STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010987	A. BUILDING: _____ B. WING _____	R-C 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME HUDSON	**1111 HEGGEN 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 08/09/2023, Surveyor conducted a complaint investigation, standard licensing survey, verification visit, and self-report investigation at Comforts of Home Hudson. Data was collected through 08/16/2023. Three of 3 complaints were unsubstantiated. One deficiency was identified. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 34	{N 000}		
N 426	83.38(1)(b) Supervision. 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: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review, interview, and observation, the provider did not ensure Resident 1 received supervision to meet his/her needs on 05/10/2023. Resident 1 eloped twice during noc (overnight) shift on 05/10/2023. Findings include:	N 426		

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

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The provider is licensed to care for 41 residents in the client groups irreversible dementia/Alzheimer's disease, advanced aged, and physically disabled.

On 05/15/2023, the Department received a self-report from the provider indicating Resident 1 eloped twice on 05/10/2023. The self-report read: "At approximately 12:00AM, staff noticed resident on lower level south patio and no alarms sounded. Lower level, RCA [resident care assistant] attempted to redirect resident inside, but unsuccessful. Resident requested to remain outside on patio furniture. RCAs on shift completed safety checks every twenty minutes. Approximately 12:45AM, RCA did not see resident. After being unable to locate resident, RCA made a phone call to the Hudson Police Department and resident was returned to the facility at 1:07am... At approximately 4:30AM, lower level south side patio door alarm sounded, and staff noticed resident was gone. Police contacted again to assist resident in getting back to the facility safely at approximately 4:45am."

On 05/16/2023, the Department received a police report that read:
"On 5/10/23 at approximately 0053 hours, I, [Officer A]of the Hudson Police Department was dispatched to a welfare check at United Gear Assembly...for a [fe/male] who stated to the caller [s/he] was involved in a domestic incident. The caller advised [s/he] seemed 'out of it.' While en-route to this call, dispatch advised there was a missing [person] from Comforts of Home who matched the same description as this [fe/male].

I arrived at United Gear Assembly and found the [person] talking with two [people] who appeared

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to be staff of the Assembly. The [fe/male] was identified as, [Resident 1]. [Resident 1] talked about names of people and locations that didn't seem to make sense. I contacted Comforts of Home staff member, [Caregiver B], who stated they didn't have enough help to be able to leave and pick [Resident 1] up. I provided [Resident 1] with a courtesy ride to Comforts of Home ...

At 0433 hours, Comforts of Home staff called again stating [Resident 1] ran away and last saw [him/her] approximately ten minutes prior. I checked the area and located [Resident 1] in a parking lot south of Fleet Farm off Beaudry Street. [Resident 1] was hesitant to come to my squad and talk to me as [s/he] initially started running, but later recognized I was an officer and spoke with me. I again provided a courtesy ride for [Resident 1] to Comforts of Home where staff took [him/her] inside.

It should be noted the Comforts of Home facility had passcode locked doors in which they needed to enter the pin for everyone to enter and exit. The residents reportedly don't know the passcodes. [Caregiver C], a staff member of Comforts of Home stated they let [Resident 1] sit outside and would periodically check on [him/her]. [Resident 1] has been known to run from the facility when left unsupervised outside. When [Resident 1] left the first time, [Caregiver C] stated it was only a few minutes, possibly ten minutes until they realized [s/he] ran off. Based off where [Resident 1] was located when United Gear Assembly staff called, [Resident 1] wouldn't have been able to walk that distance in ten minutes, it would've had to of been a longer period of time... [Resident 1] was obviously left unsupervised again after already running away once prior in the evening, in which staff didn't

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notice [s/he] was missing for another alleged ten minutes."

On 08/09/2023 at 9:30 AM, Surveyor observed the provider's patio areas. Residents were free to go from the provider's living room to the enclosed patio on the west side of the building. The patio was enclosed with a tall wrought iron fence. There was a second patio on the south end of the building that was accessible through a door with delayed egress. This patio was also enclosed by a fence.

On 08/09/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 10/19/2020. His/her individual service plan (ISP), updated 07/07/2023, indicated s/he was designated as a high elopement risk as of 08/16/2022. The ISP read, "Triggers for wandering/eloping are when [s/he] [is] upset/agitated and talks about leaving...Resident's cognition is worsening, [s/he] often thinks [his/her] children are young and [s/he] goes to look for them....Date Initiated: 02/17/2023."

Resident 1's progress notes indicated Resident 1 made attempts to jump the patio fence on 05/02/2023 and 05/08/2023:
"Resident grabbed the salt bucket out on porch and was trying to jump over fence. Staff immediately noticed and redirected. Will continue to monitor...5/2."
"Resident is attempting to climb over fence on patio several times since lunch. Will continue to monitor...5-8-23."

At 3:45 PM, Surveyor interviewed Administrator D. Administrator D stated staff was with Resident 1 on the patio on 05/10/2023 but Resident 1

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refused to come inside. The staff member decided to leave Resident 1 on the patio and check on him/her periodically. Surveyor asked if staff should have left Resident 1 outside alone considering the recent attempts to jump the fence. Administrator D stated s/he understood the concern but staff had no choice. Administrator D stated there were 2 staff working in the building the night of Resident 1's elopements. Administrator D discussed interventions to try in the event staff were unable to have direct supervision of Resident 1 when outside, such as calling his/her family or another staff to come and assist.

On 08/15/2023 at 2:16 PM, Surveyor interviewed Caregiver C. Caregiver C stated that while s/he was cleaning on 05/10/2023, s/he noticed a shadow on the south patio. S/he went outside and found Resident 1 outside. Caregiver C stated s/he was confused because the alarm never sounded and no one informed him/her that Resident 1 was outside at the beginning of Caregiver C's shift. Caregiver C stated Resident 1 was not upset, stated s/he was fine, but stated s/he did not want to come in. Caregiver C stated s/he went back inside to finish his/her cleaning task and found his/her coworker. Caregiver C stated s/he asked his/her coworker to try and get Resident 1 to come in. Caregiver C said his/her coworker tried but Resident 1 still refused. Resident 1 began getting agitated, so they decided to let Resident 1 stay outside. Resident 1 eloped sometime around 12:45 AM.

Caregiver C said that when police returned Resident 1 the first time, Resident 1 was agitated and stated s/he was looking for his/her young children. Caregiver C stated s/he reminded Resident 1 that his/her children were adults and

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N 426	Continued From page 5 Resident 1 became more upset, but the police officer and Caregiver C were able to get Resident 1 back inside. Caregiver C said s/he was in the medication room when s/he heard the alarm sound on the south exit. Caregiver C stated that by the time s/he made it to the south patio, Resident 1 had already jumped over the fence. Caregiver C stated s/he was not aware Resident 1 had made attempts to jump the fence twice in the week preceding the elopements.	N 426		