STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012426	A. BUILDING: _____ B. WING _____	R-C 10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME RIVER FALLS CBRF	2328 AURORA CIRCLE RIVER FALLS, WI 54022

(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 10/04/2023, Surveyor conducted a complaint investigation and verification visit at Comforts of Home River Falls CBRF. The complaint was substantiated. Two deficiencies were identified. One of 2 deficiencies was a repeat deficiency. See Statement of Deficiency (SOD) 1DMC12, dated 02/03/2023, SOD 1DMC11, dated 08/23/2022, and SOD TL3D11, dated 12/27/2018. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 27	{N 000}		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure Resident 1 and Resident 2 received prescribed medications in the dosage and intervals prescribed by a practitioner on 10/01/2023. This is a repeat deficiency and is being cited for the fourth time. See Statement of Deficiency (SOD) 1DMC12, dated 02/03/2023, SOD	{N 352}		

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
	0012426	A. BUILDING: _____ B. WING _____	R-C 10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME RIVER FALLS CBRF	2328 AURORA CIRCLE RIVER FALLS, WI 54022

(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 352}	Continued From page 1 1DMC11, dated 08/23/2022, and SOD TL3D11, dated 12/27/2018. Findings include: On 07/11/2023, the Department received a complaint regarding medication administration. RESIDENT 1 On 10/04/2023 at approximately 11:55 AM, Surveyor observed the medication cart with Caregiver B. Surveyor pulled a card for Resident 1's Levothyroxine 50 mcg tablet with directions to "TAKE ONE TABLET BY MOUTH EVERY MORNING AT 7AM FOR HYPOTHYROIDISM *MAY CRUSH." The card was for the month of October 2023 and had one pill in the "1" slot. Pills were popped for the "2", "3" and "4" slot. Surveyor interviewed Caregiver B and asked if the numbers on the card correlated with the day of the month. Caregiver B stated, "Yes, we pop by date." Caregiver B confirmed Resident 1 did not receive his/her Levothyroxine on 10/01/2023 as it was still in the pill pack. RESIDENT 2 On 10/04/2023 at 12:03 PM, Surveyor observed the medication refrigerator and observed a medication card for Resident 2's "Florajen Digest 15 B CELL CAP" with instructions, "*COLD SEAL*TAKE ONE CAPSULE BY MOUTH AT 8AM." The card still had one capsule in the "1" slot. Pills were popped for "2", "3" and "4" pouches. Caregiver B stated, "Looks like [Resident 2] didn't get it on 10/01/2023." On 10/04/2023 at 12:15 PM, Administrator A provided Surveyor with the medication	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012426	A. BUILDING: _____ B. WING _____	R-C 10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME RIVER FALLS CBRF	2328 AURORA CIRCLE RIVER FALLS, WI 54022

(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 352}	Continued From page 2 administration (MAR) record for Resident 1 and Resident 2, as requested. Administrator A stated, "The meds (medications) were signed off in the MAR, but not given. I started a med error report form and will notify the doctor today." Resident 1 and Resident 2 did not get medication as prescribed by their practitioner on 10/01/2023.	{N 352}		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure documentation of medication administration was completed at the time of administration when Caregiver C initialed the medication administration record (MAR) as given on 10/01/2023 but did not administer medications as ordered for Resident 1 and Resident 2. Findings include:	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012426	A. BUILDING: _____ B. WING _____	R-C 10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME RIVER FALLS CBRF	2328 AURORA CIRCLE RIVER FALLS, WI 54022

(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 415	Continued From page 3 On 07/11/2023, the Department received a complaint regarding medication administration. RESIDENT 1 On 10/04/2023 at approximately 11:55 AM, Surveyor observed the medication cart with Caregiver B. Surveyor pulled a card for Resident 1's Levothyroxine 50 mcg tablet with directions to "TAKE ONE TABLET BY MOUTH EVERY MORNING AT 7AM FOR HYPOTHYROIDISM *MAY CRUSH." The card was for the month of October 2023 and had one tablet in the "1" bubble on the pack. Pills were popped for "2", "3" and "4." Surveyor interviewed Caregiver B and asked if the numbers on the card correlated with the day of the month. Caregiver B stated, "Yes, we pop by date." Surveyor reviewed the medication administration record (MAR) for Resident 1 with Caregiver B. The MAR showed Caregiver C had marked the medication as "administered" on 10/01/2023 at 7:13 AM but did not administer the medication as ordered. Surveyor asked Caregiver B if medications were stored in another location in the facility. Caregiver B stated, "We keep some in the med (medication) fridge (refrigerator), mostly just insulin." RESIDENT 2 On 10/04/2023 at 12:03 PM, Surveyor observed the medication refrigerator and observed a medication card for Resident 2's "Florajen Digest 15 B CELL CAP" with instructions "*COLD SEAL*TAKE ONE CAPSULE BY MOUTH AT 8AM." The card still had one capsule in the "1" bubble on the pack. Pills were popped for "2", "3"	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012426	A. BUILDING: _____ B. WING _____	R-C 10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME RIVER FALLS CBRF	2328 AURORA CIRCLE RIVER FALLS, WI 54022

(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 415	Continued From page 4 and "4." Surveyor reviewed the MAR for Resident 2 with Caregiver B. The MAR showed Caregiver C had marked the medication as "administered" on 10/01/2023 at 7:53 AM but did not administer the medication as ordered.	N 415		