STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012102	A. BUILDING: _____ B. WING _____	C 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME MENOMONIE RCAC	917-22ND AVENUE NE 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
U 000	INITIAL COMMENTS On 10/31/2023, Surveyor conducted a complaint investigation at Comforts of Home Menomonie RCAC. Three of 3 complaints were unsubstantiated. Three deficiencies were identified. Census: 37 occupied apartments	U 000		
U 171	89.26(4) ANNUAL REVIEW A tenant's capabilities, needs and preferences identified in the comprehensive assessment shall be reviewed at least annually to determine whether there have been changes that would nescessitate a change in the service or risk agreement. The review may be initiated by the facility, the county department designated under sub. (3)(c)2., or at the request of or on the behalf of the tenant. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 tenants sampled (Tenant 1 and Tenant 2) were assessed on an annual basis. Findings include: On 10/31/2023, Surveyor reviewed 2 tenant records. Tenant 1 was admitted to the facility on 03/11/2022. His/her record included a comprehensive assessment dated 03/08/2022. Surveyor did not find evidence that Tenant 1 was	U 171		

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
	0012102	A. BUILDING: _____ B. WING _____	C 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME MENOMONIE RCAC	917-22ND AVENUE NE 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
U 171	Continued From page 1 assessed after 03/08/2022. Tenant 2 was admitted to the facility on 10/29/2021. Surveyor did not find evidence of a comprehensive assessment in his/her record. At 11:15 AM, Surveyor interviewed Registered Nurse (RN) A. RN A stated the provider did not complete tenant assessments annually; the provider completed them prior to admission only. RN A explained that the provider updated tenant service agreements based on observations and feedback from staff and families. RN A stated Tenant 1 had a change of condition since admission; Tenant 1 went on hospice on 07/17/2023 and was considered bed bound. RN A stated Tenant 2's condition and service had not changed since admission.	U 171		
U 188	89.27(4) SERVICE AGREEMENT REVIEW AND UPDATE. The service agreement shall be reviewed when there is a change in the comprehensive assessment or at the request of the facility or at the request or on behalf of the tenant and shall be updated as mutually agreed to by all parties to the agreement. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure service agreements were reviewed and updated when there was a change in condition. Findings include: On 10/31/2023 at 10:20 AM, Surveyor interviewed Registered Nurse (RN) A. RN A	U 188		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012102	A. BUILDING: _____ B. WING _____	C 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME MENOMONIE RCAC	917-22ND AVENUE NE 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
U 188	Continued From page 2	U 188		

identified Tenant 1 and Tenant 2 as needing "full care," which included repositioning, toileting/incontinence care, and transfer assistance via sit-to-stand (S2S). RN A stated Tenant 1 was on hospice (admitted on 07/17/2023) and recently become bed bound.

TENANT 1:
On 10/31/2023, at 11:30 AM, Surveyor interviewed Hospice Nurse (HN) B and HN C. HN C stated Tenant 1's care needs were increasing, and his/her team was actively looking for alternative placement.

At 12:00 PM, Surveyor interviewed Tenant 1 in his/her apartment. Tenant 1 was in a hospital bed with various neck supports around his/her head. Surveyor observed a S2S next to the bed. Tenant 1 said, "Staff feed me, get me out of bed... pretty much everything. They come in every couple hours." Tenant 1 indicated s/he did not get out of bed for bathing or toileting purposes.

On 10/31/2023, Surveyor reviewed Tenant 1's record. Tenant 1 was admitted to the facility on 03/11/2022. Tenant 1's service agreement, updated 10/09/2023, indicated Tenant 1 required assistance with all mobility but did not indicate the level of assistance or the need for a S2S. The agreement read, "Resident will be able to move around the facility with assistance from staff with/without assistive device. (Specify what type of device)." Tenant 1's service agreement did not indicate Tenant 1 was admitted to hospice or that s/he required assistance with feeding, incontinence care, or repositioning.

TENANT 2:
On 10/31/2023 at 11:40 AM, Surveyor interviewed Tenant 2 in his/her apartment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012102	A. BUILDING: _____ B. WING _____	C 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME MENOMONIE RCAC	917-22ND AVENUE NE 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
U 188	Continued From page 3 Surveyor observed the following assistive devices in Tenant 2's apartment: hospital bed with rails, a S2S, electric wheelchair, leg braces, a shower chair, and toilet riser. Tenant 2 stated staff assisted him/her with everything, including dressing, bathing, toileting, medications, and transfers via S2S. Tenant 2 said once s/he was in his/her electric chair, s/he was able to move about the facility independently. Tenant 2 said staff applied his/her leg braces daily. On 10/31/2023, Surveyor reviewed Tenant 2's record. Tenant 2 was admitted to the facility on 10/29/2021. Tenant 2's service agreement, updated 03/16/2023, indicated Tenant 2 required assistance with mobility but did not identify the type of assistance Tenant 2 needed. The agreement did not refer to Tenant 2's need for an electric wheelchair, transfer assistance via S2S, or leg braces. At 11:15 AM, Surveyor interviewed RN A. RN A said the provider updated tenant service agreements based on observations and feedback from staff and families, not comprehensive assessments. RN A stated the provider assessed tenants prior to admission but they did not routinely complete comprehensive assessments after admission. RN A stated Tenant 1 recently began having difficulty getting his/her food to his/her mouth, so staff were offering feeding assistance. RN A reviewed Tenant 2's record and stated Tenant 2's needs had not changed since March 2023, but his/her transfer assistance, electric wheelchair, and leg braces should have been added to the service agreement.	U 188		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012102	A. BUILDING: _____ B. WING _____	C 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME MENOMONIE RCAC	917-22ND AVENUE NE 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
U 188	Continued From page 4 Cross reference: U0171 DHS 89.26(4) Annual Review	U 188		
U 189	89.28(1) Risk Agreement (1) REQUIREMENT As a protection for both the individual tenant and the residential care apartment complex, a residential care apartment complex shall enter into a signed, jointly negotiated risk agreement with each tenant by the date of occupancy. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 tenants sampled (Tenant 2) had a risk agreement upon admission. Findings include: On 10/31/2023, Surveyor reviewed Tenant 2's record. Tenant 2 was admitted to the facility on 10/29/2021. Tenant 2' record did not include a risk agreement. At 1:30 PM, Surveyor interviewed Registered Nurse (RN) A. RN A reviewed Tenant 2's records and the provider's files. RN A stated Tenant 2 did not have a risk agreement.	U 189		