

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019091	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/10/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE GROUP HOME 2		STREET ADDRESS, CITY, STATE, ZIP CODE 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 04/10/2026, Surveyor conducted a verification visit and 1 complaint investigation. No deficiencies were identified. Four of 4 deficiencies from Statement Of Deficiency (SOD) HBOOI3, dated 11/06/2025 were substantially corrected. The complaint was unsubstantiated. Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed. Census: 8	N 000		

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

TITLE

(X6) DATE