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 _____	R-C 06/11/2025

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 06/11/2025, Surveyor conducted a verification visit at Comfort Care Group Home 2. Three deficiencies were identified. Two of 3 deficiencies were repeat violations (see Statement of Deficiency (SOD) H8OO11 and SOD W8L812). Under statutory provisions of Wis. ch. 50, a $200 revisit fee is assessed. Census: 8	{N 000}		
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 update 1 of 1 resident's Individual Service Plan (ISP) when there was a change in the resident's needs, abilities or physical or mental condition.	N 389		

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
	0019091	A. BUILDING: _____ B. WING _____	R-C 06/11/2025

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 389	Continued From page 1	N 389		

This is a repeat deficiency. See Statement of Deficiency (SOD) W8L812, dated 11/08/2024.

Resident 2's ISP was not updated to reflect his/her communication barriers, that s/he required a urinary catheter, and that s/he required a diabetic diet.

Findings include:

On 06/11/2025, at approximately 2:20 PM, Surveyor arrived at the facility and was greeted by Resident 2 and Caregiver B. Caregiver B was speaking to Resident 2 and Surveyor determined that s/he was only able to understand partial words Resident 2 spoke. Surveyor asked Caregiver B how s/he understood Resident 2's communication to determine what needs s/he required. Caregiver B stated s/he had previously worked at the home and was familiar with Resident 2's communication style, so when s/he returned to the home approximately a week ago, s/he was familiar with Resident 2. Caregiver B stated individuals who are not familiar with Resident 2's communication style would have difficulty understanding him/her.

On 06/11/2025, Surveyor reviewed Resident 2's record.

Resident 2 moved into the facility, 02/11/2023, with diagnoses including Diabetes Mellitus, intellectual disability, personality/dissociative, and mental health disorder.

Resident 2's "Member Centered Plan," dated 10/01/2024, prepared by his/her managed care organization (MCO), documented:
"Toileting - needs cues for hygiene after bowel movement and proper emptying of urinary

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 _____	R-C 06/11/2025

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 389	Continued From page 2	N 389		

catheter."
"Nutrition - Diabetic diet."

Resident 2's "30 Day Assessment (ISP)," dated 09/06/2024, documented:
"Communication Skills: [Describe resident's communication skills and any individual needs]. Resident's Desired Outcomes: To effectively communicate needs and wants."
The ISP did not identify that Resident 2 displayed aphasia (a language disorder that affects the ability to communicate) and guidelines on how staff should approach Resident 2's communication style.
"Eating: What type of diet is the resident on? (no answer)"
The ISP did not identify that Resident 2 required a diabetic diet.
"Toileting - Partial Assistance: Resident requires partial assistance from staff to complete toileting tasks. To remain clean and dry. Measurable Goals: To receive assistance with toileting through January 2025, caregivers will watch for any episodes, document, record and assist resident with any bowel movement episodes."
The ISP did not identity that Resident 2 required cares for his/her urinary catheter.

On 06/11/2025, at approximately 3:35 PM and 3:55 PM, Surveyor interviewed Licensee A. Licensee A expressed that s/he did not understand what additional information s/he was to add to Resident 2's ISP. Surveyor explained the example of Resident 2's form of aphasia when s/he is communicating. Licensee A stated, "We understand [him/her]" Surveyor asked Licensee A if s/he had reviewed the resident ISPs when s/he asked for an extension to review the ISPs after s/he was cited for this concern in 11/08/2024. Licensee A did not respond.

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 _____	R-C 06/11/2025

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 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure expired medications were securely stored separately from other medications in use for 4 of 5 residents reviewed. Resident 2's Polyvinyl Alcohol 1.4% lubricating eye drops prescription expired 10/19/2024 and the bottle of eye drops expired 01/2025 and was stored with his/her current medications.	N 406		

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 _____	R-C 06/11/2025

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 406	Continued From page 4	N 406		

Resident 3's bottles of expired Fluticasone and bottle of expired Nystatin powder were stored with his/her current medications.

Resident 4's Nitroglycerin sublingual tablets expired 03/2024 and was stored with his/her current medications.

Resident 5's Albuterol Sulfate HFA inhaler expired 01/2025 and was stored with his/her current medications.

Findings include:

On 06/11/2025, at approximately 2:50 PM, Surveyor and Caregiver B reviewed the medications in the med cabinet and observed:

Example 1: Resident 2

Resident 2's open bottle of biotene dry mouth moisturizing spray with a discard date of 08/16/2024; blister card of Docusate Sodium with a 'Do Not Use Beyond: 02/09/2024'; blister card of ibuprofen with a 'Do Not Use Beyond: 08/22/2024'; a blister card of Acetamin with a 'Do Not Use Beyond: 02/09/2024'; and a blister card of Mucinex Sinus with a 'Do Not Use Beyond: 02/09/2024'.

Example 2: Resident 3

Resident 3's empty bottle of Fluticasone, open date 12/08/2023, and an open bottle of Fluticasone, dispensed 08/27/2024, with labels that stated, "Use 1 spray into each nostril at bedtime." Surveyor observed an open bottle of Fluticasone, dispense date 04/03/2025, with a label that stated, "Spray 1 spray in each nostril daily as needed (PRN)." Surveyor observed an

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 _____	R-C 06/11/2025

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 406	Continued From page 5 open bottle of Nystatin powder, with a discard date of 01/06/2025, with a label that stated, "Apply to affected area topically twice daily." On 06/11/2025, Surveyor reviewed Resident 3's Medication Administration Record, dated 05/25/2025 to 06/21/2025, which documented: Fluticasone - Spray 1 spray in each nostril daily as needed. The MAR did not document Fluticasone and Nystatin powder as a scheduled medication. Example 3: Resident 4 Resident 4's blister cards of Acetamin with a 'Do Not Use Beyond: 08/29/2024 and 10/13/2024'; a blister card of Docusate Sodium with a 'Do Not Use Beyond: 08/29/2024' and a blister card of Dicyclomine with a 'Do Not Use Beyond: 01/26/2025'. Example 4: Resident 5 Resident 5's blister card of Melatonin with a 'Do Not Use Beyond: 05/03/2025' and blister cards of Acetamin with a 'Do Not Use Beyond: 05/30/2025 and 05/20/2025'. On 06/11/2025, at approximately 3:35 PM and 3:55 PM, Surveyor interviewed Licensee A, who is a registered nurse. Licensee A stated s/he had just completed a med audit, and all expired medications had been removed.	N 406		
{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	{N 415}		

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 _____	R-C 06/11/2025

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 415}	Continued From page 6	{N 415}		

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 3 of 3 resident records reviewed.

This is a repeat deficiency. See Statement of Deficiency (SOD) H8OO11, dated 04/03/2025.

Resident 3's, Resident 4's, and Resident 5's MAR contained blank spaces where a staff member would have initialed when med administration occurred.
Resident 5's, and Resident 6's 'as-needed' (PRN) medication administration times were not documented on the MAR.

Findings include:

On 06/11/2025, Surveyor reviewed Resident 3's, Resident 4's, and Resident 5's record.

Example 1: Resident 3

Resident 3's MAR, dated 05/25/2025 to 06/21/2025, contained blanks where med

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 _____	R-C 06/11/2025

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 415}	Continued From page 7	{N 415}		

administration should have been documented with no rationale:
05/30 8:00 AM - Trulicity
06/05 8:00 PM - Buspirone
06/06 and 06/07 8:00 AM - Gabapentin
06/08 10:00 AM and 2:00 PM - Rytary
06/08 8:00 AM - Aspirin, Buspirone, Culturelle, Diltiazem, Folic Acid, Furosemide, Metoprolol, potassium chloride, Venlafaxine, Vitamin B Complex, Vitamin B-12
06/08 2:00 PM - Buspirone, Gabapentin
06/08 6:00 PM - Gabapentin, Rytary
06/08 8:00 PM - Atorvastatin, Buspirone, Melatonin, Potassium Chloride, Pramipexole, Zonisamide

On 06/11/2025, at approximately 2:50 PM, Surveyor and Caregiver B observed the med cabinet and did not locate the undocumented medications.

Example 2: Resident 4

Resident 4's MAR, dated 05/25/2025 to 06/21/2025, contained blanks where med administration should have been documented with no rationale:
05/30 5:00 PM - Melatonin
06/05 4:00 PM - Clonazepam
06/05 5:00 PM - Melatonin
06/05 8:00 PM - Clonazepam, Divalproex, Donepezil, Metoprolol, Olanzapine, Omeprazole

On 06/11/2025, at approximately 2:50 PM, Surveyor and Caregiver B observed the med cabinet and did not locate the undocumented medications.

Example 3: Resident 5

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 _____	R-C 06/11/2025

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 415}	Continued From page 8 Resident 5's MAR, dated 05/25/2025 to 06/21/2025, contained blanks where med administration should have been documented with no rationale: 06/01 8:00 PM - Olanzapine 06/04 8:00 AM - Invega Injection 06/05 8:00 PM - Buspirone 06/09 8:00 AM - Buspirone, Fenofibrate, Fluoxetine, Pantoprazole, Propranolol, Trihexiph, Vitamin C 06/09 2:00 PM - Buspirone 06/09 8:00 PM - Buspirone, Gabapentin, Hydroxyzine, Olanzapine, Pantoprazole, Trazodone, Trihexiph On 06/11/2025, at approximately 2:50 PM, Surveyor and Caregiver B observed the med cabinet and did not locate the undocumented medications. Resident 5's MAR, dated 05/25/2025 to 06/21/2025, documented: "Artificial Tears - Instill 1 drop into each eye up to 6 times daily as needed for dry eyes." The MAR documented 24 administrations with no documented times. Licensee A had documented s/he administered 18 of the 24 administrations. On 06/11/2025, at approximately 3:00 PM, Surveyor interviewed Caregiver B. Surveyor asked how s/he was trained on medication administration regarding PRN medications. Caregiver B stated s/he had been trained to place his/her initial under the date the medication was administered. Example 4: Resident 6 Resident 6's MAR, dated 05/25/2025 to 06/21/2025, documented:	{N 415}		

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 _____	R-C 06/11/2025

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 415}	Continued From page 9 "Acetaminophen - Take 2 tablets every 4 hours as needed for pain." The MAR documented 4 administrations with no documented times. Licensee A had documented s/he administered 3 of the 4 administrations. On 06/11/2025, at approximately 3:00 PM, Surveyor interviewed Caregiver B. Surveyor asked how s/he was trained on medication administration regarding PRN medications. Caregiver B stated s/he had been trained to place his/her initial under the date the medication was administered. Caregiver B stated s/he was not aware that when administering a pain medication s/he should document a pain level and if the medication was effective. On 06/11/2025, at approximately 3:35 PM and 3:55 PM, Surveyor interviewed Licensee A. Licensee A explained that staff had been re-educated on proper med administration documentation and s/he cannot be responsible if his/her staff continue to go against his/her instruction.	{N 415}		