STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014823	A. BUILDING: _____ B. WING _____	C 08/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE 4 U 3 LLC	2100 WESTCHESTER DRIVE FITCHBURG, WI 53711

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M 000	INITIAL COMMENTS On 08/03/2023, with information gathered through 08/21/2023, Surveyor conducted a complaint investigation at Comfort Care 4 U 3 LLC. Five deficiencies were identified. One of the 5 deficiencies was a repeat violation (see Statement of Deficiency (SOD) 3W1K11). Census: 3	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not report to the Department within 24 hours, a significant change in Resident 1's condition when s/he fractured his/her elbow. Findings include: On 07/27/2023, the Department received a complaint alleging a resident had sustained an injury due to an unwitnessed fall.	M 134		

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

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M 134	Continued From page 1 On 08/03/2023, at approximately 3:30 PM, Surveyor observed Resident 1 sitting in his/her chair in his/her bedroom. Surveyor noted that Resident 1 had a cast on his/her arm. Surveyor asked Resident 1 how s/he got a cast on his/her arm. Resident 1 stated, "I fell on some boxes. The boxes had to be taken out after I fell. I am on my second cast!" On 08/03/23, at approximately 3:45 PM, Surveyor interviewed Caregiver D. Caregiver D stated Resident 1 had broken his/her arm when s/he fell in his/her room. On 08/03/2023, Surveyor reviewed Resident 1's record. Resident 1's medical record, dated 07/19/2023, documented: "Patient reports onset of symptoms yesterday. Reports was walking and tripped over something on the floor causing [him/her] to fall forward. Reports landing directly on [his/her] right arm particular [his/her] elbow. ... Patient reports has had pain to [his/her] right elbow every since. Had a x-ray performed by [his/her] primary care doctor today concerning for a displaced supracondylar humeral fracture. Patient was sent by PCP (primary care physician) for further orthopedic evaluation, splinting." "Patient with mechanical fall on right elbow yesterday. X-ray performed prior to arrival with evidence of displaced supracondylar humeral fracture. ... Case discussed with orthopedics with recommendations for splint by Orthopedics as well as close outpatient orthopedic follow-up for further likely surgical management. ..." Resident 1's progress notes documented: "07/22/2023 - [His/her] [Guardian E] call, talk to	M 134		

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M 134	Continued From page 2 [him/her]. Wanted staff to removed empty boxes out [his/her] bedroom to avoid falling again ..." On 08/04/2023 at 5:54 PM, Surveyor emailed HM B, Licensee A and Executive Assistant C that asked if a written report had been submitted to the Department regarding Resident 1's arm fracture. On 08/07/2023 at 11:43 AM, HM B emailed Surveyor stating the provider had contacted Resident 1's guardian and managed care organization consultant. On 08/07/2023, Surveyor reviewed the Department file and did not find any written report that Resident 1 had sustained an injury.	M 134		
M 324	88.05(3)(n) CLEAN, SAFE, FUNCTIONAL HOUSEHOLD ITEMS The home shall have clean, functioning and safe household items and furnishings, including the following: This Rule is not met as evidenced by: Based on observation and interviews, the home did not ensure residents had hand towels or paper toweling in the resident bathroom. Findings include: On 07/27/2023, the Department received a complaint alleging the facility did not have towels or paper toweling int the resident bathroom. On 08/03/2023, at approximately 3:20 PM, Surveyor toured the home and noted a resident	M 324		

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M 324	Continued From page 3	M 324		

was utilizing the resident bathroom; Surveyor waited for resident to finish and then observed the bathroom. Surveyor noted there were no material-based towels hanging up or paper toweling available in the bathroom for residents to dry their hands with. Surveyor also looked in the drawers of the bathroom vanity and under the sink cabinet where Surveyor observed cleaning supplies that were not securely stored but did not locate any form of toweling.

On 08/03/2023, at approximately 3:45 PM, Surveyor asked Caregiver D why there were no available towels in the resident bathroom. Caregiver D explained that residents informed staff when they needed the restroom and staff would then provide them with some paper toweling. Caregiver D explained that the paper toweling would become wet when left in the bathroom and there was not much room to store the paper toweling.

On 08/08/2023, at approximately 8:10 AM, Surveyor interviewed Resident 1's Guardian E. Guardian E stated s/he had witnessed Resident 1 use the bathroom without informing staff. Guardian E explained that Resident 1 would walk out of the bathroom while wiping his/her hands on his/her pants. Resident 1 would inform him/her that s/he would wipe his/her hands on his/her clothes when there was no toweling available.

On 08/15/2023 at 9:23 AM, Surveyor emailed Licensee A, House Manager (HM) B, and Executive Assistant C. Surveyor asked why towels were not kept in the bathroom for resident use. HN B responded that there was always paper toweling available, staff only kept it out of the bathroom to prevent it from getting wet. Residents have access to them at all times with

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M 324	Continued From page 4 help from staff.	M 324		
M 436	88.07(2)(a) SERVICES The licensee shall provide or arrange for the provision of individualized services specified in a resident's individual service plan that are the licensee's responsibility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure provisions of services as specified in the Individual Service Plan (ISP) for 1 of 1 residents reviewed. Resident 1's podiatry and dental appointments were not scheduled as outlined in his/her Individual Service Plan. This is a repeat deficiency. See Statement of Deficiency (SOD) 3W1K11 dated 06/29/2021. Findings include: On 07/27/2023, the Department received a complaint alleging resident's medical appointments were not scheduled. On 08/03/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the home on 10/31/2022. Resident 1's ISPs, dated 10/25/2022 and 07/06/2023, documented:	M 436		

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"Grooming: [S/he] should see podiatrist regularly. Possibly every 2 months. ..."
"Oral Care: The goal is to keep [his/her] teeth clean with healthy gums. [S/he] will go to the dentist when scheduled."

On 08/03/2023 at 4:38 PM, Surveyor emailed Licensee A and House Manager (HM) B and requested all medical records since Resident 1's admittance.

On 08/04/2023, HM B provided the following documentation:
"12/13/2022 - Routine Dental Exam - Patient presents to clinic with [Caregiver D] for Adult recall. ... Reviewed medications with caregiver. ... Difficult to complete cleaning, limited access as patient does not open very wide and tenses lower lip tightly. Completed cleaning as best as possible and safely. ... Next Visit: 3 month(s) recall"

Surveyor noted there were no podiatry appointments scheduled and no follow up dental exam scheduled.

On 08/04/2023 at 12:12 PM, Surveyor emailed HM B, Licensee A and Executive Assistant C and asked for clarification as to why the Resident 1's medical appointments were not scheduled as outlined in his/her ISP. HM B responded that the ISP did not specify who schedules appointments.

On 08/08/2023 at 5:17 PM, Resident 1's Guardian E emailed Surveyor email correspondence between him/her and Licensee A which documented:
"06/21/2023 from [Licensee A] to [Guardian E]: Podiatrist was attended in November and there seemed to have been a communication

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M 436	Continued From page 6 breakdown. ... Traditionally, we make an appointment after every appointment. We assumed it was done and we did not follow up. ... Dental appointments are every 6 months and last seen in December 2022." Surveyor noted follow-up for dental appointment was to be in 3 months.	M 436		
M 580	88.10(3)(p) Prompt and Adequate Treatment Prompt and adequate treatment. To receive prompt and adequate treatment and services appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure 1 of 1 residents (Resident 1) reviewed received required physical therapy equipment to ensure safety. Findings include: On 07/27/2023, the Department received a concern alleging medical equipment was not provided for residents. On 08/03/2023, at approximately 3:20 PM, Surveyor arrived at the home when Caregiver D explained that s/he was in the middle of filling out a report due to Resident 1 falling while s/he assisted Resident 1 with his/her physical therapy exercises. Caregiver D stated Resident 1 was hanging onto the half wall, in the common area, when s/he fell. On 08/03/2023, at approximately 3:30 PM, Surveyor interviewed Resident 1. Resident 1 stated s/he had just fallen while doing his/her	M 580		

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physical therapy. Surveyor observed Resident 1 had a cast on his/her right arm and was not wearing a gait belt.

On 08/03/2023, Surveyor reviewed Resident 1's record.

Resident 1 was admitted to the home, 10/31/2022, with diagnoses including osteoporosis (disease that weakens the bones), arthritis of the left hip, and atrophy (decrease of a body part) of the hip. Resident 1 has a metal in [his/her] right hip and right femur.

Resident 1's progress notes, dated 07/18/2023 to 08/03/2023, documented:
"07/18/2023 - ... [s/he] called me in and told me that [s/he] was feeling trapped on [his/her] right side and staff help [him/her] to get up ..."
"07/19/2023 - [Resident 1] came back from the hospital at 7 PM. [S/he] has a fracture on [his/her] arm."
"07/26/2023 - The PT (physical therapist) came at 11:00 AM and suggested to use a gate [sic: gait] belt and to do some activities ..."
"08/03/2023 - Had a fall by the end of the shift, while after [s/he] is done with [his/her] exercise by the moment staff turned [his/her] face to pull [his/her] walker even before [his/her] fall while [s/he] was doing [his/her] exercise [s/he] lost [his/her] balance and when [s/he] moved to the side staff pulled [him/her] back ..."

On 08/10/2023, at approximately 4:05 PM, Surveyor interviewed Resident 1's Guardian E. Guardian E stated s/he was upset that Resident 1 fell during his/her physical therapy exercises. Guardian E stated physical therapy had requested that the provider obtain a gait belt to utilize when Resident 1 was ambulating and

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during his/her exercises.

On 08/14/2023, at approximately 3:00 PM, Surveyor interviewed Resident 1's Occupational Therapist (OT) F. OT F stated there had been a delay in the provider obtaining a gait belt for Resident 1. The gait belt was requested after his/her fall on 07/18/2023 that resulted in him/her sustaining a fractured arm. OT F forwarded Surveyor the following documentation:
-Resident 1's Physical Therapist (PT) H's notes, which documented:
"07/26/2023 - [Resident 1] would benefit from a personal gait belt. [S/he] should utilize this when ambulating and during standing exercises."
-An email from Resident 1's managed care organization (MCO) Care Manager (CM) G that documented: "08/09/2023, 8:13 AM - email to [PT H], [Guardian E], Licensee A and House Manager (HM) B: I met with [Resident 1's] team yesterday to see how things are going. A question that was asked, is there a certain size gait belt that you would recommend for Resident 1. There hasn't been one purchased yet ..."
-An email from HM B to PT H that documented: "08/10/2023 - We got the plain gait belt from the [store]."

On 08/15/2023 at 9:23 AM, Surveyor emailed Licensee A, HM B and Executive Assistant C. Surveyor asked why there had been a delay in obtaining a gait belt for Resident 1. HM B responded and stated, "We are not responsible for providing gait belt, this is done by the Therapist. We confirmed this during our meeting with [his/her] team on 08/08/2023 present were CM G and Guardian E. After the meeting 08/09/2023, we received a description of the gait belt recommended for [him/her] by PT, which was provided, following a request by [CM G]."

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M 580	Continued From page 9 On 08/16/2023 at 7:00 AM, Surveyor emailed OT F and asked for additional clarification on when and who was to provide Resident 1's gait belt. OT F responded: "I can forward you the email where I was made aware that they hadn't purchased a gait belt (Wed 8/9). I said I could drop one off but they purchased one on Thursday 8/10 when I was planning to drop it off. If it is a caregiver's concern to purchase one, we are able to give one, but we generally don't carry extras with us and it is just a general supply item that people purchase. We had not been notified of any concern about getting one, but we could certainly assist if there were any concerns brought to our attention. It is rare to require a physician's order before obtaining one."	M 580		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 residents reviewed received all prescribed medications. Resident 1 did not receive the correct dosage of his/her albuterol (inhaler) and levofloxacin (antibiotic). Findings include:	M 582		

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M 582	Continued From page 10 On 07/27/2023, the Department received a concern that a resident had been prescribed an inhaler and staff did not ensure accurate administration. On 08/08/2023 at 5:17 PM, Resident 1's Guardian E emailed Surveyor email correspondence between him/her and Licensee A and House Manager (HM) B, which documented: On 06/12/2023, [Guardian E] emailed HM B: "[Resident 1] was given an inhaler at [his/her] urgent care appointment. [S/he] does not know how to use an inhaler. Is staff knowledgeable about inhalers? [S/he] would benefit from having a chamber. I don't know if they gave [him/her] one with the inhaler. I want to make sure [s/he] is using the inhaler effectively. ... [Resident 1] has sounded congested and has been coughing hard the last 2 times I've talked to [her/him]." On 06/16/2023, [Guardian E] emailed HM B: "[Resident 1] should have a chamber now for [his/her] inhaler. Please make sure staff are trained on effective use of this. It's very important that [s/he] get the inhaler done correctly. [Resident 1] should never be given the inhaler and told to do it." 06/21/2023 from [Licensee A] to [Guardian E]: "Inhaler chamber. We called [urgent care] and they never called into the pharmacy. They cannot locate a script. They are working on it and will get back to us. Staff on schedule today was trained on proper usage of inhaler without the chamber. This was done in the past, so this is a refresher training. We will train additional staff." On 08/10/2023, at approximately 4:05 PM, Surveyor interviewed Resident 1's Guardian E. Guardian E stated s/he had observed Resident 1, on 06/19/2023, use his/her inhaler and was surprised s/he did not know how to use it.	M 582		

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Guardian E stated, "[S/he] was pumping the inhaler onto [his/her] teeth and outer mouth." Guardian E stated Resident 1 did not understand that s/he had to inhale the medication. Guardian E stated two staff members watched this med administration and did not express any concerns or try to redirect Resident 1. Guardian E stated a spacer for the inhaler had been ordered at Resident 1's appointment with his/her primary physician on 06/15/2023 but staff did not pick it up. Guardian E stated, "I was on the phone during the appointment and heard the physician tell [Caregiver I] to stop at the pharmacy on the way out to pick it up. [Caregiver I] said ok but then never got it. The provider kept getting confused thinking the spacer/chamber was ordered at an urgent care visit earlier in the month despite my telling them it was ordered by the PCP (primary care physician) (and that the staff person was told at the appointment to get it on [his/her] way out). They kept calling urgent care for the spacer. Eventually they got one, but I don't know from where."

On 08/13/2023, Surveyor reviewed Resident 1's record.

Resident 1's ISPs, dated 10/25/2022 and 07/06/2023, documented:
"Medication Management: Staff will continue to administer medication to [him/her]. Staff will ensure [s/he] takes [his/her] medication/s as ordered."

Resident 1's progress notes, dated 06/06/2023 to 06/21/2023, documented:

"06/06/2023 - [Resident 1] was coughing most of the night. [s/he] did not ask for any cough syrup. [Resident 1] was good during the morning. Cough

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a lot staff report to manager."
"06/07/2023 - [s/he] did a lot of coughing in the night again. Morning staff notified. [s/he] has a Dr. (doctor) appt coming."
"06/08/2023 - [s/he] is coughs a lot"
"06/09/2023 - [Resident 1] kept coughing throughout the night. Staff checked on [him/her] and gave her some water to drink. [s/he]is coughing but [s/he] don't have a fever."
"06/10/2023 - staff took [him/her] to urgent care. we arrived at home and [s/he] took [his/her] launch [sic: lunch] and [his/her] antibiotic and albuterol from urgent."
"06/11/2023 - [s/he] did not sleep very well because [s/he] was coughing all night till this morning and is still coughing."
"06/15/2023 - took [him/her] to [his/her] doctors appointment. ... [s/he] is still coughing."
"06/16/2023 - [s/he] was coughing most of the night. Maybe if evening staff could give her PRN mucinex before [s/he] goes to bed at 8p?"
"06/17/2023 - [s/he] is coughing"
"06/19/2023 - [Resident 1] was in bed when staff arrived, [s/he] was coughing most part of the night."
"06/20/2023 - [Resident 1] coughed most of the morning starting at 6am. [s/he] was given PRN mucinex at 8:30am and [his/her] inhaler that was in [his/her] walker. Staff put [his/her] name on the inhaler and put it in med cabinet. [s/he] was encouraged to drink extra water."
"06/21/2023 - [Resident 1] was in [his/her] room coughing when staff arrived. Staff asked evening staff to give PRN mucinex. [s/he] slept most of the night but started coughing again at 5am. [s/he] was encouraged to drink more water. [s/he] also used [him/her] inhaler and took it with [him/her] with a note when [s/he] could use it again (12:10p)"
"06/22/2023 - [S/he] is still coughing but it is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014823	A. BUILDING: _____ B. WING _____	C 08/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE 4 U 3 LLC	2100 WESTCHESTER DRIVE FITCHBURG, WI 53711

(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 582	Continued From page 13	M 582		

getting a lot better."
"06/23/2023 - [S/he] was coughing for a little bit but then it stopped shortly after."
"06/25/2023 - staff checked on [him/her] through out the night, [s/he] coughed a few times and slept most part of night."
"06/26/2023 - [Resident 1] had [his/her] inhaler just before bed. [S/he] started coughing in the night continuously. [S/he] was offered water."

Resident 1's "Active Medication" report, dated 06/01/2023 to 06/30/2023, documented:
"Albuterol HFA 90 MCG (microgram) Inhaler - Inhale 2 puffs every 4 hours as needed"
"Levofloxacin 750 MG (milligram) tablet - take 1 tablet by mouth once daily for 7 days"

Resident 1's June 2023 Medication Administration Record documented that Albuteral and Levofloxacin had been administered on the following dates:
Albuterol:
06/12/2023 - Administered at 8:00 AM
06/13/2023 - Administered at 8:00 AM
06/14/2023 - Administered at 8:00 AM
06/20/2023 - Administered at 9:00 AM - 5 days since last documented administration.
Surveyor noted that on 06/20/2023 it was documented in the progress notes that staff found the inhaler on Resident 1's walker.
06/21/2023 - Administered at 8:00 AM, 9:00 PM
06/22/2023 - Administered at 8:00 AM, 4:15 PM, 8:30 PM
06/23/2023 - Administered at 8:00 AM
06/25/2023 - Administered at 5:00 PM, 9:00 PM
06/26/2023 - Administered at 8:00 AM
06/27/2023 - Administered at 8:00 AM
06/28/2023 - Administered at 8:00 AM, 5:00 PM
06/29/2023 - Administered at 8:00 AM
06/30/2023 - Administered at 8:00 AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 582	Continued From page 14 Levofloxacin: 06/12/2023 - Administered at 8:00 AM 06/13/2023 - Administered at 8:00 AM 06/14/2023 - Administered at 8:00 AM 06/15/2023 - Administered at 8:00 AM 06/16/2023 - Administered at 8:00 AM Surveyor noted only 5 of 7 doses were documented as administered. Resident 1's medical record, dated 06/15/2023, documented: "Diagnosis: chronic cough; Order Name: Spacer Bag/Reservoir (A device called a collapsible bag spacer, or reservoir bag, can be used with the inhaler.)" On 08/20/2023 at 9:17 PM, Surveyor emailed Licensee A, HM B and Executive Assistant C. Surveyor asked for clarification on Resident 1's med administration because his/her June MAR documented the Levofloxacin was administered four times and the albuterol was not administered 06/15/2023 to 06/20/2023; 06/20/2023 it was documented that the inhaler was found on her walker. As of 08/21/2023 at 7:00 PM, the Surveyor did not receive an explanation.	M 582		