

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016007	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/27/2026
NAME OF PROVIDER OR SUPPLIER COMFORT HOMES ADULT FAMILY LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 7625 BERWYN AVENUE GLENDAL, WI 53209		
(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 07/27/2026, Surveyor conducted a standard survey and verification visit at Comfort Homes Adult Family Living. All deficiencies in statement of deficiency (SOD) IMOV12 were corrected, and 5 deficiencies were cited for a second time. See SOD IMOV11 dated 03/11/2022. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee will be assessed. Census: 3	{M 000}		
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS Fire extinguishers. Every adult family home shall be equipped with one or more fire extinguishers on each floor. Each required fire extinguisher shall have a minimum 2A, 10-B-C rating. All required fire extinguishers shall be mounted. A fire extinguisher is required at the head of each stairway and in or near the kitchen except that a single fire extinguisher located in close proximity to the kitchen and the head of a stairway may be used to meet the requirement for an extinguisher at each location. Each required fire extinguisher shall be maintained in readily usable condition and shall be inspected annually by the authorized dealer or the local fire department and have an attached tag showing the date of the last dealer or fire department inspection.	M 332		

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

TITLE

(X6) DATE

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M 332	Continued From page 1 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 3 required locations was equipped with a fire extinguisher. The head of the stairway leading to the basement did not contain a fire extinguisher. Findings include: On 07/27/2026, at approximately 9:50 AM, Surveyor toured the facility and observed the following: -The head of the stairway contained a fire extinguisher mounting bracket, but no fire extinguisher was present. On 07/27/2026, at approximately 1:15 PM, Surveyor interviewed Site Manager G. Site Manager G confirmed the code requirement requiring a fire extinguisher at the head of the stairs leading to the basement. Site Manager G reported the fire extinguisher was taken to be recharged but was faulty and the facility had not acquired a replacement at the time of the survey. Site Manager G reported s/he would ensure a new fire extinguisher was acquired.	M 332		
M 346	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated annually for evacuation time, using the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than 2 minutes.	M 346		

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M 346	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the provider did not complete an annual evacuation assessment review for 2 of 2 residents (Resident 3 and Resident 5) who lived in the facility beyond one year. Resident 3 did not have an annual evacuation assessment in 2024, 2025, or to date in 2026. Resident 5 did not have an evacuation assessment completed in 2023, 2024, 2025, and to date in 2026. This is a repeat deficiency. See Statement of Deficiency (SOD) IMOV11, dated 03/11/2022. Findings include: On 11/10/2025, at 10:50 AM, Surveyors reviewed residents' records and identified the following: - Resident 3 was admitted on 01/27/2017. Resident 3's record contained a resident evacuation assessment dated 03/01/2023. Resident 3's record did not contain evidence of an updated evacuation assessment in March 2024, March 2025, or March 2026. - Resident 4 was admitted on 11/07/2019. Resident 5's record contained a resident evacuation assessment dated 01/20/2022. Resident 5s record did not contain evidence of an updated evacuation assessment in January 2023, January 2024, January 2025, or January 2026. On 07/27/2026, at approximately 1:15 PM, Surveyor interviewed Site Manager G. Site Manger G reported s/he was unaware of the code requirement. Site Manager G reported s/he would ensure annual evacuation assessments were	M 346		

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M 346	Continued From page 3 updated and completed for all residents.	M 346		
M 406	88.06(3)(b) PERSONS INVOLVED WITH ISP & ASSESSMENT The individual service plan and written assessment shall be developed by the placing agency, if any, the service coordinator, if any, the licensee, the resident and the resident's guardian, if any and designated representative, if any, with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This Rule is not met as evidenced by: Based on record review and interview, the facility did not ensure 1 of 2 (Resident 5) resident individual service plans (ISPs) were developed, signed, and dated by all persons involved in developing the plan. Resident 5's ISP was not signed by her/his legal guardian. This is a repeat deficiency. See Statement of Deficiency (SOD) IMOV11, dated 03/11/2022. Findings include: On 11/10/2025, at 10:50 AM, Surveyors reviewed Resident 5's record. Resident 5 was admitted on 11/07/2019. Resident 5's record indicated s/he had a legal guardian. Resident 5's record contained an ISP dated 03/09/2023. Resident 5's ISP was not signed by her/his ISP.	M 406		

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M 406	Continued From page 4 On 07/27/2026, at approximately 1:15 PM, Surveyor interviewed Site Manager G. Site Manger G reported s/he was responsible for updating resident ISPs. Site Manager G confirmed the code requirement. Site Manager G reported s/he was unaware why Resident 5's legal guardian did not sign her/his ISP. Cross Reference M0424 88.06(3)(f) Review of ISP	M 406		
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 2 of 2 residents'	M 424		

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M 424	Continued From page 5 (Resident 3 and Resident 5) individual service plans (ISPs) were reviewed at least once every 6 months. Resident 3's ISP was due to be reviewed in 07/2023, 01/2024, 07/2024, 01/2024, 07/2025, and 01/2026. Resident 5's ISP was due to be reviewed in 09/2023, 03/2024, 09/2024, 03/2025, 09/2025, and 03/2026. This is a repeat deficiency. See Statement of Deficiency (SOD) IMOV11, dated 03/11/2022. Findings include: On 11/10/2025, at 10:50 AM, Surveyors reviewed residents' records and identified the following: - Resident 3 was admitted on 01/27/2017. Resident 3's record contained an ISP dated 01/30/2023. Resident 3's ISP was due to be reviewed in 07/2023, 01/2024, 07/2024, 01/2024, 07/2025, and 01/2026. - Resident 5 was admitted on 11/07/2019. Resident 5's record contained an ISP dated 03/09/2023. Resident 5's ISP was due to be reviewed in 09/2023, 03/2024, 09/2024, 03/2025, 09/2025, and 03/2026. On 07/27/2026, at approximately 1:15 PM, Surveyor interviewed Site Manager G. Site Manager G reported s/he was responsible for updating resident ISPs. Site Manager G reported s/he did not fully understand the code requirement. Site Manager G reported resident managed care organization (MCO) case managers came to the facility every 6 months and Site Manager G signed the MCO member centered care plan. Site Manager G reported s/he believed this met the code requirement. Site Manager G reported s/he would update resident	M 424		

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M 424	Continued From page 6 ISPs and have all members involved in the plan sign the update. Cross reference M0406 88.06(3)(b) Person Involved with ISP & Assessment	M 424		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medications were destroyed when medications were expired for 2 of 2 residents (Resident 3 and Resident 5). Resident 3's and Resident 5's medication bins contained expired medications. This is a repeat deficiency. See Statement of Deficiency (SOD) IMOV11, dated 03/11/2022. Findings include: On 07/27/2026, at approximately 09:55 AM, Surveyor toured the facility and observed the following in the medication closet:	M 458		

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M 458	Continued From page 7 Resident 3' s medication bin contained the following expired medications: - Ibuprofen 600 milligram(mg) tablet, 4 tablets remaining, discard date May 2025 - Tizanidine hydrochloride (HCL) 2mg tablet, 58 tablets remaining, discard date May 2025 Resident 5's medication bin contained the following expired medication: - Erythromycin 5mg/ gram ointment, 1 tube remaining, discard date December 2024 On 07/27/2026, at approximately 1:15 PM, Surveyor interviewed Site Manager G. Site Manger G reported s/he was unsure of the code requirement. Site Manger G reported the medications are audited monthly and expired medications are given to the pharmacy when audits are conducted. Site Manger G reported s/he would ensure expired medications were disposed of properly.	M 458		