STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010062	A. BUILDING: _____ B. WING _____	C 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME ST CROIX FALLS I	343 MCKENNEY ST SAINT CROIX FALLS, WI 54024

(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 01/21/2026, Surveyor conducted a complaint investigation and self-report investigation at Comforts of Home St Croix Falls I. Data was collected through 01/29/2026. One of 1 complaint was unsubstantiated. One new deficiency was identified. Census: 15	N 000		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the CBRF (community based residential facility) did not provide supervision appropriate to the resident's needs. Findings include: On 12/14/2025, the Department received a self-report regarding resident elopement. The provider is licensed to care for 15 residents	N 426		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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N 426	Continued From page 1 in the client groups: physically disabled, advanced aged, and irreversible dementia/Alzheimer's disease. On 01/21/2026 at approximately 10:38 AM, Surveyor interviewed House Manager (A). Surveyor inquired about a self-report submitted on 12/14/2025 regarding Resident 1's elopement. HM A stated that on 12/14/2025, Resident 1 followed a visitor out of the building and entered another person's vehicle that was parked in a local business not far from the provider. HM A stated law enforcement was called, and Resident 1 was found approximately 20 minutes after staff noted s/he was missing. HM A stated the provider posted signs on exit doors reminding visitors not to let residents outside. HM A stated Resident 1 was supposed to only be outside at the back of the building. HM A stated when Resident 1 was out front of the building s/he had more of a chance to run but the back of the building was fenced. HM A stated Resident 1 was admitted from a psychiatric hospital and that s/he was 1:1 in the hospital due to his multiple elopement attempts. HM A stated prior to accepting the admission, s/he asked the hospital to remove the 1:1 and report elopements attempts. HM A stated Resident 1 only attempted to leave the hospital 1 time. On 01/29/2026, Surveyor reviewed Resident 1's record. -Resident 1's admission record read, in part, " ...admitted on 12/09/2026 ...has a Power of Attorney (POA) ...Resident 1 was diagnosed with unspecified dementia, moderate with agitation ...bilateral primary osteoarthritis of knee ...other cervical disc degeneration ...and has a history of	N 426		

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N 426	Continued From page 2 falls..." -A Pre-assessment document read, in part, " ...Behaviors ...will try to elope ...elopement risk ...eloped on 12/7, was able to redirect ...can become aggressive when [s/he] is unable to get out, staff too [sic] just keep distance." -A Service Plan Report dated 12/09/2026 read, in part, " ...MOBILITY ...uses 4wheeled [sic] walker and a cane at times ...Date Initiated: 12/09/2025...ELOPEMENT RISK ...Facility staff to monitor resident for elopement concerns and report changes or concerns to management ... Date Initiated: 12/09/2025. Resident is at risk for elopement. Date Initiated: 12/30/2025. Resident is required direct staff accompaniment at all times while outside. Date Initiated: 12/30/2025. Resident will sit by door asking to be let out ...Date Initiated 12/15/2025 ... TOBACCO USE: Resident to be smoking on the back patio. Date Initiated: 12/23/2025 ...BEHAVIORS ...Known triggers for elopement are wanting to go home, pacing, talking about elopement ...Revision on 12/30/2025 ...Resident had an elopement on 12/10/2025 ...appeared to be willing to go back inside but wouldn't until [sic] police intervention arrived. Date Initiated: 12/11/2025 ...When resident becomes agitated, [s/he] will attempt to elope- ...Date Initiated 12/30/2025." A Safety Check document dated 12/2025 read, in part, " ...SAFETY CHECKS: Staff to provide safety checks ...If resident is not safe ...NOT in the facility due to possible elopement ...follow procedure ..." The document indicated 2-hour checks began on 12/09/2025 and were initiated by staff. On 12/30/2025 checks increased to every 30 minutes and were initiated by staff. Surveyor reviewed Assisted Living Self-Reports	N 426		

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N 426	Continued From page 3	N 426		

for Resident 1 that indicated the following:
-12/10/2025 at 6:11 PM: staff alerted as Resident 1 pushed the green exit button. Resident 1 exited the building. Staff were unable to redirect back into the building. Law enforcement was called for assistance.
-12/16/2025 at 12:00 PM: Resident 1 exited the building behind a visitor. Staff noted Resident 1 was no longer sitting by the door. Law enforcement was called, and resident was found near the building. Resident 1 was missing for approximately 20 minutes. Signs were added to the exit door alerting visitors to not let residents outside.
-On 12/20/2025 at 12:00 AM: Resident 1 was let outside on the front patio to smoke. Staff from the neighboring building (licensed by the same provider) called to inform them Resident 1 was in the other building and was yelling and looking for his significant other. Staff were unable to redirect and law enforcement were called. Staff directed to let Resident 1 smoke on the back gated patio.
-12/25/2025 at 5:15 AM: Resident 1 eloped by removing his/her bedroom screen. Law enforcement was contacted and Resident 1 located at a local business.
-12/29/2025 at 7:00 PM, Resident 1 in the supervised smoking area when s/he abruptly left the area and ran to a nearby business. Resident 1 was not responsive to redirection and law enforcement was called. Immediately following this incident, Resident 1 was put on 30-minute checks. Smoking was to only occur under staff supervision. Staff were re-educated on identification of elopement behaviors.
-01/21/2026 at 4:30 AM, Staff entered Resident 1's room and were unable to find him/her. Staff noted footprints in the snow outside of a window from where s/he appeared to have exited the building. Law enforcement was called, and

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N 426	Continued From page 4	N 426		

Resident 1 was found near the building.

On 01/21/2026 at approximately 11:34 AM, Surveyor interviewed Resident 1 who stated. "Staff won't let me outside/out front cause they think I will run. Staff called the police on me cause someone let me out last night, out front."

On 01/22/2026, Surveyor received an email communication from HM A and included, " ...In-service was completed on 1/8/26 with staff to review de-escalation training and redirection ..."

On 01/29/2026 from 11:54 AM to 12:57 PM, Surveyor interviewed HM A and Assisted Manager (AM) B. HM A stated for the 12/14/2025 self-report Resident 1 was found at a local park about 2 blocks from the building. HM A stated for the 12/20/2025 self-report staff were directed to only have Resident 1 smoke in the gated back patio. HM A stated for the 12/29/2025 elopement Caregiver C had let Resident 1 out the front door, but Caregiver D (who was working in the building licensed and next to the same provider) had eyes on Resident 1 the whole time. HM A stated on 12/30/2026, Resident 1's individualized service plan (ISP) was updated to reflect that when Resident 1 was smoking staff were to have eyes on him/her at all times.

Surveyor inquired about the 01/21/2026 self-report for Resident 1 that was sent to the Department during the survey. HM A stated that Resident 1 should not have gotten out of the building.

HM A stated s/he felt elopement interventions should have been added quicker than they were and confirmed that additional staff training occurred on 01/08/2026. Surveyor observed the

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N 426	Continued From page 5 training was completed approximately 10 days after the 12/29/2025 elopement. The provider did not ensure Resident 1 had supervision appropriate to his/her needs.	N 426		