

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014560	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 02/13/2025
NAME OF PROVIDER OR SUPPLIER COMFORT CARE 4 U 2 LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 ST ANDREWS CIRCLE MADISON, WI 53717		
(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 02/13/2025, Surveyor conducted a verification visit at Comfort Care 4 U 2, an AFH located in Madison, WI. As a result of the survey, 0 violations of Chapter DHS 88 were issued. One violation from previous Statement of Deficiency FT4W14 dated 07/10/2024 was corrected. Under statutory provisions of Wis. Stat. Chapter 50, a \$200 revisit fee is being assessed. Census: 4	{M 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE