STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014271	A. BUILDING: _____ B. WING _____	R-C 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME HUDSON II	805 HEGGEN ST HUDSON, WI 54016

(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 02/23/2026, Surveyors conducted a standard licensure survey, a complaint investigation, and a verification visit at Comforts of Home Hudson II. Data was collected through 02/26/2026. Two of 2 complaints were substantiated. Two repeat violations were identified. See Statement of Deficiency (SOD) 92G311, dated 09/01/2021; SOD 92G315, dated 03/07/2024; SOD 92G316, dated 06/28/2024; and SOD 92G317, dated 08/28/2025. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 38	{N 000}		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 6 residents had the right to receive medication as prescribed. This is a repeat violation. See Statement of Deficiencies (SOD) 92G315, dated 03/07/2024; and SOD 92G317, dated 08/28/2025. Findings include:	{N 352}		

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

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{N 352}	Continued From page 1 On 02/23/2026, Surveyor reviewed facility and resident records. Medication error reports for Resident 1 and Resident 5 indicated they had not received medications as ordered due to being out of stock. Medication error reports for Resident 2 and Resident 3 indicated they had missed doses of narcotic medication when the narcotics were audited during the following shift and extra unadministered doses were found. A medication error report for Resident 4 indicated s/he had not received medication as ordered due to a charting error. A medication error report for Resident 6 only indicated s/he had not received medication as prescribed. Records included the following information for Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, and Resident 6: - Resident 1: Resident 1's September 2025 medication administration record (MAR) read, in part, "OLANZAPINE 20 MG** TABLET TAKE ONE TABLET BY MOUTH AT BEDTIME AT 8PM..." The MAR indicated Resident 1's olanzapine was not in the facility 11 out of 22 days. The MAR indicated Resident 1 was absent and was without his/her olanzapine 1 out of 22 days. A medication error report, dated 09/24/2025, indicated that Resident 1's daily dose of 20 milligram (mg) olanzapine was not administered as prescribed from 09/01/2025 to 09/20/2025. The report read, in part, "...medication was to come with cycle, the medication has been documented out of facility since the beginning of the month. Pharmacy was called to ensure medication was delivered..."	{N 352}		

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{N 352}	Continued From page 2 - Resident 2: A medication error report, dated 02/02/2026, indicated a caregiver had not administered Resident 2's tramadol 50 mg dose when the caregiver did not count the narcotics as required after passing medications on 02/01/2026. The report read, in part, "staff member was not reading MAR when popping medications and wrote narcotics in at end of medication pass. Staff member did not count cart back before leaving after med [medication] pass...shift change count was off..." Resident 2's February 2026 MAR read, in part, "TRAMADOL HCL 50 MG TABLET **REORDER WHEN DOWN TO A 7 DAY SUPPLY** TAKE 1 AND 1/2 TABLETS (75MG) BY MOUTH [sic] TWICE DAILY AT 8AM AND 8PM..." Resident 2's February 2025 MAR indicated s/he had been administered his/her tramadol on 02/01/2026. - Resident 3: A medication error report, dated 02/02/2026, indicated a caregiver had not administered Resident 3's pregabalin 150 mg dose when the caregiver did not count the narcotics as required after passing medications on 02/01/2026. The medication error report read that physician orders were for Resident 3 to "take one capsule by mouth at 8am & 8pm..." The report read, in part, "staff member was not reading MAR when popping medications and wrote narcotics in at end of medication pass. Staff member did not count cart back before leaving after med [medication] pass...shift change count was off..." - Resident 4: A medication error report, dated 01/02/2026, indicated that Resident 4's twice-daily dosage of tamsulosin had not been administered for four days from 12/29/2025 to 01/01/2026. The report read, in part, "...tamsulosin...take one capsule by mouth twice	{N 352}		

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{N 352}	Continued From page 3	{N 352}		

daily at 8 AM & 8 PM...the tamsulosin was approved by [Assistant Manager B] as unsupervised administration, therefore it does not show on electronic system for staff to chart. The resident did not receive the medication on 12/29/25 to 1/1/26. Resident resumed medication on 1/2/26..."

- Resident 5: A medication error report, dated 09/04/2025, indicated Resident 5's daily dose of sertraline was not administered. The report read, in part, "What are physician orders? Take one capsule by mouth twice daily at 8am & 8pm...medication marked administered in MAR, med [medication] [not] in facility...was going too fast in the MAR and click [sic] administered...medication was not given due to medication not in facility..."

- Resident 6: A medication error report, dated 10/02/2025, indicated that Resident 6's ketorolac and acetaminophen were not administered as prescribed. The report read, in part, "Time of Error: 1000 [sic] pm & 600 [sic] am...Medication Given: Ketorolac 10 mg tab [tablet]...10pm dose...Ketorolac 10mg tab...6am dose...Acetaminophen 500 mg tab...6am dose...What was physician's order? Ketorolac 10 mg TID [three times a day] @ 6A-2p-10p for 3 doses Acetaminophen 500 mg TID @ 6a-2p-10pm x 14 days...medication was not given as ordered...resident's pain was not controlled."

At approximately 3:10 PM, Surveyor interviewed House Manager (HM) A regarding the multiple medication errors. HM A stated staff had been instructed to order residents' medications when there was a 7-day supply left. HM A stated in the instance of Resident 1's olanzapine, staff had not left a note to advise that it was out of stock. HM A

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{N 352}	Continued From page 4 stated in the instance of Resident 2's tramadol and Resident 3's pregabalin, extra doses were found during the narcotic count after the time they were supposed to be administered. HM A indicated staff had erroneously marked a dose of tramadol as administered to Resident 2 in his/her MAR. HM A stated an extra dose was found in the narcotic count, indicating Resident 2 had not received it. HM A stated staff had been re-educated after medication errors. In summary, Resident 1 did not receive his/her olanzapine as prescribed, and Resident 5 did not receive his/her sertraline as prescribed when staff did not re-order out-of-stock medications, resulting in missed doses. Resident 2 missed a dose of tramadol, and Resident 3 missed a dose of pregabalin due to staff erroneously charting doses as administered when they were not. Resident 4 did not receive tamsulosin as prescribed due to a charting error. Resident 6 did not receive ketorolac and acetaminophen as prescribed. The provider did not ensure each resident had the right to receive medication as prescribed.	{N 352}		
{N 431}	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services	{N 431}		

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{N 431}	Continued From page 5 unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 7 received health monitoring services adequate to meet his/her needs. The provider did not document all communication with each residents' health care providers and did not record changes in Resident 7's skin until Resident 7's entire back was pink and macerated from his/her shoulders to his/her hips. This is a repeat deficiency. See Statement of Deficiencies (SOD) 92G317, dated 08/28/2025, SOD 92G316 dated 06/28/2024, SOD 92G315, dated 03/07/2024, and SOD 92G311, dated 09/01/2021. Findings include: On 11/07/2025 and 11/10/2025, the Department received complaints regarding resident care.	{N 431}		

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{N 431}	Continued From page 6 On 09/04/2025, the Department issued a notice and order letter with SOD 92G317 that read: "1. Pursuant to Wis. Stat. §§ 50.03(5g)(b)6, the licensee shall develop and implement corrective measures to ensure residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. The licensee shall develop and implement corrective measures to resolve each deficiency identified in Statement of Deficiency (SOD) 92G317. WITHIN 45 DAYS of receipt of this notice, the licensee will develop (or review/revise) written procedures and staff training (as appropriate) to address: Health Monitoring: Including how the provider will: (a) monitor and document changes in the resident's health or mental health; (b) notify the physician, notify the resident's legal representative or family, notify the care manager (if any) when a resident experiences a change of condition, accident, injury, or medical emergency; resident's legal representative and care manager (if any) when a resident experiences a change of condition, accident, injury, or medical emergency; (c) obtain timely medical care (clinical assessments, prompt medical treatment); (d) review and revise individualized service plans annually or when there is a change in a resident's needs, abilities, or physical or mental condition; (e) provide or arrange prompt or adequate services to address each resident's health care needs. Additionally: - All managers and resident care staff (as appropriate) will receive in-service training	{N 431}		

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regarding the provider's written procedures required by Order #1.
-Training will be documented in the employee files and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content.
-A copy of the written procedures will be made available to department representatives upon request."

On 02/24/2026, Surveyor reviewed the provider's training documentation, which indicated staff had been retrained in health monitoring and notification procedures on 10/08/2025.

On 02/23/2026, Surveyor reviewed Resident 7's record.

Resident 7's face sheet indicated s/he was admitted on 02/25/2025 and discharged on 11/17/2025. Resident 7 had multiple diagnoses including: dementia, psychotic disturbance, mood disturbance, anxiety, and depression.

Resident 7 had a Power of Attorney.

Resident 7's Pre-Assessment, dated 02/24/2025, read, in part: " ...Skin Problems ...No history of or current skin problems ..."

On 10/24/2025, Resident 7 was admitted to hospice after s/he fell, fractured his/her hip, and was hospitalized. Hospice orders indicated Resident 7 was on bed rest and was to be turned every 4 hours.

Resident 7's individual service plan (ISP), dated 10/22/2025, included the following:
" ...Skin Integrity ...will remain intact with no redness ...Staff to observe for skin redness, open

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area, scratches, cuts, tears, or bruising/discoloration ....Reposition every 2 hours while in bed or in wheelchair ...Bed Mobility: Requires total assistance from 2 care team members to turn and reposition in bed every 2 hours as necessary ...Bathing: Facility staff to assist resident with bathing to ensure cleanliness ...report ...changes in ability to bathe or skin changes ..."

On 02/23/2026 at approximately 10:00 AM, Surveyor interviewed House Manager (HM) A who stated that [Hospice Name] had not noted a rash on Resident 7's back. HM A stated that after Resident 7 had surgery from a broken hip, s/he had increased pain and was only receiving bed baths and those baths occurred 2 days a week. HM A stated Resident 7 did often refuse cares. HM A stated staff discovered a significant rash on Resident 7's back on 11/05/2026. HM A stated staff were trained to write a care note for any skin changes found when completing baths.

At approximately 12:00 PM, Surveyor interviewed Lead Caregiver (LC) C who stated after Resident 7 returned to the facility post hip surgery s/he often changed his/her bedding. LC C stated Resident 7 often spilled his/her juice, resulting in his/her shirt needing changing up to 3-4 times a shift. LC C stated Resident 7 no longer wanted to shower so staff performed bed baths that were typically scheduled 2 times per week. Surveyor asked LC C to indicate on Resident 7's daily task tracking where showers/bed baths were documented in October and November 2025. LC C was unable to locate documentation. LC C stated if skin concerns were observed during bathing they would enter a care note but sometimes the caregivers were not very good at doing so. LC C stated when the reddened area

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on Resident 7's back was discovered s/he suspected some staff were not documenting and may not have been completing cares such as bathing and repositioning.

At approximately 3:15 PM, Surveyors interviewed HM A and Quality Assurance (QA) D who confirmed that s/he was unable to locate tracking of Resident 7's bed baths.

Surveyor reviewed Resident 7's Progress Notes and found 1 entry dated 10/30/2025 that read, "Staff completely changed residents [sic] linen as well as put resident in gown for comfort, staff reposition [sic] resident and before fully changing staff administered PRN [as needed] for pain to provide the best level of comfort for resident."

On 02/24/2026 an email communication received from QA D read, "The most recent hospice visit prior to the skin breakdown was completed on 10/27, and there were no skin concerns documented at that time. Additionally, a progress note entered by facility staff on 10/30 indicated a linen and gown change, with no skin issues noted then either. Attached to the email was a document from [Name Hospice] dated 11/05/2025 at 3:53 PM read, in part, " ...Report of skin issue ...Facility aide is reporting new skin breakdown that spans from patients [sic] shoulders to hip, appears to be a yeast infection. Skin is red, pink, macerated and shiny from photo sent to RN [registered nurse] for assessment...additional photos were taken ...RN voices concern [his/her] concern for potential neglect of patient due to [his/her] resistance of cares and declining of cares ...Plan is to do a vulnerable adult report ..."

The provider did not monitor Resident 7's skin

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{N 431}	Continued From page 10 and document changes in Resident 7's record. October 30, 2025, was the last documentation that staff observed Resident 7's skin for changes. On 11/05/2025, staff contacted hospice when it was discovered Resident 7's back was pink and macerated from his/her shoulders to his/her hips. It was unclear if staff were providing cares per Resident 7's service plan and monitoring Resident 7's skin due to the lack of documentation.	{N 431}		