STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525642	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hope Health and Rehab	438 Ashford Ave. Lomira, WI 53048

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility did not maintain a safe and sanitary environment in which food is prepared, stored, and distributed. This has the potential to affect all 32 residents who reside in the facility. Surveyor observed [NAME] E use the same dirty alcohol wipe to sanitize a thermometer while testing the temperature of several foods. Surveyor observed DA D (Dietary Aide) washing dirty dishes causing his clothing to get wet and then Surveyor observed DA D carrying clean dishes up against his dirty/wet clothing to put them away. Surveyor also observed DA D to not wash his hands after cleaning dirty dishes and before putting away clean dishes. Surveyor observed food in the resident refrigerator to be undated and unlabeled. Staff were unsure of when the food was placed in the refrigerator. Evidenced by: Example 1: Facility policy, titled Food Service Department, dated 2/18/18, does not include to cover clothing when spraying food debris off dirty dishes and then remove the cover when handling clean dishes. It also does not include to wash hands after working with dirty dishes and before working with clean dishes. On 6/18/26 at 9:01 AM, Surveyor observed DA D (Dietary Aide) spray food debris off plates spattering his clothing. Surveyor observed DA D touch dirty pans and then organize clean dishes that just came out of the dishwasher without washing his hands (after handling dirty dishware and before handling clean dishware). DA D indicated his clothing does get wet at times when he is spraying food debris off dirty dishware. Surveyor shared observation with DA D. DA D indicated he should wash his hands with soap after handling dirty dishes and before handling clean dishes. DA D indicated clean dishware has the potential to touch his clothing when he is carrying them. DA D also indicated he should wear some kind of cover over his clothing while spraying dirty dishware, but he has never have been told to. DA D stated, There is potential for the dirty water on my shirt to come in contact with the clean dishes. On 6/18/26 at 11:43 AM DM C (Dietary Manager) indicated she does have plastic aprons available for staff to use while washing dishes.On 6/18/26 at 12:09 PM NHA A (Nursing Home Administrator) indicated staff should cover clothing while spraying food debris off plates and should remove the clothing cover before handling clean dishware or prepping food. Example 2Facility policy, titled Meal Service Palatability Food Temp Policy and Procedure, undated, does not include procedures for temping the food including to sanitize the thermometer with a fresh alcohol swab and allowing it to air dry prior to temping food. On 6/18/26 at 11:42 AM [NAME] E used an alcohol swab to sanitize her thermometer. Then she used the thermometer to probe soup. After getting a temperature reading of the soup, [NAME] E used the same alcohol swab to sanitize her thermometer. Then she used the thermometer to temp mashed potatoes.Cook E used the same alcohol swab to sanitize the thermometer a third time. Then she used the thermometer to get a temperature reading of mechanical soft chicken.Surveyor shared observation with [NAME] E. [NAME] E indicated she used the alcohol wipe to sanitize a dirty thermometer and then used it again to sanitize a dirty thermometer and then used it again to sanitize a dirty thermometer. [NAME] E stated, I should use a new alcohol wipe each time I sanitize the thermometer. On 6/18/26 at 11:43 AM DM C stated, She is not a wasteful person, but she should use a new alcohol swab each time. On 6/18/26 at 12:09 PM NHA A indicated staff should not use a dirty alcohol wipe to sanitize a thermometer before probing food. Example 3Facility (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	policy, titled Use and Storage of Foods, updated 6/16/26, includes: Food or beverage that is brought in from the outside will be monitored by nursing staff for spoilage, contamination, and safety.On 6/16/26 at 8:51 AM Surveyor observed a chocolate and vanilla ice cream to be in the resident freezer without being in a sealed packaging and without a label or date on it. Surveyor observed the following in the resident refrigerator without a label or date on it: a container with pizza, a Styrofoam container of fried meat and French fries, and a Ziplock bag of sliced sausage and cheese.On 06/18/26 at 11:43 AM DM C indicated staff are responsible for sealing, labeling, and dating resident food items that are brought into the facility.On 6/18/26 at 12:09 PM NHA A indicated staff are responsible for sealing, labeling, and dating resident food items that are brought into the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made to the State Agency, this affected 1 of 18 residents (R18). R18 voiced concern on 2/10/26 that CNA F (Certified Nursing Assistant) was rough with her, this was not reported to the State Agency. R18 voiced concern on 2/21/26 that Agency CNA H was rough with her, this was not reported to the State Agency. This is evidenced by: The Facilities Policy and Procedure entitled Abuse Prevention, Investigation, and Reporting Policy dated 2/16/26, documents in part: .Allegations, suspicions, observations, or reports of misconduct will be taken seriously, addressed immediately, thoroughly investigated, and reported in accordance with federal and state law .Reporting Requirements, In accordance with federal regulation, the Administrator or designee will report allegations of abuse, neglect, exploitation, misappropriation of resident property, involuntary seclusion, or injuries of unknown source to the Wisconsin Division of Quality Assurance (DQA). If the allegation involves abuse or results in serious bodily injury, the report will be made within two (2) hours of the facility becoming aware of the allegation . R18 is a long-term resident of the facility. R18's most recent MDS (minimum data set) dated 5/26/26, documents a score of 11 for her BIMS Brief Interview of Mental Status), which indicates R18 is moderately impaired cognitively. R18 has the following diagnoses: multiple sclerosis, alcohol dependence, Wernicke's encephalopathy (brain injury caused by a severe deficiency of thiamine (vitamin B1), people who drink a lot of alcohol may not get enough thiamine), anxiety disorder, depression, and personal history of transient ischemia attack (TIA- mini-stroke). R18 admitted to this facility in October of 2025. Example 1 Facilities investigation notes document in part:On 2/10/26 at 12:30 PM, NHA A (Nursing Home Administrator) was notified that R18 reported an incident involving a CNA (Certified Nursing Assistant) giving cares early morning 2/10/26. R18 alleged that CNA F had been rough when inserting a bedpan under R18, and that when R18 called out Ow! You're hurting me, that CNA did not stop what she was doing and told R18 just pull harder (on the enabler bar) so I can slide this under .R18 reported to NHA A an alleged incident occurred early morning of 2/10/26 during care given by CNA F. R18 alleges that around 5:30 AM CNA F came into her room to respond to her call light. R18 requested to use the bedpan (states that this is her preference throughout the night as opposed to using the toilet). States that CNA F did help position the bedpan, but was very rough during the process and not responsive to R18's exclamations of pain. R18 claims CNA F was jamming the bedpan into her backside, and that when she called out that the aide was hurting her the aide's response was to forcefully tell R18 that she needed to pull harder on the bed railing to make enough space to slide the bedpan underneath. R18 states that in the end CNA F did position the bedpan under her and she was able to use it appropriately. R18 denies any pain or injury from the interaction .It is important to note that the Facilities notes from this incident do not clarify whether or not R18 felt this was abuse nor is it documented whether or not R18 felt safe following this incident. Example 2 Facilities investigation notes document in part:On 2/21/26 at 12:50 PM, NHA A (Nursing Home Administrator) notified @ 12:50 PM by RN G (Registered Nurse) that R18 alleges that there was an incident involving a CNA giving cares early morning 2/21/26. R18 alleged that Agency CNA H had been rough when inserting a bedpan under the R18. R18 alleged that Agency CNA H had pushed her into the wall when rolling to place bed pan, bashing her foot against the wall and causing R18 to scream in pain .Due to previous investigation results, all CNA interactions with R18 occur with buddy system .NHA A re-interviewed all residents from RN G's list on 2/23/24 and they confirmed all statements forwarded from RN G. NHA A also informed R18 that Agency CNA H would no longer be working at the facility (unrelated to investigation) and R18 stated that she feels safe with facility aides . [SIC]On 6/17/26 at 10:22 AM, Surveyor interviewed R18. Surveyor asked (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18 if she could tell us a little bit about the incidents with the CNA's that she had reported. R18 explained that Agency CNA H shoved her over in bed, she had RLE (right lower extremity) boot on from breaking her toes and ankle, bashing my leg into wood by window (R18 was pointing to wood framing around windows), R18 said she was crying, it (RLE) was throbbing, Agency CNA H screamed shut up, stop being a baby, quit being a wuss, R18 said I buried my face in the pillow so she wouldn't yell at me again. Surveyor asked R18 did you feel like this was abuse, R18 stated oh yes and I don't want her hurting anyone else so she filed a report. Surveyor asked R18 if she knew who the CNA was, R18 replied CNA wasn't one from here she was filling in. Surveyor asked R18 if this CNA cares for her any longer, R18 said no, CNA was moved to a different hallway. Surveyor asked R18 what she could tell us about the incident with facility CNA F prior to this incident, R18 explained she just kept shoving the bedpan underneath me and told me I needed to pull myself over further so she could get it under me correctly. Surveyor asked R18 did you feel this was abuse, R18 said yes. Surveyor asked R18 do you feel safe here, R18 replied yes I feel safe with all the facility staff that take care of me now. It is important to note that R18's verbal description of the events from 2/10/26 and 2/21/26 on 6/17/26 match with the facility documentation of those events. On 6/18/2026 at 2:15 PM, Surveyor interviewed NHA A. Surveyor asked NHA A could an allegation of staff being rough be considered abuse, NHA A stated that would need to be drilled down more to get specifics, it does warrant some investigation. Surveyor asked NHA A was R18 asked if she felt these situations from 2/10/26 and 2/21/26 were abuse; NHA A replied we ask about harm and if they are feeling unsafe. Surveyor asked NHA A should abuse be reported to the State Agency, NHA A said yes if substantiated or unclear at the time. It is important to note that R18 was not asked if she felt these incidents were abuse and R18 was not asked if she felt safe after the 2/10/26 incident. The facility provided additional information, the following was documented, in part: .The two grievances reviewed during the survey involved reports by a resident (R18) with cognitive impairment secondary to Wernicke's encephalopathy with progression to Korsakoff syndrome. This condition is characterized by profound short-term memory deficits, impaired insight, and confabulation, in which individuals may unintentionally misinterpret or create events to fill gaps in memory. As such, the resident's (R18) reports were carefully evaluated within this clinical framework. Psychiatry initial evaluation on 3/11/26 and a Psychiatry follow up dated 5/13/26 were reviewed. R18 voiced concern on 2/10/26 and 2/21/26 that staff were rough with her, these were not reported to the State Agency.