STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016290	A. BUILDING: _____ B. WING _____	C 10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE AND COMFORT 2 ADULT FAMILY HOME	**6111 E WIND LAKE DR UNION GROVE, WI 53182**

(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
M 000	INITIAL COMMENTS On 10/14/2024, Surveyor completed a standard survey and 3 complaint investigations at Care and Comfort 2. As a result, 2 deficiencies were identified. Three complaints were unsubstantiated. Census: 4	M 000		
M 380	88.06(2)(a) ADMISSION-HEALTH EXAM Except as provided in subd. 2., the licensee shall ensure that a new resident of an adult family home receives a health examination by a physician to identify health problems and is screened for communicable disease, including tuberculosis. Screening for communicable disease may be provided by a physician, a registered nurse or a physician assistant. The health examination and screening shall take place within 90 days prior to admission to the home or within 7 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents (Resident 1 and Resident 2) reviewed received a health exam, including a screening for communicable disease, including tuberculosis (TB), within 90 days prior to admission to the home or within 7 days after admission. Findings include: On 09/17/2024, at 10:38 AM, Surveyor reviewed resident files for Resident 1 and Resident 2.	M 380		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016290	A. BUILDING: _____ B. WING _____	C 10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE AND COMFORT 2 ADULT FAMILY HOME	6111 E WIND LAKE DR UNION GROVE, WI 53182

(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
M 380	Continued From page 1 Resident 1's file documented the following: Resident 1 was admitted to the home on 07/11/2019, without a screening for communicable disease or a health exam. A TB test was completed for Resident 1 on 07/11/2019. Resident 2's file documented the following: Resident 2 was admitted to the home on 03/10/2024, without a screening for communicable disease, including TB, or a health exam. On 09/17/2024, at approximately 11:00 AM, Surveyor interviewed Licensee A and Medical Coordinator (MC) C. Licensee A reported Guardian D liked to manage all medical appointments and screenings for Resident 2. Licensee A and MC C reported a communicable disease screening was completed for Resident 2, but Guardian D took her/him to the appointment and did not provide the documentation. Licensee A reported s/he would obtain the documentation from Guardian D and email it. As of 10/09/2024, at 12:00 PM, Surveyor did not receive evidence of an initial health exam, including screening for communicable disease, including TB for Resident 2. On 10/09/2024, at 2:00 PM, Surveyor interviewed Licensee A. Licensee A reported s/he reviewed notes from the case manager which noted Resident 2 had a health exam and TB test done. Licensee A located a TB test for Resident 1 but did not locate an admission health exam or communicable disease screening. Licensee A reported this was not just a problem with	M 380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016290	A. BUILDING: _____ B. WING _____	C 10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE AND COMFORT 2 ADULT FAMILY HOME	6111 E WIND LAKE DR UNION GROVE, WI 53182

(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
M 380	Continued From page 2 Resident 1, other residents within the home and the sister home did not have admission health exams. Resident 1 was admitted previous to Licensee A promoting from the administrator role to licensee. Licensee A did not know where previous paperwork could be located. Licensee A reported s/he would correct this moving forward.	M 380		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 residents' (Resident 1) individual service plans (ISP) was reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, in any, the placing agency with the	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016290	A. BUILDING: _____ B. WING _____	C 10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE AND COMFORT 2 ADULT FAMILY HOME	6111 E WIND LAKE DR UNION GROVE, WI 53182

(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
M 424	Continued From page 3 resident participating in a manner appropriate for the resident's level of understanding and method of communication. Findings include: On 09/17/2024, at 10:57 AM, Surveyor reviewed Resident 1's file. Resident 1 was admitted on 07/11/2019 with diagnoses including developmentally disabled and mental illness. Resident 1's ISP reviews were dated 03/30/2022, and 07/10/2019. ISP reviews for Resident 1 should have occurred on 01/10/2020, 07/10/2020, 01/10/2021, 07/10/2021, 01/10/2022, 09/30/2022, 03/30/2023, 09/30/2023, and 03/30/2024. On 09/17/2024, at 12:15 PM, Surveyor interviewed Licensee A. Licensee A reported s/he did not have any other ISPs for Resident 1 and the ISP dated 03/30/2022 was the most recent. S/He did not offer an explanation as to why ISPs were not updated at least every 6 months. On 10/02/2024, at 7:22 PM, Surveyor received an email from Licensee A which included ISPs for Resident 1, which were dated 11/14/2023 and 05/14/2024. On 10/09/2024, at 2:00 PM, Surveyor interviewed Licensee A. Licensee A reported s/he had taken over as the licensee in March 2023, but had served as the administrator prior to that. Licensee A was unsure if s/he had ISP reviews for Resident 1 prior to her/him assuming the licensee role, or between 03/30/2022 and 11/14/2023. Licensee A confirmed the requirement ISP reviews were to occur every 6 months or with changes. Licensee A reported s/he would correct this moving forward.	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016290	A. BUILDING: _____ B. WING _____	C 10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE AND COMFORT 2 ADULT FAMILY HOME	**6111 E WIND LAKE DR UNION GROVE, WI 53182**

(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
M 424	Continued From page 4 On 10/12/2024, at 3:50 PM, Surveyor received an email from Licensee A which included an ISP review for Resident 1, which was dated 10/07/2022. ISPs for Resident 1 were completed on the following dates: 07/10/2019, 03/30/2022, 10/07/2022, 11/14/2023, and 05/14/2024. ISP reviews for Resident 1 should have occurred on 01/10/2020, 07/10/2020, 01/10/2021, 07/10/2021, 01/10/2022, 07/10/2022, 04/07/2023, 10/07/2023, and 04/07/2024.	M 424		