STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013677	A. BUILDING: _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME MENOMONIE CBRF	**2211 WHITE PINE LANE MENOMONIE, WI 54751**

(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 11/07/2023, Surveyor conducted a complaint investigation and standard licensing survey at Comforts of Home Menomonie CBRF. Data was collected through 11/09/2023. The complaint was substantiated. Four violations were identified. Census: 30	N 000		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents sampled had a communicable health screen that included tuberculosis screening within 90 days before or 7 days after admission.	N 302		

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
	0013677	A. BUILDING: _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME MENOMONIE CBRF	2211 WHITE PINE LANE MENOMONIE, WI 54751

(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 302	Continued From page 1 Findings include: On 11/07/2023, Surveyor reviewed Resident 1's (admitted on 09/29/2022) and Resident 2's (admitted on 02/19/2022) records. Neither record contained evidence of a baseline tuberculosis test. At approximately 3:00 PM, Surveyor interviewed Registered Nurse (RN) A. RN A stated the provider did not obtain baseline TB tests in the past. RN A stated the provider recently began encouraging TB tests upon admission. RN A stated the new procedure included a physician assessment form with a signed acknowledgment that the resident was free of communicable tuberculosis and clinically apparent disease. RN A provided Resident 1's form, dated 09/28/2022. The form did not include evidence of a baseline TB test.	N 302		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure a safe environment to residents that cannot safeguard	N 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013677	A. BUILDING: _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME MENOMONIE CBRF	2211 WHITE PINE LANE MENOMONIE, WI 54751

(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 358	Continued From page 2	N 358		

themselves from environmental hazards. Resident 2's bedroom had a wall-mounted space heater within Resident 2's reach that was hot enough to cause injury.

Findings include:

On 08/29/2023, the Department received a complaint related to environmental safety.

On 11/07/2023, Surveyor reviewed the provider's maintenance log, which included a request dated 06/13/2023 that read, "If the heater is ours, can you put it in room #11 (wall heater in maintenance room)."

At 10:18 AM, Surveyor interviewed Maintenance Worker (MW) B. MW B said s/he installed wall heaters in various units. MW B said s/he could show Surveyor an example of the type of heater s/he installed in Resident 2's room a few months ago. MW B said Resident 2 always had the heater on.

At 10:22 AM, Surveyor observed Resident 2 in his/her wheelchair in his/her room. The wall heater was on and radiating heat that could be felt upon entry to Resident 2's room. The wall heater was mounted at approximately 3 feet high on the wall opposite of Resident 2's bedside. Surveyor was unable to hold his/her hand on the surface of the unit for more than 5 seconds before it became uncomfortably hot. Surveyor asked MW B if the heater felt hot to the touch. MW B placed his/her hand on the surface of the heater and stated it was hot. MW B agreed it was hot enough to cause injury with prolonged contact.

Surveyor reviewed Resident 2's record. Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013677	A. BUILDING: _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME MENOMONIE CBRF	2211 WHITE PINE LANE MENOMONIE, WI 54751

(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 358	Continued From page 3 2 was admitted on 02/19/2022 with diagnoses that included Parkinson's disease and dementia. Resident 2's individual service plan (ISP) indicated s/he required assistance of 1 for all activities of daily living (implemented on 03/09/2023) and 2-hour safety checks (implemented on 03/16/2023). At approximately 3:00 PM, Surveyor interviewed Registered Nurse (RN) A. RN A stated s/he would have the heater removed from Resident 2's room by the end of the day.	N 358		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure Resident 3's individual service plan (ISP) was implemented as written. Findings include: On 11/07/2023 at approximately 10:40 AM, Surveyor observed Resident 3 at a dining room table. Resident 3 had a significant amount of facial hair that could be seen at a distance of 15 feet. Surveyor reviewed Resident 3's record. Resident 3 was admitted to the facility on 04/20/2022 with diagnoses that included dementia. His/her ISP, dated 08/10/2022, indicated Resident 3 was supposed to receive assistance with facial shaving.	N 388		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013677	A. BUILDING: _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME MENOMONIE CBRF	2211 WHITE PINE LANE MENOMONIE, WI 54751

(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 388	Continued From page 4 At 2:05 PM, Surveyor interviewed Caregiver C. Caregiver C stated staff tried to stay on top of shaving fe/male residents' facial hair. Caregiver C stated s/he was unsure how often they were supposed to shave Resident 3, but s/he thought Registered Nurse (RN) A or Assistant Manager (AM) D normally took care of it. At approximately 2:30 PM, Surveyor interviewed RN A and AM D. RN A stated Resident 3 was supposed to receive daily shaving services. Resident 3 should not have visible facial hair. RN A stated they had educated staff on this, but they continue not do it. RN A stated s/he would create a scheduled task in the provider's electronic system so staff were prompted to complete the task daily.	N 388		
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:	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013677	A. BUILDING: _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME MENOMONIE CBRF	2211 WHITE PINE LANE MENOMONIE, WI 54751

(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 5	N 389		

Based on observation, interview, and record review, the provider did not ensure individual service plans (ISPs) were updated upon changes in condition for 2 of 2 residents sampled. Resident 1's ISP did not include guidance or interventions related to an unstable health condition or behavioral interventions. Resident 2's ISP did not include dietary accommodations.

Findings include:

RESIDENT 1
On 11/07/2023 at 10:45 AM, Surveyor interviewed Registered Nurse (RN) A. RN A provided a summary of Resident 1's needs and condition. According to RN A, Resident 1 had frequent emergency blood transfusions related to anemia. RN A said Resident 1 recently went on hospice services. RN A stated Resident 1 used to use incontinence briefs, but Resident 1 would rip them up and hide them around his/her room. Recently, Resident 1 began using regular undergarments and a proactive toileting schedule.

At 2:04 PM, Surveyor observed Resident 1's room and bathroom. Resident 1's bathroom did not have toiletries such as toilet paper, wipes, or hand towels. There were no observable means to wash/clean or dry oneself.

At 2:05 PM, Surveyor interviewed Caregiver C. Caregiver C stated Resident 1's toiletries were kept in a tote on top of a cabinet in his/her bathroom. Caregiver C stated they did this because if the items were within Resident 1's reach, s/he would destroy them and/or clog his/her sink and toilet with them.

Surveyor asked Caregiver C about Resident 1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013677	A. BUILDING: _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME MENOMONIE CBRF	2211 WHITE PINE LANE MENOMONIE, WI 54751

(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 6	N 389		

anemia and when to contact emergency services. Caregiver C stated staff monitored Resident 1 for increased confusion and light-headedness; staff were to contact RN A if Resident 1 displayed either symptom.

Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 09/29/2022 with diagnoses that included dementia and chronic kidney disease. Between May 2023 and August 2023, Resident 1 required emergency treatment (blood transfusions) 5 times. On 08/27/2023, Resident 1 was sent to the ER after a fall that resulted in a head injury. Resident 1's hemoglobin was low upon admission, and s/he received a blood transfusion and was hospitalized through 08/30/2023. The hospital discharge notes read: "...past medical history of vascular dementia, gastrointestinal hemorrhage with chronic anemia and chronic blood loss from colon carcinoma not on treatment, hypertension, dyslipidemia. [S/he] was found by staff of assisted living on the floor with large amount of blood and laceration on the posterior of [his/her] head... Patient has required monthly transfusions as an outpatient from [his/her] GI (gastrointestinal) bleeding. Patient's hemoglobin dropped from 9.2 on admission to 7.3 on 08/29. I discussed the plan of care for transfusions with the [family]. We transfused [Resident 1] 1 unit of packed red blood cells on 08/29 given the drop in [his/her] hemoglobin in the hospital and [his/her] history of the need for recurring transfusions... Since the patient will be entering hospice the [family] will consider discontinuing transfusions in the future. Hospice would potentially give palliative transfusions up to once every 3 weeks but given the patient's poor level of function right now, there may not be much benefit to the transfusions in the future."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013677	A. BUILDING: _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME MENOMONIE CBRF	2211 WHITE PINE LANE MENOMONIE, WI 54751

(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 7 Surveyor reviewed Resident 1's ISP (updated 10/17/2023). The ISP provided a list of Resident 1's medical diagnoses. The intervention for all medical diagnoses included, "Staff will monitor the safety of resident/tenant related to medical diagnoses." The list did not include anemia, gastrointestinal hemorrhage, or colon cancer. The ISP indicated Resident 1 enrolled in hospice services on 08/30/2023 but there was no information on how to manage Resident 1's anemia-related symptoms. Resident 1's ISP did not include reference to Resident 1's history of anemia, blood transfusions, or the need to monitor for symptoms. Resident 1's ISP read, "Needs assistance to change incontinence product... uses incontinence products, pull ups. Supply and disposal managed by care team." The ISP referenced behaviors that included disrobing and removing incontinence products. Behavior interventions included monitor and document behaviors. The ISP did not reference Resident 1's plan to discontinue use of incontinence products or Resident 1's need to have restricted access to his/her bathroom supplies. At approximately 2:30 PM, Surveyor interviewed RN A. RN A stated Resident 1's anemia warning signs included an obvious change in color. RN A stated staff and Resident 1 were not able to discern changes to Resident 1's weakness, confusion, or dizziness due to his/her disease progression, so staff were supposed to monitor Resident 1 for changes in his/her skin color and call hospice. RN A stated Resident 1 had rectal bleeding that caused blood loss and odorous bowel movements.	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013677	A. BUILDING: _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME MENOMONIE CBRF	2211 WHITE PINE LANE MENOMONIE, WI 54751

(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 8 Surveyor reviewed Resident 1's ISP. Resident 1's ISP did not reference Resident 1's tendency to have abnormal bowel movements. RESIDENT 2 On 11/07/2023 at 12:10 PM, Surveyor observed the lunch meal. Resident 2 was served and ate pureed food. At 2:05 PM, Surveyor interviewed Caregiver C. Caregiver C stated Resident 2 had received a pureed diet the entire time Caregiver C had been employed at the facility (hired 06/07/2023). Surveyor reviewed Resident 2's ISP (updated 03/16/2023) which read, "Diet: General regular diet." At approximately 2:30 PM, Surveyor interviewed RN A. RN A explained that Resident 2 had an incident that prompted him/her to try a pureed diet. Resident 2 had since graduated to a regular diet, but Resident 2 was afraid of choking so s/he continued to eat a pureed diet. RN A stated s/he was aware Resident 2's ISP had not been updated to include his/her preference for pureed diet.	N 389		