

Wisconsin Department of Health Services

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                 |                                                                                                                          |                                                                |
|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0010062</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C<br/>01/16/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>COMFORTS OF HOME ST CROIX FALLS I</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>343 MCKENNEY ST<br/>SAINT CROIX FALLS, WI 54024</b> |                                                                                                                          |                                                                |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                       |
| {N 000}                                                                      | <p>Initial Comments</p> <p>On 01/11/2024, Surveyor conducted a verification visit and complaint investigation at Comforts of Home St Croix Falls I. Data was collected through 01/16/2024.</p> <p>The complaint was unsubstantiated.</p> <p>The deficiencies from SOD TFY611, dated 08/28/2023, were corrected.</p> <p>No new deficiencies were identified.</p> <p>Census: 13</p> <p>Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed.</p> | {N 000}                                                                                         |                                                                                                                          |                                                                |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE