STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019091	A. BUILDING: _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE GROUP HOME 2	17150 RUBY LANE BROOKFIELD, WI 53005

(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 03/31/2025, with information gathered through 04/03/2025, Surveyor conducted a complaint investigation at Comfort Care Group Home 2. Three deficiencies were identified. Complaint was unsubstantiated. Census: 8	N 000		
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 within 3 working days when 1 of 1 resident (Resident 1) sustained falls on 10/20/2024 and 03/05/2025 that resulted in hospitalization. Findings include: On 03/17/2025, the Department received a concern alleging a resident had sustained a fall resulting in hospitalization. On 03/31/2025, Surveyor reviewed Resident 1s record. Resident 1's "Incidents" documented: "10/20/2024 - I was cleaning up when I heard [him/her] screaming in the bathroom and the door	N 165		

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N 165	Continued From page 1	N 165		

was locked on [him/her], I opened the door on [him/her] then I saw that [s/he] was trying to use the bathroom, [s/he] was trying to get up the wheelchair then [s/he] fell on the floor on [his/her] head. I called 911."
"03/05/2025 - [Resident 1] tried to reach out [his/her] shampoo without [his/her] walker."

Resident 1's medical documentation stated:
10/20/2024 - ... Presented to the ER (emergency room) after a fall. [S/he] felt that [s/he] was dizzy with standing and [s/he] fell in the bathroom. [S/he] hit the back of [his/her] head ... Discharged 10/22/2024.

03/06/2025 - 03/13/2025 - [S/he] says [s/he] lost balance and landed on [his/her] left hip. ... Reviewed XR (x-ray) of the pelvis. Study demonstrates left femoral neck fracture (hip fracture).

On 03/31/2025, at approximately 12:00 PM, Surveyor interviewed Administrator A. Surveyor asked if s/he had reported these incidents that resulted in hospitalization to the department. Administrator A stated, "I cannot afford another cite."

On 03/31/2025, Surveyor reviewed the Department file and noted that no written reports had been submitted to the Department regarding Resident 1's falls which required hospitalization.

On 04/01/2025 at 5:31 PM, Surveyor emailed Administrator A and asked him/her to submit his/her written reports that s/he had submitted to the department regarding Resident 1's falls requiring hospitalization.

As of 04/03/2025 at 5:00 PM, Surveyor did not

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N 165	Continued From page 2 receive a response or any additional documentation.	N 165		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure proper documentation on the Medication Administration Record (MAR) for 1 of 1 resident reviewed. Resident 1's as-needed (PRN) Oxycodone medication was not documented when administered, why administered, and if the medication was effective. Resident 1's PRN acetaminophen was documented as a scheduled medication. Findings include: On 03/31/2025, at approximately 11:20 AM, Surveyor and Administrator A observed Resident 1's blister card of as-needed (PRN) Oxycodone	N 415		

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N 415	Continued From page 3	N 415		

(schedule II pain medication) in the med cabinet. The blister card had 6 out of 10 remaining capsules.

On 03/31/2025, Surveyor reviewed Resident 1's record.

Resident 1 admitted to the facility 10/31/2023.

Resident 1's March 2025 Medication Administration Record (MAR) documented:
Oxycodone 5 MG (milligram) - Take 1 tablet by mouth every 6 hours as needed for pain. Start Date: 03/26/2025.
Administered 03/19 and 03/20
The MAR did not document what time the medication was given, a rationale for why the medication was given, and if the medication was effective.

On 03/31/2025, at approximately 11:30 AM, Surveyor commented to Administrator A that Resident 1's Oxycodone was documented as administered when the medication was not prescribed, and 4 capsules were dispensed and only 2 dates of administration were documented. Administrator A reviewed the MAR and could not explain why the documentation did not line up with the available medication. Administrator A did not provide a comment regarding the requirements of documenting a PRN medication.

Resident 1's January, February, and March MARs documented:
Acetaminophen 500 MG - Take 2 tablets 3 times a day as needed for pain. Start Date: 12/23/2024.
The MARs documented that the medications were scheduled at 8:00 AM and 8:00 PM.
The acetaminophen was dispensed 34 times at

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N 415	Continued From page 4 8:00 AM and 41 times at 8:00 PM. On 03/31/2025, at approximately 11:40 AM, Surveyor commented to Administrator A that the PRN acetaminophen appeared to have designated administration times on the MARs. Administrator A stated staff wrote the "scheduled times" in so that they would remember the medication was available. Surveyor stated the physician order states that Resident 1 could have the acetaminophen up to 3 times a day, but staff only documented two "reminder times." Administrator A repeated that staff wrote in the 8:00 AM and 8:00 PM times as reminders that the medication was available. Surveyor asked if staff were required to write down what time a PRN medication was administered, why they administered the medication, and if the medication was effective. Administrator A asked if this concern was going to result in a finding. Cross Reference: N0423 DHS 83.37(3)(g) Medication Storage: Controlled Substances	N 415		
N 423	83.37(3)(g) Medication storage: controlled substances. Controlled substances. The CBRF shall provide separately locked and securely fastened boxes or drawers or permanently fixed compartments within the locked medications area for storage of schedule II drugs subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 1 resident's (Resident 1)	N 423		

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N 423	Continued From page 5 scheduled II drug (Oxycodone) was in a separately locked area within the locked medications area. Findings include: On 03/31/2025, at approximately 11:20 AM, Surveyor and Administrator A observed Resident 1's blister card of as-needed (PRN) Oxycodone (schedule II pain medication) in the med cabinet. The blister card had 6 out of 10 remaining capsules. On 03/31/2025, at approximately 12:15 PM, Surveyor interviewed Administrator A. Licensee A acknowledged the concern and stated they would ensure all schedule II drugs were stored in a separately locked area within the medication cabinet going forward.	N 423		