STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014985	A. BUILDING: _____ B. WING _____	R-C 02/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE 4 U 4 LLC	213 GLACIER DRIVE MADISON, WI 53705

(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 02/05/2024, Surveyor conducted a verification visit at Comfort Care 4 U 4 LLC, an AFH in Madison. Two deficiencies were identified. Two deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) 5IXK11, dated 05/30/2018; SOD IUQP11, dated 09/27/2022 and IUQP14, dated 09/13/2023. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 4	{M 000}		
{M 232}	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 caregivers reviewed had been screened for illness detrimental to residents, including for tuberculosis, within 90 days before the start of providing services. Caregiver J did not have a	{M 232}		

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
	0014985	A. BUILDING: _____ B. WING _____	R-C 02/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE 4 U 4 LLC	213 GLACIER DRIVE MADISON, WI 53705

(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 232}	Continued From page 1 tuberculosis test within 90 days before the start of providing services. This is a repeat deficiency. See Statement of Deficiency (SOD) 5IXK11, dated 05/30/2018; SOD IUQP11, dated 09/27/2022 and SOD IUQP14, dated 09/13/2023. Findings include: On 02/05/2024 at approximately 11:45 a.m., Surveyor requested Caregiver J's tuberculosis test from House Manager A. On 02/05/2024 at approximately 12:10 p.m., Surveyor reviewed Caregiver J's record. Caregiver J was hired on 06/01/2023. House Manager A provided Surveyor with documentation of a tuberculosis test completed on 12/13/2021, greater than 90 days prior to hire. Surveyor reviewed concern with House Manager A that SOD IUQP14, dated 09/13/2023, identified Caregiver J had not had a tuberculosis test completed within 90 days prior to hire and asked if the provider had Caregiver J complete a tuberculosis test since the concern was identified. House Manager A replied, "No. We don't have one."	{M 232}		
{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	{M 424}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014985	A. BUILDING: _____ B. WING _____	R-C 02/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE 4 U 4 LLC	213 GLACIER DRIVE MADISON, WI 53705

(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 424}	Continued From page 2	{M 424}		

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 observation, record review and interview, the provider did not ensure 1 of 1 individual service plans (ISP) were updated when there was a change in the resident's need. Resident 4's ISP was not updated when s/he no longer required sharp objects be kept secured. Resident 4's ISP was not reviewed within the past six months.

This is a repeat deficiency. See Statement of Deficiency (SOD) 5IXK11, dated 05/30/2018 and IUQP14, dated 09/13/2023.

Findings include:

On 02/05/2024 at approximately 11:50 a.m., Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider's facility on 06/27/2023. Resident 4's record included an ISP, dated 07/10/2023, that stated s/he had suicidal tendencies so sharp objects must be kept secured.

On 02/05/2024 at approximately 11:55 a.m., Surveyor observed 2 sharp knives in an accessible kitchen drawer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014985	A. BUILDING: _____ B. WING _____	R-C 02/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE 4 U 4 LLC	213 GLACIER DRIVE MADISON, WI 53705

(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 424}	Continued From page 3 On 02/05/2024 at approximately 12:15 p.m., Surveyor reviewed concern with House Manager A that Resident 4's ISP indicated sharp objects should be kept secured; however, knives were observed accessible in the kitchen. House Manager A stated access to sharp objects was no longer a concern due to Resident 4's change in mobility. House Manager A stated s/he was unsure of the last time Resident 4 had verbalized suicidal ideation. House Manager A stated s/he planned to remove the intervention of keeping sharp knives locked when s/he did Resident 4's next ISP update, but had yet to do so.	{M 424}		