF13 was issued on 08/29/2024. There was 1 repeat violation (see SOD 95N711, dated 09/15/2022, SOD J0PF11, dated 10/06/2023 and SOD J0PF12, dated 06/04/2024). One deficiency was identified: 1. 83.32(3)(h) Rights Of Residents: Receive Medication On 09/27/2024, the provider was sent a Notice and Order letter with SOD J0PF13 which included special orders. The special orders read, in part, "The licensee shall ensure each resident's right to receive all prescribed medications in the dosage and at intervals prescribed by the practitioner. The resident has the right to refuse medication unless the medication is court ordered." SOD J0PF14 was issued on 05/07/2025. Five of 6 complaints were substantiated, and there were 5 repeat violations (see SOD 8WZX12, dated 07/23/2021, SOD H7LH11, dated 04/07/2022, and SOD J0PF11, dated 10/06/2023). Seven deficiencies were identified: 1. 83.20(2)(a)-(d) Department-Approved Training Courses 2. 83.22(1)-)4) Task Specific Training 3. 83.32(3)(j) Rights of Residents: Treatment Options 4. 83.35(3)(a) Comprehensive Individualized Service Plan 5. 83.38(1)(b) Supervision	N 196		

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N 196	Continued From page 24 6. 83.38(1)(i) Behavior Management 7. 83.43(1) Environment Safe, Clean, And Comfortable On 07/09/2025, the provider was sent a Notice and Order letter with SOD J0PF14 which included special orders. The special orders read, in part, "The licensee shall develop and implement corrective measures to ensure all resident care staff 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." SOD J0PF15 was issued on 02/04/2026. Two of 5 complaints were substantiated, and there were 5 repeat violations (see SOD Y23911, dated 06/02/2022, SOD 8WZX12, dated 07/23/2021, SOD 8WZX13, dated 11/11/2021, SOD H7LH11, dated 04/07/2022, and SOD J0PF11, dated 10/06/2023). Ten deficiencies were identified: 1. 83.17(1) Licensee Conduct Caregiver Background Check 2. 83.17(2)(a) Employees Screened For Communicable Disease 3. 83.20(2)(a)-(d) Department-Approved Training Courses 4. 83.25 Continuing Education 5. 83.35(3)(a) Comprehensive Individualized Service Plan 6. 83.37(1)(k) Medication Error Or Adverse Reaction 7. 83.37(2)(e) Other Administration Given Or Delegated By RN 8. 83.38(1)(g) Health Monitoring 9. 83.46(1)(c) Heating System Maintenance 10. 83.48(3)(a) Fire Detection Systems Inspected Annually	N 196		

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N 196	Continued From page 25 On 03/13/2026, the provider was sent a Notice and Order letter with SOD J0PF15 which included an order not to admit new or additional residents. It also included special orders that read, in part, "The licensee shall ensure all residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected." On 04/28/2026, Surveyors conducted a 10-complaint investigation at Hope Stay Memory Care. From 05/11/2026 at 10:00 AM until 12:15 PM, Surveyors interviewed Administrator A, Director B and Administrator Assistant (AA) N. Surveyors discussed concerns related to current complaints and history of noncompliance. Director B stated the provider was looking at "handing off" the facility to a management company. Director B stated s/he and Administrator A would remain the owners, and the management company would handle all operations. On 05/15/2026, an additional complaint was received and added to the investigation. Ten of 11 complaints were substantiated. Fifteen deficiencies were identified. Six of the 15 violations were repeat deficiencies. Cross Reference N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse and Neglect N0160 DHS 83.12(2)(c) Report to Law Enforcement And Coroner N0161 DHS 83.12(3)(a) Investigate Injuries of Unknown Source N0165 DHS 83.12(4)(c) Reporting Incidents With	N 196		

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N 196	Continued From page 26 Serious Injury N0169 DHS 83.12(5)(a) Notification: Incident, Injury, Changes N0333 DHS 83.31(6)(b) Return Resident Funds Within 14 Days N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0410 DHS 83.37(1)(k) Medication Error Or Adverse Reaction N0431 DHS 83.38(1)(g) Health Monitoring N0481 DHS 83.43(1) Environment Safe, Clean, And Comfortable Y3244 DHS 50.0(1)(L) Care	N 196		
N 333	83.31(6)(b) Return resident funds within 14 days Disbursement of funds. The CBRF shall return all resident funds held by the CBRF to the resident or the resident ' s legal representative within 14 days after discharge as required under s. DHS 83.34(4). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was reimbursed funds being held by the facility within 14 days after discharge. Findings include: On 04/06/2026, the department received a complaint alleging the provider did not return	N 333		

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N 333	Continued From page 27 resident funds. On 04/28/2026, at approximately 10:05 AM, Surveyors interviewed Administrator A and Director B. Administrator A stated Resident 1's guardian initiated a discharge because Resident 1's guardian did not feel Resident 1 was safe. Surveyors requested a closed record review of Resident 1's record. Resident 1 was admitted on 10/20/2023 and had a legal guardian. Resident 1's discharge date was 04/06/2026. On 04/29/2026, at 1:45 PM, Surveyor interviewed Resident 1's guardian via phone. Guardian F confirmed s/he was Resident 1's legal guardian. Guardian F stated s/he still had not received Resident 1's funds and an itemized statement for Resident 1's account. Guardian F stated s/he called the provider and asked the receptionist to send the funds along with the ledger. Guardian F stated the provider was still in possession of Resident 1's funds. Guardian F stated s/he emailed the provider on 04/21/2026 and had not gotten a response or an acknowledgment the funds had been mailed. On 05/11/2026, Surveyors interviewed Administrator A via Teams meeting. When asked about Resident 1's funds, Administrator A stated s/he had forgotten to return Resident 1's funds. Administrator A stated Resident 1's guardian called to ask about it and Administrator A sent the funds via mail 16 days after Resident 1's discharge. Surveyor requested a copy of any notifications related to Resident 1's funds. At 5:02 PM, Surveyor received an email from	N 333		

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N 333	Continued From page 28 Administrator A with 2 attachments. The body of the email read, in part, "Also, petty cash document of when I sent out the check on 4/22/26 ..." The provider did not ensure Resident 1 was reimbursed funds being held by the provider within 14 days after discharge when the provider did not mail out the refund check until 16 days after discharge.	N 333		
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 residents received all medications in the dosages and at intervals prescribed by a practitioner. Resident 2 did not receive his/her scheduled insulin medication between 03/06/2026 and 03/16/2026. Resident 5 did not receive his prescribed Novolog insulin at the correct time from 02/01/2026 through 04/24/2026. This is a repeat deficiency. See Statement of Deficiency (SOD) J0PF11, dated 10/06/2023, SOD J0PF12, dated 06/04/2024, SOD J0PF13,	N 352		

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N 352	Continued From page 29 dated 08/29/2024, and SOD 95N711, dated 09/15/2022. Findings include: On 03/03/2026, 03/10/2026, 03/17/2026, and 04/21/2026, the department received complaints regarding the provider's medication management. RESIDENT 2 On 04/28/2026, at approximately 10:15 AM, Surveyors interviewed Administrator A and Director B. When asked about any recently identified staff misconduct, Administrator A stated a misconduct incident report (MIR) was submitted related to Resident 2's medications. Administrator A stated Caregiver G was terminated after it was reported s/he did not offer Resident 2 his/her insulin. Caregiver G had documented the insulin was refused by Resident 2 and that was false. Surveyors reviewed Resident 2's records. Resident 2 was admitted on 07/28/2025 and had multiple diagnoses including Type 2 diabetes mellitus with diabetic chronic kidney disease. Resident 2's medication administration record (MAR) for March 2026 identified the following: Novolog Flexpen Prefilled Syr. Inject 3 units Sub-Q 3 times a day with meals (ok to hold if eating less than 25%). The medication was scheduled at 9:00 AM, 12:30 PM, and 5:00 PM. Under the staff notations, it read, "resident refused" on the following dates: 03/04/2026, 03/06/2026, 03/07/2026, 03/08/2026, 03/09/2026, 03/11/2026, 03/12/2026, 03/13/2026, 03/14/2026, 03/15/2026, and 03/16/2026.	N 352		

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N 352	Continued From page 30 The MIR included an incident summary that read, in part, "On 03/17/26 staff member [Care Coordinator (CC) H] conducted the medication refusal audit and discovered tere [sic] was a lot of medication refusals from 3/6/26-3/16/26 for resident [Resident 2]. It was very suspicious as to why this resident were [sic] refusing [his/her] medications when [s/he] normally do [sic] not refused [sic]." On page 7 of 9 of the investigation report, it read, in part, "Conclusion: Based on my investigation, I believe the Med Passer [Caregiver G] ... failed to deliver or administer [his/her] medication to [Resident 2]." RESIDENT 5 On 04/29/2026, Surveyor reviewed Resident 5's record. Resident 5 was admitted on 03/27/2025. Resident 5 had diagnoses of type 2 diabetes and long term current use of insulin. Resident 5's February, March, and April 2026 medication administration records (MAR) indicated Resident 5 received his/her Novolog insulin at 8:00 a.m., 12:00 p.m., and 8:00 p.m. from 02/01/2026 until 04/24/2026. On 04/25/2026, the MAR was changed to reflect Resident 5 receiving his/her Novolog insulin at 4:00 p.m. instead of 8:00 p.m. On 04/29/2026, Surveyor emailed Administrator A and Director B and requested additional information for Resident 5 including his/her insulin orders. On 05/04/2026, Administrator A replied via email with additional documentation. The email contained Resident 5's insulin orders including the following orders for Novolog insulin: 01/05/2026 - inject 4 units under skin 3 times daily before meals plus correction scale.	N 352		

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N 352	Continued From page 31 02/18/2026 - inject 6 units under skin 3 times daily before meals plus correction scale. 03/03/2026 - inject 8 units under skin 3 times daily before meals plus correction scale. 04/07/2026 - inject 10 units under skin 3 times daily before meals plus correction scale. From 05/11/2026 at 10:00 a.m. until 12:15 p.m., Surveyor interviewed Administrator A, Director B and Administrator Assistant (AA) N. Surveyor reviewed Resident 5's Novolog insulin orders which included instructions to administer the insulin before meals. Resident 5's MAR indicated Resident 5 did not receive Novolog insulin before supper, instead Resident 5 received Novolog insulin at 8:00 p.m. Director B said s/he did not know why Resident 5 received the Novolog insulin at 8:00 p.m. when they had supper at 5:00 p.m. AA N said s/he was the person who changed the Novolog insulin on 04/25/2026 from 8:00 p.m. to 4:00 p.m., AA N said, "a lot of staff were questioning it." Surveyor explained that was a medication error as Resident 5 did not receive Novolog insulin at the correct time. Director B said, "I agree." Director B said, "That falls upon the person who added in ECP (electronic health record), falls back to [Care Coordinator (CC) H] ... If I get an order and it currently tells me before meals, I know it's before breakfast, lunch and dinner. It's their job to check this clearly every single time. That falls on the person, [CC H]." The provider did not ensure Resident 2 and Resident 5 received their Novolog insulin at the correct time.	N 352		
N 388	83.35(3)(c) Implement, follow the individual service plan	N 388		

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N 388	Continued From page 32	N 388		

Implementation. The CBRF shall implement and follow the individual service plan as written.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure the individual service plan (ISP) was implemented as written for 1 of 9 residents reviewed.

Resident 9 was not provided with thickened liquids as identified in his/her ISP.

Findings include:

On 04/24/2026, the department received a complaint regarding resident care.

On 04/28/2026, Surveyor reviewed Resident 9's record.

Resident 9 was admitted on 01/23/2023 and had multiple diagnoses including gastro-esophageal reflux disease without esophagitis.

A document identified as a needs assessment, dated 04/16/2026, included a section titled, "Special Dietary Needs." Under the "Resident's Needs/Preferences" section, it read, in part, "***Mechanical Soft Diet and thickened liquids***"

On 05/04/2026, Surveyor requested hospice notes for Resident 9.

On 05/05/2026, Surveyor received an email from Administrator A including Resident 9's hospice notes.

A hospice note, dated 04/15/2026, read, in part, "GO (gastroenterologist) agrees to try thickened liquids and mechanical soft diet again as well as

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N 388	Continued From page 33 equipment recommendations." A hospice note, dated 05/01/2026, read, in part, "Juice was not thickened." On 05/05/2026, Surveyor emailed Administrator A and asked for clarification if the needs assessment was considered Resident 9's ISP. Surveyor asked Administrator A if s/he had any other ISPs to provide for Resident 9. At 1:52 PM, Surveyor received an email from Administrator A that read, in part, "So we usually don't use the Matrix Care plan format. We only use the active care plan (see attached) for staff and MCP (member care plan) meeting with the care team. We also use ISP format (see attached) for updating ...Any updates in the ISP will show on the active care plan ..." At 2:16 PM, Surveyor received an email from Administrator A including Resident 9's active care plan. The active care plan also included instruction for staff to offer thickened liquids to Resident 9. The start date for the thickened liquids was 04/16/2026. On 05/11/2026, at approximately 11:50 AM, Surveyors interviewed Administrator A and Administrator Assistant (AA) N via Teams meeting. When asked if Resident 9 had any special dietary orders, AA N stated Resident 9 was on thickened liquids and a mechanical soft diet. Surveyor asked about the hospice note identifying Resident 9 was not offered thickened liquids. AA N stated when s/he found that out, s/he went straight to the staff and asked them if they were following the ISP and reminded them to be following it. AA N stated s/he reviewed the ISP to make sure the orders were in there. AA N	N 388		

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N 388	Continued From page 34 stated it was very concerning when hospice brought it up and the provider was reinforcing the importance of following the ISP.	N 388		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure Resident 9's, Resident 8's, and Resident 7's individual service plans (ISP) were reviewed and revised to accurately reflect their condition and needs. Resident 9's ISP did not identify use of a Broda chair and the need for a cushion to be placed on the chair to prevent skin breakdown. Resident 8's ISP did not identify his/her diabetic and vascular ulcers to his/her lower extremities with interventions to promote healing. Resident 8's ISP did not identify his/her noncompliance with interventions for staff when Resident 8	N 389		

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N 389	Continued From page 35 refused care and appointments. Resident 7's ISP did not identify his/her past history of wounds and his/her pressure injuries with interventions to promote healing. Resident 7's ISP was not updated after Resident 7 sustained a fall. Resident 7 fell again and fractured 3 of his/her transverse process on his/her spine. Findings include: On 04/24/2026, the department received a complaint regarding resident care. RESIDENT 9 On 04/28/2026, Surveyor reviewed Resident 9's record. Resident 9 was admitted on 01/23/2023 and had multiple diagnoses including Pressure ulcer of unspecified buttock, stage 2. A document identified as a needs assessment, dated 04/16/2026, included a section titled, "Mobility and Transferring." Under a "Service Provider Responsibilities" section, it read, "Use Sit to Stand and gait belt with 2 staff. Staff with have 2 person assist for resident at all transfers. Staff to monitor that personal alarms are in place on every security check, due to resident self-transfers, to prevent falls. **Alarm and Security checks are hourly.**" The assessment did not identify Resident 9's Broda chair or cushion. The assessment did not include information related to Resident 9's skin integrity or strategies to prevent skin breakdown. On 05/04/2026, Surveyor requested hospice notes for Resident 9.	N 389		

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N 389	Continued From page 36 On 05/05/2026, Surveyor received an email from Administrator A including Resident 9's hospice notes. A hospice note, dated 04/08/2026, stated, in part, "Cushion needs to be on Broda chair when patient sitting in it to prevent skin breakdown." At 1:52 PM, Surveyor received an email from Administrator A that read, in part, " ...Any updates in the ISP will show on the active care plan ..." At 2:16 PM, Surveyor received an email from Administrator A including Resident 9's active care plan. The care plan did not include information related to Resident 9's skin integrity or strategies to prevent skin breakdown. It did not identify the use of a Broda chair. On 05/11/2026, at approximately 11:45 AM, Surveyors interviewed Administrator A and Administrator Assistant (AA) N via Teams meeting. Surveyor asked about the hospice note referencing Resident 9's Broda chair and the need for a cushion. Administrator A stated s/he remembered when the hospice nurse told him/her to make sure staff were putting the cushion on the chair. When asked if the Broda chair and instruction to use the cushion was added to Resident 9's ISP, Administrator A stated s/he did not think it was added in the ISP. Administrator A stated they just sent messages to the group. RESIDENT 8 On 04/28/2026, at 11:24 AM, Surveyor observed Resident 8 in his/her room. Resident 8 was in bed. His/her left foot appeared dry and scaley. The left heel was resting directly on the bed and there was a bandage across the shin of Resident	N 389		

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N 389	Continued From page 37 8's left leg. Resident 8's right leg was amputated above the foot. There was a small wound (approximately 2 millimeters round) above the amputated area. Resident 8 had a urinary catheter. The bag for the catheter was hanging on the side of a garbage can next to the bed. Caregiver O was present during this observation. Surveyor asked Caregiver O if they provided any wound care for Resident 8. Caregiver O said, "No." S/he said an agency came in for wound care. Caregiver O said they did put zinc on the right leg and nystatin in his/her abdominal folds. On 04/28/2026 at approximately 4:45 PM, Surveyor interviewed Administrator A and Director B. Surveyor asked who developed the ISPs and who did the review/revisions of ISPs. Administrator A told Surveyor s/he completed the initial ISP, and the care coordinator was responsible for updating the ISP with changes. On 04/30/2026, Surveyor reviewed Resident 8's record. Resident 8 was admitted to the facility on 07/15/2025. S/he did not have a legal representative. S/he had multiple diagnoses that placed him/her at risk for skin breakdown including: sepsis, type 2 diabetes with polyneuropathy, type 2 diabetes with foot ulcer, morbid obesity, chronic pain, phantom limb syndrome with pain, congestive heart failure, atherosclerosis of native arteries of left leg with ulceration of heel and midfoot, lymphedema, non-pressure chronic ulcer of left heel and midfoot with fat layer exposed, muscle weakness, acquired absence of limb, patient's noncompliance with other medical treatment and regimen due to unspecified reason.	N 389		

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N 389	Continued From page 38 Resident 8's ISP, dated 03/25/2026, read, in part: "Toileting - Full Assistance... Provide full assistance with toileting. Assist with dressing and undressing, toileting and clean-up. *Resident is using a bedpan for BM's (bowel movements) Resident's Needs/Preferences: Requires full assistance including physcial and verbal assistance with toileting needs. Hands-on assistance with undressing/dressing, washing/wiping and any physical assistance necessary. Resident's Desired Goals & Outcomes: To efficiently and cleanly execute proper toileting. Service Provider Responsibilities: Staff assist resident with toileting when [s/he] wakes up in the morning, before, after meals, at night and as needed. * Resident has hourly security checks in place* **RESIDENT USING A BEDPAN FOR BMs** Measurable Goals, Outcomes and Review: Resident will have help with toileting... Chronic Illness Non Scheduled Item Resident's Needs/Preferences: Has chronic illness(es) that requires proper treatment and management. Chronic diastolic (congestive) heart failure Chronic kidney disease, stage 3 unspecified Chronic respiratory failure with hypoxia Resident's Desired Goals & Outcomes: Continue and enjoy desired activities and daily functions as conditions allow. Service Provider Responsibilities: Staff to administer all ordered medications and alert physician of effectiveness ... Short Term Illnesses Do they have a short term illness that requires	N 389		

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N 389	Continued From page 39 assistance from staff? [blank] ... Recurring Illnesses Do they have recurring illness [sic] that require staff monitoring? [blank] ... Physical Disabilities Describe any physical disabilities Physical Disabilities Non Scheduled Item Resident's Needs/Preferences: [Identify physical disabilities and specify individual needs]. Loss of limb/leg below knee. Uses wheelchair and transferring assistance from staff Resident's Desired Goals & Outcomes: [blank] Service Provider Responsibilities: [blank] ... Nursing Procedures Describe the required nursing procedures. [blank]" On 01/23/2026, Registered Nurse (RN) I documented, in part: "[Home health nurse] comes to RN office to report that resident is refusing to sign any and all paperwork for [him/her] and that because [s/he] no longer has a PCP (primary care provider) [home health] wound cares must be discontinued at this time ... [home health nurse] states that resident does have an open wound to [his/her] LLE (left lower extremity) at this time ..." On 03/02/2026, staff documented, in part: "Resident's sore on [his/her] right foot is very open and exposed ..."	N 389		

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N 389	Continued From page 40 On 03/11/2026, staff documented: "Resident has a significant wound festering on [his/her] left lower leg. [S/he] has open blisters and ulcer like sore on [his/her] leg. Resident said at one point [his/her] leg was wrapped and covered, but [s/he] took the bandages off. [S/he] had zinc cream [s/he] was using that [s/he] felt was helping but has run out of supply in [his/her] room and feels that is what has caused [his/her] wound issues. Resident 's left lower leg up to [his/her] mid-thigh appears to be swollen. Resident complains of a lot of pain. On the left shin it is purple/pink in color and looks to be 'fluidy' as well as having open sore and blisters seeping down [his/her] leg. There is one blister that has yet to pop but is rather large in size. Resident's right foot also had an open sore on the top of the ankle. It too is very open, but less drainage and just painful. Resident doesn't feel heard about [his/her] pain and feels at a loss on who to ask for help. Will continue to monitor." On 03/11/2026, staff documented an incident report that read, in part: "Resident had blood dripping from [his/her] left foot and requested to go into the hospital." An after visit summary, dated 03/11/2026, from the emergency department indicated the following diagnoses: Wound Lower Leg Open Subsequent Right Wound Lower Leg Open Subsequent Left Wound Foot Open Subsequent Left On 03/19/2026, a physician visit form indicated Resident 8 had a wound care visit. The report indicated the following: "Reason for Visit: Wound care Physician Findings: Moderate amount of drainage to LLE (left lower extremity). Return to wound	N 389		

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N 389	Continued From page 41 clinic in 1 month ... Physician's Recommendations: Daily dressing change to LLE. Cleanse with soap and water. Dry well. Apply Hydraguard or moisture barrier equivalent to intact skin. Apply Aquacel to open wounds. Cover with ABD pads. Secure with Kerlix roll gauze. Wear tubigrip for edema management. 3 times a week dressing change to RLE (right lower extremity) shin. Cleanse with soap and water. Dry. Aquacel to wound. Cover with Mepilex border." On 04/20/2026, RN K documented: "Yeasty areas underneath pannus (abdominal fold) is well improved this morning. Area cleansed and nystatin cream have been applied. Viva paper towel daily tucked in pannus would be great." On 05/04/2026 at approximately 10:40 a.m., Surveyor interviewed Home Health Nurse Director (HHND) Q. HHND Q told Surveyor a nurse was providing wound care for Resident 8 on a daily basis. HHND Q said Resident 8's wounds to the lower extremity were diabetic/vascular ulcers. HHND Q told Surveyor s/he was concerned Resident 8 refused his/her appointments. S/he said if Resident 8 did not go to his/her doctor's appointment the home health agency would not be able to continue to provide wound care without orders and supplies. HHND Q said s/he did not know if staff were explaining the importance of Resident 8 going to his/her appointments or if they just let Resident 8 refuse. The provider did not review and revise Resident 8's ISP to accurately reflect Resident 8's current needs with interventions to meet those needs. Resident 8's risk for developing wounds with interventions to prevent wounds was not identified on the ISP.	N 389		

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Resident 8's ISP was not reviewed and revised when s/he developed wounds with interventions to promote healing and prevent infection.
Resident 8's ISP was not updated to reflect his/her nursing procedures being provided by the home health agency.
Resident 8's ISP did not indicate s/he had a urinary catheter.
Resident 8's ISP did not indicate which leg was amputated below the knee or the reason it was amputated.
Resident 8's ISP did not identify his/her noncompliance history with interventions for staff to use when s/he refused cares and appointments.

RESIDENT 7
On 04/29/2026, Surveyor reviewed Resident 7's record.

Resident 7 was admitted to the facility on 12/11/2025. Resident 7 did have a legal representative. Resident 7 had multiple diagnoses that placed him/her at risk for skin breakdown including: type 2 diabetes with polyneuropathy, morbid obesity, chronic peripheral venous insufficiency, lymphedema, weakness, acquired absence of other left toe(s), presence of artificial skin, and unspecified intellectual disabilities.

Resident 7's ISP, dated 02/09/2026, read, in part:
"Chronic Illnesses
Non Scheduled Item
Resident's Needs/Preferences:
Has chronic illness(es) that require proper treatment and management. Chronic atrial fibrillation, unspecified Chronic kidney disease, stage 3a
Resident's Desired Goals & Outcomes:

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N 389	Continued From page 43 Continue and enjoy desired activities and daily functions as conditions allow. Service Provider Responsibilities: [blank] ... Short Term Illness - Assist Daily @ As Needed Provide assistance as directed to care for/manage short term illness. Monitor and contact appropriate provider with changes, questions or concerns. Resident's Needs/Preferences: Has a short term illness that requires proper treatment/management. Staff assistance as directed by provider. Resident's Desired Goals & Outcomes: To properly monitor, manage and cure short term illnesses. Service Provider Responsibilities: Staff Reposition Pillow every 2 hours: Reposition a pillow under resident's buttocks every 2 hours. EX: (example) Place pillow under RIGHT buttocks, at 2-security check, Remove pillow from right buttock and place under LEFT buttocks etc. (et cetera). Recurring Illnesses Do they have recurring illness that requires staff monitoring? [blank] ... Physical Disabilities Non Scheduled Item Resident's Needs/Preferences: Acquired absence of other left toes(s) and history of falling. Resident's Desired Goals & Outcomes: [blank] Service Provider Responsibilities: Staff will provide assistance with all transferring	N 389		

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needs ...

Nursing Procedures
Describe the required nursing procedures.
[blank] ..."

A document, titled "Service Plan Task" indicated the task for Resident 7's repositioning was started on 02/09/2026.

On 01/01/2026, staff documented: "resident has open wound on coccyx. (top left)"

On 01/09/2026, RN I documented: "Call placed to PCP (primary care provider) office requesting Rx (prescription) for nystatin powder to be sent to [pharmacy] for resident. Per staff report resident has some skin breakdown under [his/her] [chest]."

On 01/21/2026, Resident 7 was seen by Medical Doctor (MD) R. MD R's note read, in part: "[S/he] sleeps in [his/her] recliner. During the day [s/he] elevates [his/her] feet to try to control [his/her] chronic edema. [His/her] prior foot ulcerations have healed ... States [s/he] wears [his/her] stockings most of the time. Is not wearing them today."

On 01/27/2026, staff documented: "resident refused shower reason was because open sore on the back of [his/her] leg was bleeding and [s/he] says it hurts."

On 01/28/2026, staff documented: "staff noticed when changing resident [s/he] has a sore on the inside of [his/her] thigh."

On 02/01/2026, staff documented: "Resident has 3 skin tears on [his/her] mid-inner thigh. They are

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N 389	Continued From page 45 wide open and bleeding ..." On 02/04/2026, Resident 7 was seen by a nurse practitioner for an office visit. Nurse Practitioner (NP) S documented, in part: "[Resident 7] is seen today for an acute concern as requested by Hope Stay assisted living home staff. [S/he] has had sores on [his/her] bottom, for what patients [sic] says has been present for a long time ... With two person assistance and a walker, [s/he] was able to pivot into [sic] the exam table ... Skin: right inner thigh with pressure sore stage 2, area is blanchable. Right buttock with a small pressure sore stage 1. Left inner buttock with a smaller stage 2 pressure sore." The assessment and plan included the following for Resident 7's stage 2 pressure injury of right thigh: "Area is cleansed and dressing placed by RN. Until this patient is able to be seen by a wound care RN recommendations are for every 3 day dressing changes with normal saline wash, then apply Aquacel dressing followed by duoderm. - Wound Care Referral." Resident 7's "Service Plan Task" form indicated the following treatment was added on 02/06/2026: "Wound dressing Change Instructions: Change dressing every 3 days. 1. Cleanse with saline. 2. Apply Aquaphor 3. Cover with miraplex [sic] *wound care referral sent to wound clinic 2/4/26" The wound care orders on the task sheet were different than the orders from the clinic office. Aquacel was a silver type dressing that killed bacteria in a wound. Aquaphor was a lotion or skin protectant ointment. Duoderm was a hydrocolloid (absorbent) dressing used to promote healing in pressure injuries. Miraplex may have meant Mepilex which was a foam	N 389		

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dressing.

Resident 7's task administration record (TAR) did not indicate the wound care was completed by staff.

Resident 7's ISP did not include the above wounds identified with interventions to promote healing. The ISP did not include his/her previous history foot ulceration with interventions to prevent recurrence. The ISP did not indicate Resident 7 wore stockings. The ISP did not include nursing procedures for wound care.

An incident report, dated 02/05/2026, read, in part: "Writer and another RCA (resident care assistant) were walking the resident to the bathroom with [his/her] walker. Residents [sic] became unsteady and staff lowered [him/her] to the floor ... Resident stated [his/her] leg gave out but [s/he] did not want to be sent in."

The provider's procedure, titled, "Resident Fall and Injury Procedures Did Not Send Resident to ER," read, in part: "Hope Stay Administrator Responsibilities: The Administrator will investigate, document, and file the report to the appropriate department ... - Change of condition routine checklist - Fall Risk Assessment and update ISP - Review Incident Report."

Resident 7's ISP was not updated after s/he fell on 02/05/2026.

An incident report, dated 02/08/2026, read, in part: "While transferring resident to [his/her] bathroom, resident lost balance with walker and fell backwards on butt ... Staff called Ems [emergency medical services) and sent [him/her] out."

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N 389	Continued From page 47 An after visit summary (AVS), dated 02/08/2026, read, in part: "You have broken the bony handles on your 3 upper low back spine bones, which are going to cause pain whenever you try to move." The AVS indicated a diagnosis of lumbar transverse process fracture, closed, initial encounter. Resident 7's "Service Plan Task" form indicated on 02/08/2026, Resident 7's transferring status was changed to: "Provide full assistance with transferring to/from wheelchair, chair, bed, standing position, etc. **USE EZ STAND FOR ALL TRANSFERS** **Resident has scheduled 2-hour security checks. Staff will assist as needed** Status: Requires full assistance from staff for all transfers." On 02/10/2026, Resident 7 was seen at the wound clinic. NP T documented, in part: "1. Pressure ulcer of upper thigh, right, stage III - first assessment. [Resident 7's] intellectual disability impairs [his/her] ability to self-advocate. [S/he] requires an increased level of care due to multiple wounds and persistent saturated urinary briefs which has contributed to right thigh and buttock wounds. Has a blood blister on right heel wound that required nursing home admission and skin substitute grafts for healing. If blood blister progresses, this will result in new ulceration. The current assisted living facility is not adequately meeting [his/her] care needs. Nursing staff to reach out to [managed care organization] to verbalize these concerns. 2. Pressure injury of buttock, stage 2, unspecified laterality - first assessment 3. Lymphedema - stable. NEEDS TO HAVE FARROW WRAPS (compression wraps) ON DURING DAY TIME NOT JUST UNDER LINER	N 389		

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N 389	Continued From page 48 4. Diabetic ulcer of right heel associated with type 2 diabetes mellitus, with fat layer exposed - recurrent. Blood blister present today. Area will be padded with Mepilex and assisted living facility instructed to elevate legs frequently to alleviate pressure from heel along with minimize time spent in seated, dependent position with extra pressure to right heel ..." The AVS, dated 02/10/2026, included the following instructions: "Daily and PRN (as needed) cares to buttocks area and right thigh: Cleanse area with mild soap and water. Pat day. Apply Zguard (zinc oxide) to all areas. May hold in place with viva paper towel. *Zguard does not need to be removed from the skin entirely before each application. Please only cleanse the soiled top layer off with incontinence care, pat skin dry an [sic] apply new as needed. - Should the skin need to be assessed. Use a clean, DRY cloth or gauze to remove from the skin. Apply 4x4 mepilex to right heel. Carefully peel back dressing daily to assess underlying skin. Foam dressing can stay in place for up to 5 days or until it becomes 70% saturated with wound drainage. Please date mepilex dressings. Change depends [sic] brief 3 times per day. Wear farrow wrap on right and left leg. Assist patient with leg elevation in bed for 45 minutes 3 times per day. Patient should not wear shoes on right foot when not ambulating or transferring as they are causing wounds on right heel and right foot." Resident 7's Service Plan Task indicated the following tasks were added: 02/09/2026 - Reposition pillow every 2 hours - "Reposition a pillow under resident's buttocks	N 389		

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every 2 hours. EX: Place pillow under RIGHT buttocks, at 2-security check, Remove pillow from right buttock and place under LEFT buttocks etc."
02/09/2026 - "Provide assistance as directed to care for/mange short term illness. Monitor and contact appropriate provider with changes, questions or concerns. Status: Has a short term illness that requires proper treatment/management. Staff assistance as directed by provider."
02/10/2026 - Compression stockings - "Apply compression socks every morning and remove every night before bed."
02/11/2026 - Toileting - Full Assistance - "Provide full assistance with toileting, hourly as needed ..."

The Service Plan Task did not identify what the short term illness was to monitor for changes or what treatment was required.

None of the other instructions from the AVS, dated 02/10/2026, were added to the ISP such as: Zguard and Viva towels to buttocks and right thigh daily and as needed, the Mepilex to the right heel every 5 days, leg elevation in bed for 45 minutes, 3 times per day; and not wearing shoes on right foot when not ambulating or transferring.

The wound clinic note indicated Resident 7's wounds worsened, and s/he developed a blood blister to his/her right heel that s/he previously had to receive skin grafting for.

An incident report, dated 02/12/2026, read, in part: "During routine care, staff observed active bleeding from a wound located on the resident's buttocks. The area was assessed, and bleeding was noted to be ongoing. Due to the change in condition and concern for further evaluation and treatment, staff notified the appropriate on-call

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N 389	Continued From page 50 personnel and arranged for the resident to be sent to the emergency room ..." On 02/13/2026, Administrator A documented: "[Hospital RN] called and gave us updated [sic] that resident will be going to a skilled nursing home until [his/her] open wound is healed ..." The provider's procedure, titled, "Resident Medical Condition Change Procedure" indicated the care coordinator should: "- The Care Coordinator will investigate, document, and file the report to the appropriate department ... - Talk to RCA that witnessed the incident or anyone that may have been aware of the situation. Especially if this is an on-going issue/situation. - Talk to RN and management team regarding the finding. - Change of condition routine checklist - Review Incident Report - Fall Risk Assessment and update ISP - Go over the finding and updated ISP with POA (power of attorney) and MCO (managed care team) to make sure everyone is aware of the situation and on the same page regarding care and supervision going forward." The provider failed to review and revise Resident 9's, Resident 8's, and Resident 7's ISPs to accurately reflect their condition and needs.	N 389		
N 410	83.37(1)(k) Medication error or adverse reaction. 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	N 410		

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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 record review and interview, the provider did not document a medication error in Resident 5's record and did not immediately report the medication error to a licensed practitioner, supervising nurse or pharmacist.

Findings include:

On 03/10/2026, the Department received a complaint alleging residents were not having their diabetic care managed appropriately.

On 04/29/2026, Surveyor reviewed Resident 5's record. Resident 5 was admitted on 03/27/2025. Resident 5 had diagnoses of type 2 diabetes and long term current use of insulin.

On 04/29/2026, Surveyor emailed Administrator A and Director B and requested additional information for Resident 5 including: insulin orders and any incident reports from 02/01/2026 to 04/29/2026.

On 05/04/2026, Administrator A replied via email with additional documentation. The email

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N 410	Continued From page 52	N 410		

contained Resident 5's insulin orders including the following orders for Novolog insulin:
01/05/2026 - inject 4 units under skin 3 times daily before meals plus correction scale.
02/18/2026 - inject 6 units under skin 3 times daily before meals plus correction scale.
03/03/2026 - inject 8 units under skin 3 times daily before meals plus correction scale.
04/07/2026 - inject 10 units under skin 3 times daily before meals plus correction scale.

Resident 5's February, March, and April 2026 medication administration records (MAR) indicated Resident 5 received his/her Novolog insulin at 8:00 a.m., 12:00 p.m., and 8:00 p.m. from 02/01/2026 until 04/24/2026. On 04/25/2026, the MAR was changed to reflect Resident 5 was to receive his/her Novolog insulin at 4:00 p.m., instead of 8:00 p.m.

There was no documentation in Resident 5's record identifying that as a medication error.

From 05/11/2026 at 10:00 a.m. until 12:15 p.m., Surveyor interviewed Administrator A, Director B and Administrator Assistant (AA) N. Surveyor reviewed Resident 5's Novolog insulin orders which included instructions to administer the insulin before meals. Resident 5's MAR indicated Resident 5 did not receive Novolog insulin before supper, instead Resident 5 received Novolog insulin at 8:00 p.m. AA N said s/he was the person who changed the Novolog insulin on 04/25/2026 from 8:00 p.m. to 4:00 p.m. AA N said, "a lot of staff were questioning it." Surveyor explained that was a medication error as Resident 5 did not receive Novolog insulin at the correct time. Director B said, "I agree." Surveyor asked if Resident 5's prescribing physician was made aware of the medication error. Director B

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N 410	Continued From page 53 said, "We'll get on that right away." Cross Reference N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication	N 410		
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 record review and interview, the provider did not ensure personal care services were adequate to meet the needs for Resident 8. Resident 8 did not receive showers weekly and did not receive proper urinary catheter care. This is a repeat deficiency. See Statement of Deficiency (SOD) J0PF11, dated 10/06/2023 and SOD J0PF12, dated 06/04/2024. Findings include:	N 425		

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N 425	Continued From page 54 On 03/10/2026, 03/17/2026, 04/06/2026, 04/13/2026, and 04/23/2026, the Department received complaints alleging inadequate care was being provided for the residents. On 04/28/2026 at approximately 11:30 a.m., Surveyor interviewed Caregiver P. Caregiver P told Surveyor sometimes they did not have enough time to get all the showers completed. Surveyor observed Caregiver P empty Resident 8's urinary catheter bag. Resident 8's urinary catheter bag was hanging over his/her garbage can. The garbage can was half full of garbage and did not have a garbage bag in it. Caregiver P emptied the urine from the bag into a cylinder. Caregiver P did not swab the spout of the bag with alcohol when s/he was finished emptying the bag. According to the Cleveland Clinic, you should clean the spout with alcohol after emptying the urine from the catheter bag. "Here are the steps for emptying your leg bag: · Empty your bag when it's 50% full. Don't wait until it's full! · Wash your hands with soap and water to help reduce the odds of contamination and infection. Try not to let the bag or openings touch any dirty surfaces like countertops or toilets. · Keep the bag below your waist or hip when you empty it. · You can either empty the bag directly into a toilet or into a plastic container your provider gives you. · Drainage bags open in different ways: a drain spout that you remove from its sleeve, a clamp that you open to the side or an opening that you twist off. Whichever method you use, be sure not to touch the spout when you let the pee out of the	N 425		

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N 425	Continued From page 55	N 425		

bag.
· If possible, clean the spout with rubbing alcohol and a cotton ball or gauze.
· When the bag is empty, close the clamp or twist the cap on the bag.
· Attach the bag to your leg again. Don't put it on the floor.
· Wash your hands with soap and water."
(Retrieved on 05/13/2026 from: https://my.clevelandclinic.org/health/articles/14832-catheter-bags)

On 04/30/2026, Surveyor reviewed Resident 8's record. Resident 8 was admitted on 07/15/2025. S/he had multiple diagnoses including: sepsis, type 2 diabetes, chronic ulcers of left heel and midfoot with fat layer exposed, obstructive and reflux uropathy, acute kidney failure, chronic kidney disease, urinary tract infections, benign prostatic hyperplasia, retention of urine, proteinuria, acquired absence of limb, and noncompliance with other medical treatment and regimen due to unspecified reason.

Resident 8's individual service plan (ISP), dated 03/25/2026, read, in part:
"Bathing - Full Assistance
Weekly [Fri] @ 2nd Shift
1 person(s) required for this task.
Provide full assistance bathing/showering. Assist with dressing and undressing, wash, shampoo and [sic] with all required physical assistance.
Resident's Need/Preferences:
Requires full assistance including physical and verbal assistance. Requires hands-on assistance with washing, shampooing and getting in and out of tub/shower.
Resident's Desired Goals & Outcomes:
Maintain personal hygiene and cleanliness with assistance from the staff.

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N 425	Continued From page 56 Service Provider Responsibilities: Staff to assist resident to get into shower, wash hair, back and clip nails after shower. Measurable Goals, Outcomes and Review: Resident will maintain good hygiene ... Toileting - Full Assistance Daily @ 1st shift, 2nd shift, NOC (overnight shift), As Needed 1 person(s) required for this task. Provide full assistance with toileting. Assist with dressing ad undressing, toileting and clean-up. *Resident is using a bedpan for BM's (bowel movements) Resident's Needs/Preferences: Requires full assistance including physical and verbal assistance with toileting needs. Hands-on assistance with undressing/dressing, washing/wiping and any physical assistance necessary. Resident's desired Goals & Outcomes: To efficiently and cleanly execute proper toileting. Service Provider Responsibilities: Staff assist resident with toileting when [s/he] wakes up in the morning, before, after meals, at night and as needed. *Resident has hourly security checks in place* **RESIDENT USING A BEDPAN FOR BMs** Measurable Goals, Outcomes and Review: Resident will have help with toileting." The ISP did not include Resident 8's urinary catheter. Resident 8's active care tasks included the following: "CATHETER CARE Instructions: Please change catheter bag from day bag to night bag." Start date - 01/19/2026. "OUTPUT	N 425		

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N 425	Continued From page 57 Instructions: Document resident's total output and color." Start date - 09/03/2025. Resident 8's task administration record (TAR) from 01/01/2026 - 04/30/2026 indicated the following: 01/02/2026- Bathing not issued reason: "Other" 01/19/2026 - Bathing was initialed as given. 01/12/2026 - Bathing was initialed as given. 01/16/2026 - Bathing not issued reason: "Other ... resident told me they were not going to get in the shower and to get out of [his/her] room" 01/23/2026 - Bathing not issued reason: "Other ... refused" 01/30/2026 - Bathing was left blank. 02/06/2026 - Bathing was left blank. 02/13/2026 - Bathing not issued reason - "Other ... resident refused." 02/20/2026 - Bathing was initialed as given. 02/27/2026 - Bathing not issued reason: "Other ... refused" 03/06/2026 - Bathing was initialed as given. 03/13/2026 - Bathing not issued reason: "Other ... refused per [Resident 8]." 03/20/2026 - Bathing not issued reason: "Other ... Did not get too [sic] due to short staff, will do tomorrow" Resident 8's bath did not get signed off as given on 03/21/2026. 03/27/2026 - Bathing not issued reason: "Other ... resident refused" 04/03/2026 - Bathing was initialed as given. 04/10/2026 - "OTH" was documented meaning not issued reason: other. 04/17/2026 - "OTH" was documented meaning not issued reason: other. 04/24/2026 - Bathing was left blank. Surveyor did not receive documentation of staff's notations for April 2026 TAR.	N 425		

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N 425	Continued From page 58 Resident 8's ISP did not indicate Resident 8 refused cares. On 01/12/2026, staff documented: "resident received shower due to being covered in bm. Bed sheets and clothing were all cleaned and changed ..." On 02/01/2026, staff documented: "Resident does not have a container to dump [his/her] catheter into. [His/her] catheter bag was unable to be emptied this morning due to this missing." On 02/03/2026 - staff documented, in part: "This staff was able to locate a 'potty hat' to be able to empty [his/her] catheter into and record [his/her] output ..." On 02/15/2026 - staff documented, in part: "[S/he] also refused to allow this staff to empty [his/her] catheter bag ..." On 02/22/2026 - staff documented, in part: "writer noticed resident catheter bag was dark red [sic] writer and other staff advised resident [s/he] should go into urgent care to get [his/her] catheter looked at ... resident said no [s/he] would rather just die writer called non-emergency they came and resident wouldn't [sic] go in ..." On 03/02/2026, Administrator A documented: "Spoke to [adult protective services (APS)] regarding some concerns we had with this resident. [S/he's] been refusing medications, cares, and medical appts (appointments). Per [APS], there is nothing APS could do due to [s/he] is [his/her] own person. We just make a noted [sic] of it." On 04/19/2026, staff documented, in part: "resident was covered in feces, open wounds on back side and severe irritation towards [his/her] abdomen causing redness to spread to [his/her] upper fold. Also when assisting writer and nurse changed [his/her] catheter bag and visibly seen brown urine and emptied approximately 3100 ml	N 425		

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N 425	Continued From page 59 (milliliters) of urine. [s/he] also received a shower from writer and nurse all necessary prescribed creams were applied on said resident and clean bedding and clothing were also applied. Please be sure to check on resident frequently even if pendant doesn't go off [s/he] needs to be checked on. As incidents like this wouldn't occur if frequency occurred from all staff." On 05/04/2026 at approximately 10:40 a.m., Surveyor interviewed Home Health Nurse Director (HHND) Q. HHND Q told Surveyor a nurse went to the facility daily to provide wound care for Resident 8. HHND Q told Surveyor, the nurses have reported Resident 8 was "unkempt" and had fecal matter on his/her feet where his/her wounds were located. The provider did not ensure staff provided personal care adequately for Resident 8. Resident 8 did not receive showers weekly and did not receive adequate indwelling urinary catheter care.	N 425		
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	N 431		

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an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.

This Rule is not met as evidenced by:
Based on record review and interview, the provider failed to monitor Resident 5's diabetic care adequately.

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

Findings include:

On 03/10/2026, the Department received a complaint alleging residents were not having their diabetic care managed appropriately.

On 04/29/2026, Surveyor reviewed Resident 5's record. Resident 5 was admitted on 03/27/2025. S/he did not have a legal representative. Resident 5 had diagnoses of type 2 diabetes and long term current use of insulin.

Resident 5's individual service plan (ISP), dated 03/28/2026, read, in part:
"Diabetic - Blood Sugar checks

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N 431	Continued From page 61 Daily @ before Breakfast, Before Lunch, Before Dinner, Bed Time [sic], As Needed ... Resident's Need/Preferences: Requires blood sugars to be taken 4x's a day (before meals and at bed time [sic].) Resident's Desired Goals & Outcomes: Resident to maintain controlled blood glucose levels Service Provider Responsibilities: Staff" On 04/29/2026 at approximately 2:15 p.m., Surveyor interviewed Paramedic V on the phone. Paramedic V said s/he responded to the facility on 03/02/2026 for an emergency service request for Resident 5's high blood sugars. S/he said they had orders for sliding scale insulin, but the staff said they were unable to give it to Resident 5. Staff wanted Resident 5 sent to the hospital for elevated blood sugars. Paramedic V said Resident 5 refused transport and Resident 5 was frustrated. Paramedic V told Surveyor the facility lacked oversight. S/he said the caregiver administering medications was in tears and appeared "defeated." Paramedic V explained to Surveyor when facilities did not manage resident care and just sent the resident to the emergency department it placed a drain on the system. The emergency department was "slammed", and the resident would have to sit for 6 hours. On 04/29/2026, Surveyor emailed Administrator A and Director B and requested additional information for Resident 5 including: insulin orders, orders for blood sugar checks, parameters for when staff should call on-call or nurse for blood sugars, Resident 5's blood sugars from 02/01/2026 to 04/29/2026, and any incident reports from 02/01/2026 to 04/29/2026.	N 431		

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On 05/04/2026, Administrator A replied via email with additional documentation. The email indicated they received a verbal order to check Resident 5's blood sugars three times a day.

The information provided in Administrator A's email was different than what Resident 5's ISP indicated.

The email contained a document with parameters for blood pressures, heart rate, respiratory rate, oxygen saturation and temperature. The document did not include blood sugar level parameters.

The email contained Resident 5's insulin orders including the following orders for Novolog insulin:
01/05/2026 - inject 4 units under skin 3 times daily before meals plus correction scale.
02/18/2026 - inject 6 units under skin 3 times daily before meals plus correction scale.
03/03/2026 - Inject 8 units under skin 3 times daily before meals plus correction scale.
04/07/2026 - Inject 10 units under skin 3 times daily before meals plus correction scale.

Resident 5's February, March, and April 2026 medication administration records (MAR) indicated Resident 5 was scheduled to receive his/her Novolog insulin at 8:00 a.m., 12:00 p.m., and 8:00 p.m. from 02/01/2026 until 04/24/2026. On 04/25/2026, the MAR was changed to reflect Resident 5 was to receive his/her Novolog insulin at 4:00 p.m., instead of 8:00 p.m.

On 05/04/2026, Surveyor reviewed Resident 5's documented blood sugar checks from 02/18/2026 - 04/29/2026.

On 02/19/2026, there was no documented blood

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sugar check before supper.
On 02/21/2026, there was no documented blood sugar check before lunch and before supper.
On 02/27/2026, there was no documented blood sugar check before supper.
On 03/13/2026, there was no documented blood sugar check at bedtime.
On 03/14/2026, there was no documented blood sugar check before supper.
On 03/15/2026, there was no documented blood sugar check at bedtime.
On 03/16/2026, there was no documented blood sugar check before supper.
On 03/18/2026, there was no documented blood sugar check before supper.
On 03/28/2026, there was no documented blood sugar check before supper.
On 03/30/2026, there was no documented blood sugar check before breakfast.
On 04/05/2026, there was no documented blood sugar check before supper.
On 04/11/2026, there was no documented blood sugar check before supper.
On 04/17/2026, there was no documented blood sugar check before lunch.
On 04/18/2026, there was no documented blood sugar check before supper.
On 04/19/2026, there was no documented blood sugar check before supper.
On 04/25/2026, there was no documented blood sugar check before supper.

On 02/08/2026 at 10:15 p.m., staff documented: "was very tired tonight. [S/he] said [s/he] was light headed. Sugar was at 437 and is going down slowly. Keep an eye on [him/her]. Check [his/her] blood pressure [sic] every 3- 4 hours."

On 02/22/2026 at 8:49 p.m. and 9:06 p.m. staff documented a blood sugar of 403.

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N 431	Continued From page 64 On 02/28/2026 at 4:26 p.m., staff documented a blood sugar of 416. An incident report, dated 02/28/2026, read, in part: "Resident has a blood sugar reading of 400+, staff called EMT (emergency medical technician) to come evaluate resident because staff observed slurred speech. EMT explained the severity of high blood sugars. Resident refused to go in. Resident received recommended insulin dosage during bedtime med (medication) pass." The report indicated the physician was not notified. The report indicated the supervisor was notified via "groupchat [sic]." On 03/02/2026 at 6:05 p.m., staff documented a blood sugar of 463. At 8:13 p.m., staff documented a blood sugar of 403. An ambulance report indicated emergency medical services were dispatched to the facility on 03/02/2026 at 6:17 p.m. for Resident 5. The report's chief complaint was high blood sugar. The report read, in part: "Facility staff reported that the patient has been having high blood sugars in the 400s for the past couple days. Facility staff reported that the patient takes insulin, but they can only give it three times a day. The last time patient has insulin was 1200 (12:00 p.m.). The patient reported that [s/he] has been thirstier than usual and been urinating more than usual ... The patient reported that [s/he] did not wish to be transported to hospital by ambulance at this time ... Medic on scene went to consult with facility staff about insulin orders. Facility staff agreed to administer insulin per standing order tonight instead of sending patient to ER (emergency room) by ambulance. Facility staff reported that they would have their lead nurse	N 431		

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contact the patient's provider tomorrow morning to have insulin orders adjusted as needed." The report indicated Resident 5's blood sugar was 419 at 6:18 p.m.

There was no documentation in Resident 5's record to indicate Resident 5's physician was notified for Resident 5's elevated blood sugars.

On 03/10/2026 at 12:08 p.m., staff documented a blood sugar of 403.

On 03/12/2026 at 11:28 a.m., staff documented a blood sugar of 403.

On 03/16/2026 at 8:56 p.m., staff documented a blood sugar of 550.

On 03/21/2026 at 10:26 p.m., staff documented a blood sugar of 483.

On 03/21/2026, staff documented an observation note, that read: "resident bloodsugar [sic] is at 483. [S/he's] [his/her] own poa (power of attorney), called [spouse] and [s/he] said, just keep checking [his/her] sugar because [s/he] wont [sic] go in. resident [sic] said [s/he] doesn't [sic] want to go in either. Check on resident to make sure Bloodsugar [sic] goes down."

On 04/10/2026 at 4:00 p.m. staff documented a blood sugar of 64.

On 04/11/2026 at 8:00 p.m., staff documented a blood sugar of 400.

On 04/14/2026 at 11:32 a.m., staff documented a blood sugar of 400.

On 04/16/2026 at 11:32 a.m., staff documented a

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N 431	Continued From page 66 blood sugar of 400. On 04/23/2026 at 1:15 p.m., Registered Nurse (RN) K documented: "Blood sugar at 115 [sic] was 238. Given 16 units of insulin per sliding scale and scheduled orders. BS (blood sugar) dropped to 40, then 48 at 122pm. Ate 100% of lunch and two glasses of orange juice. At 1:18pm BS 130." There was no documentation in Resident 5's record to indicate Resident 5's physician was notified when Resident 5's blood sugars were 400 or more or when they dropped to 64 and 40. From 05/11/2026 at 10:00 a.m. until 12:15 p.m., Surveyor interviewed Administrator A, Director B and Administrator Assistant (AA) N. Surveyor asked when staff were to call the nurse or on-call for blood sugars. Administrator A said s/he thought s/he emailed that. Surveyor explained the sheet s/he emailed had vital sign parameters but did not have blood sugar parameters. Surveyor asked what they did when Resident 5's blood sugars would hit 400 and higher. Administrator A said they tried to send him/her to the ER, but Resident 5 refused to go. Surveyor asked if Resident 5's physician was notified of his/her blood sugar readings when they would get that high. Administrator A said they were communicating with Resident 5's physician. Surveyor explained that was not documented in Resident 5's record. Administrator A said the communication was probably through email and not documented in the observation notes. Administrator A told Surveyor if a resident's blood sugar was 400 or over, staff would call EMS. Director B said they did have a parameter for Resident 5's blood sugar. Director B said it was in their electronic record system. Surveyor	N 431		

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requested documentation on that. Surveyor reviewed the ambulance report from 03/02/2026 for Resident 5, which was not documented in Resident 5's chart. Administrator A said if staff called EMS they should document an incident report. Surveyor explained Administrator A did not email an incident report for EMS being called to the facility on 03/02/2026. Administrator A said s/he would look into that. Surveyor asked for clarification on how often staff were supposed to be checking Resident 5's blood sugars. Administrator A said, "I don't think we have an order." Administrator A said they checked the blood sugar 3 times a day when Resident 5 received his/her insulin.

On 05/11/2026, Administrator A emailed Surveyor, which read, in part: "Attached is email communication regarding [Resident 5's] blood sugar started end of March. Per [Clinic RN] at [Clinic Name], there is no blood sugar parameter for [Resident 5]. We just know that it is not good if [his/her] blood sugar reached [sic] 400 or higher and to call. Regarding, the EMS called on 3/2/26. This individual is employee [name] is no longer employed here. Staff was supposed to notify management and completed [sic] an incident report. We were not notified of this incident that's why we couldn't follow up on getting this employee to completed [sic] the incident report at the time."

The email included an attached email between the clinic RN and Resident 5's care team, which included Administrator A, Director B, RN I, and Care Coordinator (CC) H. The email was initiated by the clinic RN on 03/31/2026. The email from the clinic RN to Resident 5's care team read, in part: "[Administrator A], have you been able to take [Resident 5's] CGM (continuous glucose

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meter) reader to be downloaded at the pharmacy in Holmen. If you are able or have please let me or the Endocrinology dept (department) know ... so they can access it from the cloud and review the numbers. I also requested [his/her] blood sugars to be faxed to me in the interim by [AA N] ... until we can have [his/her] reader downloaded. Just to make sure this isn't contributing to [his/her] 'dizziness.' I haven't received them yet though ..."

The email included an attached document that Resident 5 signed on 03/02/2026 refusing transport by ambulance. The form included instructions and read, "OTHER SPECIFIC INSTRUCTIONS TO PATIENT: Spoke w/ (with) [name] RCA (resident care assistant) will follow up w/ RN & primary tomorrow to get insulin orders adjusted. Pt. (patient) refused transport."

The provider failed to monitor Resident 5's diabetic care by the following:
The provider did not have orders on how often staff should check Resident 5's blood sugars.
The provider did not have instructions for staff to follow when Resident 5's blood sugars were 400 or greater or when his/blood sugar dropped to 64 and 40.
The provider did not ensure Resident 5's insulin orders were entered correctly onto the medication administration record and Resident 5 did not receive insulin at the correct time.
The provider did not document communication of notification in Resident 5's record when his/her insulin reached 400 or higher.
The provider did not ensure all incidents were documented in Resident 5's record.

Cross References:
N0352 DHS 83.32(3)(h) Rights of Residents:

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N 431	Continued From page 69 Receive Medication N0410 DHS 83.37(1)(k) Medication Error Or Adverse Reaction	N 431		
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, record review and interview, the provider did not ensure the living environment for Resident 8 was safe, clean, comfortable, and homelike. This is a repeat deficiency. See Statment of Deficiency (SOD) J0PF11, dated 10/06/2023 and SOD J0PF14, dated 05/07/2025. Findings include: On 03/06/2026 and 04/13/2026, the Department received complaints alleging residents' rooms were not being cleaned. On 04/28/2026 at 11:24 p.m., Surveyor observed Resident 8 in his/her room lying in bed. There was a plate tipped upside down on the floor near the head of Resident 8's bed. There was a garbage can half full with no garbage bag inside the can. Resident 8's catheter bag was hanging on the edge of the garbage can. While Surveyor was in Resident 8's room, Caregiver O came into	N 481		

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the room to check Resident 8's blood sugar and Caregiver P came in the room to empty Resident 8's catheter.

On 04/28/2026 at 2:50 p.m., Surveyor observed Resident 8 in his/her room. The plate was picked up off the floor, but the food that spilled off the plate remained on the floor along with silverware. There was a dirty plate and cup on the bedside table. The garbage can remained half full with no garbage bag. Resident 8's catheter remained hanging on the garbage can. (Photo 1).

On 05/04/2026 at approximately 10:40 a.m., Surveyor interviewed Home Health Nurse Director (HHND) Q. HHND Q told Surveyor that nurses go to the facility daily to provide wound care for Resident 8. HHND Q said the nurses have reported Resident 8's room was not clean, there had been food dumped on the floor and Resident 8 was unkempt.

On 05/05/2026, Surveyor reviewed Resident 8's active care tasks, which included the following:
"Housekeeping - Assist
Instructions: Provide assistance with upkeep of room. Assist with all room care needs and all required physical assistance.
Status; Requires assistance with housekeeping needs."

On 05/11/2026 from 10:00 a.m. until 12:15 p.m., Surveyor interviewed Administrator A, Director B, and Administrator Assistant N. Surveyor explained observations of Resident 8's room. Administrator A told Surveyor, Resident 8 was a "messy person." Administrator A said it was not just the housekeeper's job to keep residents' rooms clean. S/he said staff needed to be picking up residents' rooms if they saw it was messy.

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N 481	Continued From page 71 The provider did not ensure the living environment for Resident 8 was safe, clean, comfortable, and homelike.	N 481		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents reviewed (Resident 7 and Resident 8), that had wounds, received adequate and appropriate care to prevent wounds and promote healing once wounds developed. Findings include: On 03/10/2026 and 03/18/2026, the Department	Y3244		

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received complaints alleging wound care was not being completed.

RESIDENT 8
On 04/28/2026 at 11:24 a.m., Surveyor observed Resident 8 in his/her room. Resident 8 was in bed. His/her left foot appeared dry and scaley. The left heel was resting directly on the bed and there was a bandage across the shin of Resident 8's left leg. Resident 8's right leg was amputated above the foot. There was a small wound (approximately 2 millimeters round) above the amputated area. Caregiver O was present during that observation. Surveyor asked Caregiver O if they provided any wound care for Resident 8. Caregiver O said, "No." S/he said an agency came in for wound care. Caregiver O said they did put zinc on the right leg and nystatin in his/her abdominal folds.

On 04/28/2026 at 11:55 a.m., Surveyor interviewed Registered Nurse (RN) K. Surveyor asked what wound care was provided to the residents who had wounds, including Resident 8. RN K told Surveyor, "We don't do wound care." S/he said home health came to the facility to do wound care. Surveyor asked about documentation of the residents' wounds. RN K said home health did the wound assessments. Surveyor asked RN K if they did not document the wounds, how would they know if there were any changes that would require notifications. RN K then said they did health monitoring of the wounds.

On 04/28/2026 at approximately 1:15 p.m., Surveyor interviewed Administrator A. Surveyor asked when staff documented on residents' skin. Administrator A said staff were to assess residents' skin on their bath days. Administrator A

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said if staff noticed anything different, they were to document that in the electronic record and complete a skin sheet that would go to Administrator A and the nurse.

On 04/30/2026, Surveyor reviewed Resident 8's record.

Resident 8 was admitted on 07/15/2025. S/he did not have a legal representative. S/he had multiple diagnoses that placed him/her at risk for skin breakdown including: sepsis, type 2 diabetes with polyneuropathy, type 2 diabetes with foot ulcer, morbid obesity, chronic pain, phantom limb syndrome with pain, congestive heart failure, atherosclerosis of native arteries of left leg with ulceration of heel and midfoot, lymphedema, non-pressure chronic ulcer of left heel and midfoot with fat layer exposed, muscle weakness, acquired absence of limb, patient's noncompliance with other medical treatment and regimen due to unspecified reason.

Resident 8's individual service plan (ISP), dated 03/25/2026, did not indicate Resident 8 had a history of wounds, risk for developing wounds, or any current wounds.

From 01/01/2026 until 04/30/2026, staff documented the following observation notes related to Resident 8's skin:

On 01/23/2026, (RN) I documented, in part: "[Home health nurse] comes to RN office to report that resident is refusing to sign any and all paperwork for [him/her] and that because [s/he] no longer has a PCP (primary care provider) [home health] wound cares must be discontinued at this time ... [home health nurse] states that resident does have an open wound to [his/her]

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Y3244	Continued From page 74 LLE (left lower extremity) at this time ..." The next documentation on Resident 8's skin was on 03/02/2026 - "Resident's sore on [his/her] right foot is very open and exposed. [S/he] continues to try to scratch and pick at it. [S/he] asked for a cream to put on it. Med (medication) passer was notified, but the cream [s/he] is referring to cannot be located. Will continue to monitor." On 03/11/2026, staff documented: "Resident has a significant wound festering on [his/her] left lower leg. [S/he] has open blisters and ulcer like sore on [his/her] leg. Resident said at one point [his/her] leg was wrapped and covered, but [s/he] took the bandages off. [S/he] had zinc cream [s/he] was using that [s/he] felt was helping but has run out of supply in [his/her] room and feels that is what has caused [his/her] wound issues. Resident's left lower leg up to [his/her] mid-thigh appears to be swollen. Resident complains of a lot of pain. On the left shin it is purple/pink in color and looks to be 'fluidy' as well as having open sore and blisters seeping down [his/her] leg. There is one blister that has yet to pop but is rather large in size. Resident's right foot also had an open sore on the top of the ankle. It too is very open, but less drainage and just painful. Resident doesn't feel heard about [his/her] pain and feels at a loss on who to ask for help. Will continue to monitor." On 03/11/2026, staff documented an incident report that read, in part: "Resident had blood dripping from [his/her] left foot and requested to go into the hospital." An after visit summary, dated 03/11/2026, from the emergency department indicated the following diagnoses:	Y3244		

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Y3244	Continued From page 75 Wound Lower Leg Open Subsequent Right Wound Lower Leg Open Subsequent Left Wound Foot Open Subsequent Left "Instructions A referral/order with wound care has been placed in case more frequent wound cares are necessary and patient is in agreement to receive these cares. Encourage possible communication with the patient 1 day prior to anticipated appointments to help facilitate receiving of such care versus reported consistent refusal, which patient states that is due to [him/her] not being aware of these appointments and feeling rushed. Return to the emergency department for signs of infection including fevers or chills, change in mental status, purulent drainage." On 03/19/2026, a physician visit form indicated Resident 8 had a wound care visit. The report indicated the following: "Reason for Visit: Wound care Physician Findings: Moderate amount of drainage to LLE (left lower extremity). Return to wound clinic in 1 month ... Physician's Recommendations: Daily dressing change to LLE. Cleanse with soap and water. Dry well. Apply Hydraguard or moisture barrier equivalent to intact skin. Apply Aquacel to open wounds. Cover with ABD pads. Secure with Kerlix roll gauze. Wear tubigrip for edema management. 3 times a week dressing change to RLE (right lower extremity) shin. Cleanse with soap and water. Dry. Aquacel to wound. Cover with Mepilex border." An email, dated 03/19/2026, from Administrator Assistant (AA) N to Resident 8's managed care team, read: "Attached is the physician order from [sic] [Resident 8] indicating the need for wound	Y3244		

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care. Could we please proceed with obtaining a referral and arranging in-house wound care services for [him/her]? Please note Hope Stay does not provide wound care."

On 03/22/2026, staff documented: "[Resident 8] is cutting the bandages off [his/her] ankles and it stinks really bad ..."

On 03/27/2026, staff documented a "Skin Monitoring: Comprehensive CNA (certified Nurse assistant) Shower Review" sheet for Resident 8. Staff documented multiple areas of subnormal looking skin on both lower extremities and abdominal area. That was the only skin monitoring sheet Surveyor received from Administrator A when Surveyor requested all skin documentation.

On 04/19/2026, staff documented: "Yesterday, April 19th a Nurse [sic] came to check on residents [sic] wounds and asked for assistance which writer and another RCA (resident care assistant) helped assist the nurse. As further assistance happened nurse, writer and other RCA visibly saw resident was covered in feces, open wounds on back side and severe irritation towards [his/her] abdomen causing redness to spread to [his/her] upper fold ..."

On 04/20/2026, RN K documented: "Yeasty areas underneath pannus (abdominal fold) is well improved this morning. Area cleansed and nystatin cream have been applied. Viva paper towel daily tucked in pannus would be great."

On 05/04/2026 at approximately 10:40 a.m., Surveyor interviewed Home Health Nurse Director (HHND) Q. HHND Q told Surveyor a nurse was providing wound care for Resident 8

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Y3244	Continued From page 77	Y3244		

on a daily basis. HHND Q said Resident 8's wounds to the lower extremity were diabetic/vascular ulcers. HHND Q said the nurses had reported Resident 8 was unkempt at times with fecal matter on his/her foot. HHND Q told Surveyor s/he was concerned Resident 8 refused his/her appointments. S/he said if Resident 8 did not go to his/her doctor's appointment the home health agency would not be able to continue to provide wound care without orders and supplies. HHND Q said s/he did not know if staff were explaining the importance of Resident 8 going to his/her appointments or if they just let Resident 8 refuse.

There was no documentation in Resident 8's record to indicate when the home health agency started to provide wound care for Resident 8.

On 05/11/2026 from 10:00 a.m. until 12:15 p.m., Surveyor interviewed Administrator A, Director B, and AA N. Surveyor asked about Resident 8's wounds. Administrator A said Resident 8 had wounds on his/her heel and his/her amputated leg. Surveyor asked what interventions they provided for Resident 8 to promote healing of his/her wounds. Administrator A said they documented the wounds, contacted the care team to get a wound agency to come in and take care of the wound. Administrator A said Resident 8 refused appointments often, so they did not always have primary care physician for Resident 8 to contact regarding changes in his/her skin. Surveyor explained concerns that Resident 8's wounds were not identified in his/her ISP with interventions to promote healing. Director B said there was only so much the team could do if Resident 8 did not have orders. Surveyor explained concerns that documentation did not include who was notified each time staff

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Y3244	Continued From page 78 documented a change in Resident 8's skin. RESIDENT 7 From 04/29/2026 to 05/05/2026, Surveyor reviewed Resident 7's record, including records obtained from Resident 7's medical providers. Resident 7 was admitted on 12/11/2025 and had a legal representative. Resident 7 had multiple diagnoses that placed him/her at risk for skin breakdown including: type 2 diabetes with polyneuropathy, morbid obesity, chronic peripheral venous insufficiency, lymphedema, weakness, acquired absence of other left toe(s), presence of artificial skin, and unspecified intellectual disabilities. Resident 7's ISP, dated 02/09/2026, indicated Resident 7 had a short term illness. The ISP read, in part: "Provide assistance as directed to care for/manage short term illness. Monitor and contact appropriate provider with changes, questions or concerns. Resident's Needs/Preferences: Has a short term illness that requires proper treatment/management. Staff assistance as directed by provider. Resident's Desired Goals & Outcomes: To properly monitor, manage and cure short term illnesses. Service Provider Responsibilities: Staff Reposition Pillow every 2 hours: Reposition a pillow under resident's buttocks every 2 hours. EX: (example) Place pillow under RIGHT buttocks, at 2-security check, Remove pillow from right buttock and place under LEFT buttocks etc. (et cetera)." The ISP did not indicate what the short term illness was. The ISP did not indicate Resident 7's	Y3244		

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risk for skin breakdown or if s/he had any current wounds or history of wounds.

The "Service Plan Task" sheet indicated the task for Resident 7's repositioning was started on 02/09/2026.

On 01/01/2026, staff documented: "resident has open wound on coccyx. (top left)"

There was no documentation to indicate legal guardian or physician was notified. There was no description of the open wound.

On 01/09/2026, Registered Nurse (RN) I documented: "Call placed to PCP (primary care provider) office requesting Rx (prescription) for nystatin powder to be sent to [pharmacy] for resident. Per staff report resident has some skin breakdown under [his/her] [chest]."

RN I did not document on the previous note of open wound to Resident 7's coccyx.

An office visit note, by Medical Doctor (MD) R, indicated Resident 7 was seen in the medical clinic on 01/21/2026, by MD R for an evaluation for a bariatric lift chair. MD R documented a note, which read, in part: "[S/he] sleeps in [his/her] recliner. During the day [s/he] elevates [his/her] feet to try to control [his/her] chronic edema. [His/her] prior foot ulcerations have healed. Denies new sores or weeping from legs. [S/he] feels [his/her] swelling is well controlled. States [s/he] wears [his/her] stockings most of the time. Is not wearing them today."

On 01/27/2026, staff documented: "resident refused shower [sic] reason was because open sore on the back of [his/her] leg was bleeding and

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Y3244	Continued From page 80 [s/he] says it hurts." On 01/28/2026, staff documented: "staff noticed when changing resident [s/he] has a sore on the inside of [his/her] thigh." On 02/01/2026, staff documented: "Resident has 3 skin tears on [his/her] mid-inner thigh. They are wide open and bleeding. Gauze and a bandage was applied to the area and it was taped up and covered. Resident did say it has hurt [him/her] for a few days. This staff reminded resident to make sure to let us know when something hurts or it is difficult to know when things hurt if not told. Will continue to monitor." The staff notes above from 01/27/2026, 01/28/2026, and 02/01/2026, did not indicate if staff notified Resident 7's guardian or physician with changes in his/her skin. An office visit note, by Nurse Practitioner (NP) S, indicated Resident 7 was seen in the medical clinic on 02/04/2026, by NP S. NP S documented, in part: "[Resident 7] is seen today for an acute concern as requested by Hope Stay assisted living home staff. [S/he] has had sores on [his/her] bottom, for what patients [sic] says has been present for a long time. The facility is interested in care instructions or wound clinic referral. Denies any fevers. [S/he] is mostly wheelchair bound, [s/he] does get up with a walker at least daily. Does have some soreness of [his/her] buttock ... With two person assistance and a walker, [s/he] was able to pivot into [sic] the exam table. [S/he] is a poor historian. Skin: right inner thigh with pressure sore stage 2, area is blanchable. Right buttock with a small pressure sore stage 1. Left inner buttock with a smaller stage 2 pressure sore." The assessment and	Y3244		

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plan included the following for Resident 7's stage 2 pressure injury of right thigh: "Area is cleansed and dressing placed by RN. Until this patient is able to be seen by a wound care RN recommendations are for every 3 day dressing changes with normal saline wash, then apply Aquacel dressing followed by duoderm. - Wound Care Referral."

There was no observation note in Resident 7's record about that appointment.

An email, dated 02/06/2026, from Care Coordinator (CC) H to Resident 7's care team read, in part: "Attached is a physician's report form for [Resident 7] for appointment visit on 2.4.26. As you can see the doctor sent a referral to Wound Clinic. [His/her] appointment is set up on 2/10/26 @3:25pm. [S/he] may need in-home wound care-just a heads up. Right now, I have a treatment in the med (medication) pass per instructed on the physician's form. As you know if wound care is ordered we do not perform this at Hope Stay ..."

Resident 7's "Service Plan Task" form indicated the following treatment was added on 02/06/2026: "Wound dressing Change Instructions: Change dressing every 3 days. 1. Cleanse with saline. 2. Apply Aquaphor 3. Cover with miraplex [sic] *wound care referral sent to wound clinic 2/4/26"

The wound care orders on the task sheet were different than the orders from the clinic office. Aquacel was a silver type dressing that killed bacteria in a wound. Aquaphor was a lotion or skin protectant ointment. Duoderm was a hydrocolloid (absorbent) dressing used to promote healing in pressure injuries. Miraplex

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Y3244	Continued From page 82 may have meant Mepilex is a foam dressing. Resident 7's task administration record (TAR) did not indicate the wound care was completed by staff. On 02/06/2026, Resident 7 was sent to the emergency department for urinary tract infection symptoms. An emergency department note, dated 02/06/2026, indicated Resident 7 was seen in the emergency department for: "Wound Check/Recheck and Urinary Pain." The note read, in part: "Various stage I-II pressure ulcers noted on the anterior thighs and buttocks, photos placed in media tab." An incident report, dated 02/08/2026, indicated on 02/08/2026, Resident 7 fell while staff was ambulating Resident 7 to the bathroom. Emergency medical services were called. Resident 7 went to the emergency department. An after visit summary from the emergency department, dated 02/08/2026, indicated Resident 7 and was diagnosed with lumbar transverse process fractures. An office visit note, dated 02/09/2026, by Doctor of Osteopathic (DO) Z, indicated Resident 7 was seen at the medical clinic by DO Z to follow-up from his/her fall with fracture. DO Z documented, in part: "Discussed care with guardian and patient. I do feel [s/he] is more appropriate for SNF (skilled nursing facility) care based on co-morbidities, wound care needed and ongoing fall risk." The note indicated the wounds were not evaluated. An office visit note, dated 02/10/2026, by NP T, inidcated Resident 7 was seen at the wound clinic on 02/10/2026 for wound evaluation and	Y3244		

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management. NP T documented, in part:
"1. Pressure ulcer of upper thigh, right, stage III - first assessment. [Resident 7's] intellectual disability impairs [his/her] ability to self-advocate. [S/he] requires an increased level of care due to multiple wounds and persistent saturated urinary briefs which has contributed to right thigh and buttock wounds. Has a blood blister on right heel wound that required nursing home admission and skin substitute grafts for healing. If blood blister progresses, this will result in new ulceration. The current assisted living facility is not adequately meeting [his/her] care needs. Nursing staff to reach out to [managed care organization] to verbalize these concerns.
2. Pressure injury of buttock, stage 2, unspecified laterality - first assessment
3. Lymphedema - stable. NEEDS TO HAVE FARROW WRAPS (compression wraps) ON DURING DAY TIME NOT JUST UNDER LINER
4. Diabetic ulcer of right heel associated with type 2 diabetes mellitus, with fat layer exposed - recurrent. Blood blister present today. Area will be padded with Mepilex and assisted living facility instructed to elevate legs frequently to alleviate pressure from heel along with minimize time spent in seated, dependent position with extra pressure to right heel ...

PLAN:
1. Start zinc oxide cream as primary dressing to right buttock, left buttock, and and [sic] right thigh once daily.
2. Viva paper towel used for secondary dressing.
3. Zinc and viva [sic] to be changed daily and more frequently if saturated or soiled.
4. Start mepilex [sic] boarder dressing as primary dressing to right dorsal foot callous and right heel blister.
5. Change dressing twice weekly.

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Y3244	Continued From page 84 6. Consult placed to social services for home health to assist with dressing changes. 7. Assisted living facility instructed to change depends [sic] brief 3 times per day for incontinence. 8. Assisted living facility instructed to apply farrow wraps to right and left leg daily for lymphedema. 9. Assisted living facility instructed to not wear shoes on feet when NOT ambulating. 10. [S/he] needs to be in recliner chair elevating legs and offloading pressure from heel wound. 11. Follow up in wound center in 1 month for reevaluation. Subjective HISTORY OF PRESENT ILLNESS: [Resident 7] returns in follow-up for wound care evaluation and management. The wound(s) is/are located on the right medial thigh, right and left buttock, and right heel. Difficult to obtain history due to patient intellectual disability. [S/he] does not know how long wounds have been present. Assisted living paper work is sparse for information. been [sic] present for unknown amount of time. [Resident 7] was last seen in wound center in November 2025. Prior right heel wound required multiple Grafix PL prime (skin substitute) and nursing home admission for healing purposes. Wound was healed and then the patient transition [sic] back into [his/her] group home/assisted living Hope Stay. Unclear what assisted living facility is using for treatment of wounds. Has brown stock paper towel under abdominal folds. Patient reports siting [sic] in [his/her] wheelchair all day long. Sleeps in recliner chair at night. Ambulates with walker to bathroom per report but also required hoyer [sic] (mechanical lift) lift today for transfer. Incontinence brief is saturated with urine. No dressings on buttock, or thigh wound. Has	Y3244		

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diabetic shoes on and undergarment for farrow wraps ... Important comorbidities that contribute to the onset and persistence of wound include cognitive impairment, type 2 diabetes with diabetic polyneuropathy, lymphedema, venous stasis, CKD stage III (chronic kidney disease stage 3), amputation of right toes, impaired mobility and inadequate hygiene/care at assisted ling facility ..."

The provider did not document the orders from Resident 7's wound care visit into Resident 7's notes, ISP, medication administration record, or his/her task administration record.

On 02/12/2026, staff documented an incident report for change in condition for Resident 7. The report read, in part: "During routine care, staff observed active bleeding from a wound located on the resident's buttocks. The area was assessed, and bleeding was noted to be ongoing. Due to the change in condition and concern for further evaluation and treatment, staff notified the appropriate on-call personnel and arranged for the resident to be sent to the emergency room. Resident was transported without incident."

On 02/13/2026, Administrator A documented: "[Hospital RN] called and gave us an updated [sic] that resident will be going to a skilled nursing home until [his/her] wound is healed ..."

On 05/05/2026 at 11:20 a.m., Surveyor interviewed Guardian U. Guardian U was Resident 7's legal representative. Guardian U said Resident 7 was diabetic and prone to skin breakdown. S/he said Resident 7 previously resided at Hope Stay Memory Care, but s/he had problems with wound care and went to a skilled nursing facility for approximately 1 year. Guardian

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U said when Resident 7 returned to Hope Stay Memory Care, s/he went "south really fast." Guardian U said Resident 7 resided there for approximately 1 and ½ months. S/he said they were without a nurse for a while, which "exacerbated" things.

On 05/11/2026 from 10:00 a.m. until 12:15 p.m., Surveyor interviewed Administrator A, Director B, and AA N. Surveyor asked if Resident 7 had wounds when s/he resided at the facility previously. Administrator A told Surveyor, "Yes, I think it's [his/her] foot or heel." Surveyor asked what interventions they put into place to prevent Resident 7 from having wounds when s/he returned to the facility. Administrator A told Surveyor that Resident 7 did not have any wounds when Resident 7 returned to the facility. Administrator A said, AA N and RN I did Resident 7's assessment and Resident 7 did not have any skin issues, so they readmitted Resident 7. Administrator A told Surveyor they monitored Resident 7 for skin breakdown and when s/he had skin breakdown they contacted Resident 7's care team to get home health to come in to do wound care. Administrator A told Surveyor, "We don't do wound care." Administrator A said they could put a cream on and monitor the wound, if it were to get worse or infected, they would send the resident out. Surveyor asked what their procedure was when staff identified a wound on a resident. Administrator A told Surveyor, staff would fill out a skin assessment form, which would go to the nurse. Administrator A said if they could not take care of it, they sent the resident out and contacted the resident's care team if the resident required wound care. Director B said the managed care organization contacts the wound care agency and they see how fast they can get the agency to come in, "that's on them." Surveyor

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Y3244	Continued From page 87 asked about documentation in Resident 7's record regarding changes in his/her skin as it was not clear if and when staff notified Resident 7's guardian, care team, and doctor with changes. Director B said CC H was communicating with Resident 7's care team via email. Surveyor explained documentation of communication should be in Resident 7's record. Surveyor asked who was responsible for updating a resident's ISP when a wound was discovered. Director B told Surveyor the care coordinator, who was CC H, was responsible for updating the ISPs. Director B told Surveyor they could not implement interventions unless the doctor ordered them. Director B stated cream would be an example of an intervention. The provider failed to provide adequate and appropriate care for Resident 7 and Resident 8. Resident 7 and Resident 8 had comorbidities that placed them at risk for skin breakdown, including previous wounds. The provider did not develop and implement an ISP to prevent skin breakdown. Resident 7 and Resident 8 developed wounds. There was no documentation to indicate the provider immediately notified Resident 7's and Resident 8's physicians and care teams when staff first documented changes in their skin. The provider failed to ensure Resident 7's wound care orders were implemented. Resident 7 developed various pressure injuries to his/her buttocks and thighs along with a blood blister on his/her heel where s/he previously had skin grafts of artificial skin to heal a wound. Resident 8 developed various diabetic and vascular ulcers to his/her lower extremities. Cross Reference N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	Y3244		

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