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 _____	C 04/23/2025

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 04/22/2025, Surveyors conducted a complaint investigation at Comforts of Home Hudson. Data was collected through 04/23/2025. The complaint was unsubstantiated. One violation was identified. Census: 30	N 000		
N 433	83.38(1)(i) Behavior management. 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: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not provide or arrange for services to meet Resident 1's behavior management needs. Provider implemented interventions to manage Resident 1's behaviors but behaviors continued to occur. Resident 1 displayed aggressive behaviors that were harmful to him/herself, residents, and staff over 25 times in 2025. Residents and staff were scared of Resident 1 when s/he was agitated. Findings include: The provider is licensed to care for 41 residents	N 433		

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

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in the client groups physically disabled, irreversible dementia/Alzheimer's disease, and advanced aged. The facility has 2 levels. The lower level is a secured memory unit.

On 04/22/2025 at 10:45 AM, Surveyor observed Resident 1 wandering around the memory care unit. Resident 1 was ambulatory without use of an assistive device and walked without issue.

On 04/22/2025 at 10:55 AM, Surveyor interviewed Caregiver A. Caregiver A stated there was, on average, 1 resident-to-resident altercation per week within the memory care unit. Caregiver A said Resident 1 displayed the most behaviors. These behaviors included physical aggression toward residents and staff. Caregiver A stated Resident 1's most recent incident occurred on 04/21/2025.

On 04/22/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 09/06/2024, with Alzheimer's disease. Resident 1's 2025 progress notes and incident reports included the following incidents:

- 01/13/2025, Resident 1 was yelling at another resident. Staff intervened and Resident 1 punched the staff member in the ribs.
- 01/24/2025, Resident 1 was involved in a resident altercation. Resident 1 kicked a resident, and the resident pushed Resident 1 in response. Resident 1 ended up with injuries and was sent to the emergency department.
- 01/29/2025, Resident 1 became agitated at a resident who was having behaviors. Resident 1 hit the resident and told him/her to shut up.
- 01/30/2025, Resident 1 "smacked" another resident.
- 02/03/2025, Resident 1 shoved and hit staff.

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N 433	Continued From page 2 - 02/24/2025, Resident 1 approached a staff that was mopping the floor and stated, "Get out of my car or I will kill you. You got 3 minutes." - 02/27/2025, A resident walked by Resident 1, attempting to converse with him/her. Resident 1 grabbed the resident's arm. - 02/28/2025, Resident 1 grabbed a resident's left arm and would not let go. - 03/01/2025, Resident 1 was talking with another resident. Resident 1 slapped the other resident on the face. - 03/02/2025, Resident 1 was throwing furniture, being physically aggressive with staff, and attempting to jump the patio fence. Police were called to intervene. - 03/09/2025, Resident 1 pushed a resident's walker down and stole a resident's sweater. Staff intervened and Resident 1 hit staff with the sweater. - 03/10/2025, Resident 1 was wandering the hallways yelling for his/her spouse. Resident 1 attempted to hit staff. - 03/12/2025, Resident 1 was agitated, and another resident crossed his/her path. Resident 1 gripped hard on the resident's shoulders and would not let go. - 03/13/2025, Resident 1 was sitting by another resident on the couch and the other resident claimed Resident 1 was attempting to touch him/her sexually. - 03/14/2025, Resident 1 attempted to choke a resident sitting at the table. - 03/18/2025, Resident 1 "did not receive a shower due to resident being aggressive towards [sic] staff and other residents." Resident 1 was verbally and physically aggressive "all morning." Resident 1 hit another resident in the face. Resident 1 "charged at another resident and staff with a chair." - 03/21/2025, Resident 1 took off his/her shirt in	N 433		

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the dining room. Staff attempted to help Resident 1, but Resident 1 became aggressive.
- 03/21/2025, Resident 1 got aggressive with staff while staff were assisting another resident. Resident pushed staff from behind while they were assisting a resident during a transfer.
- 03/22/2025, Resident 1 was attempting to trip staff in the hallway. "After supper, [Resident 1] kept charging after staff... staff told [him/her] that [s/he] can not [sic] come with [sic] into another residents [sic] room...When staff shut [Resident 1] out of the residents [sic] room, [Resident 1] started banging and punching the door, swearing at staff."
- 03/23/2025, Resident 1 charged at and cornered staff. Resident 1 grabbed the staff's breast, stomach, and shirt aggressively. Resident 1 refused to let go. A visiting family member intervened.
- 03/26/2025, Resident 1 chased staff. Resident 1 was screaming, yelling, throwing furniture, trying to break tables, pulled a resident's hair, swung at staff, and attempting to flip chairs that residents were sitting in.
- 03/30/2025, Resident 1 was aggressive toward residents in the living room. Staff redirection was unsuccessful.
- 04/03/2025, Resident 1 was following another resident around while yelling and growling at him/her. Resident 1 ran into another resident sitting on the couch and yelled, "What the hell. Get out of my way." Resident 1 yelled at the resident to move somewhere else.
- 04/06/2025, Resident 1 approached staff while they were helping another resident. Resident 1 acted like s/he was going to hit staff then stated, "I'm going to smack you across the face."
- 04/11/2025, Resident 1 was "very aggressive towards [sic] staff. Tried hitting staff multiple times."

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- 04/12/2025, Resident 1 slapped another resident across the face. The resident who got slapped was sitting at the dining table.
- 04/12/2025, Resident 1 became agitated when a walker was blocking his/her way. Staff attempted to direct Resident 1 to go a different way. Resident 1 picked up the walker, swung it and hit another resident in the face. Resident 1 attempted to hit staff with it.
- 04/20/2025, Resident 1 shoved staff into the wall and attempted to punch staff. Staff wrote, "[S/he] keeps yelling out for [family member] and it [sic] having hallucinations that are making [him/her] more aggressive... [Resident 1] will not calm down even after staff has tried multiple attempts to redirected [sic]. [Resident 1] has been throwing chairs around and moving the dining room tables."
- 04/21/2025, Resident 1 grabbed another resident's head, pushed him/her, and pulled his/her hair.

A progress note, dated 04/15/2024, indicated Resident 1's behavior was scaring other residents. Progress notes also indicated staff attempted to utilize pharmacological interventions, however, Resident 1 often refused medications, spit them out, or the as-needed psychotropic medications were not effective.

An incident report, dated 03/12/2025, indicated Resident 1 was given an involuntary discharge notice on 03/12/2025.

Resident 1's individual service plan (ISP), updated 04/10/2025, indicated Resident 1 had a history of experiencing hallucinations that caused agitation, exit seeking, elopement attempts, and urinating in inappropriate areas. Resident 1 also had a history of physical aggression and mood

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changes throughout the day; "At times, there is no known trigger for agitation and it comes out of the blue." The ISP included the following interventions:
- Staff to provide Resident 1 personal space and re-approach once s/he has calmed down.
- "Resident 1 often prefers that others are not in [his/her] personal space as this causes increased agitation. Staff to monitor for times of agitation, and when observing, staff to encourage resident to occupy a quiet area or away from others to avoid physical aggression."
- Hourly safety checks
- When Resident 1 was agitated, offer food/sweet treats, ensure Resident 1 that his/her spouse would be visiting soon, assist Resident 1 to the bathroom, or show Resident 1 pictures of children.
- When approaching Resident 1, stand at least 1 arm length away, call him/her by name, make eye contact, and bring up a topic of interest like fishing or country music.

On 04/22/2025 at approximately 1:00 PM, Surveyor interviewed Assistant Manager (AM) B. AM B stated Resident 1 was given an involuntary discharge notice over 30 days ago, but Resident 1's team was unable to find alternative placement due to his/her behaviors. AM B stated staff were doing what they could to prevent behaviors, but interventions were not always successful. AM B noted Resident 1's aggressive behavior occurred abruptly and without warning. Surveyor asked if Resident 1 had injured other residents. AM B said Resident 1 had not significantly injured anyone to date, but Resident 1 was scary when s/he was agitated due to his/her size and strength. AM B stated the provider had utilized law enforcement to help control Resident 1's behavior in the past.