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 _____	C 07/21/2026

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 07/21/2026, Surveyor conducted a complaint investigation and standard survey at Comforts of Home River Falls CBRF. The complaint was unsubstantiated. One deficiency was identified. Census: 28	N 000		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 2 of 2 employees responsible for the administration of medically oriented tasks including eye drops and injectables were delegated by a registered nurse. Medication administration described under sub. (2)(e) was not delegated to non-licensed employees pursuant to s.N6.03(3). Findings include: On 07/21/2026, at approximately 1:15 PM, Surveyor interviewed Caregiver A and asked if s/he was responsible for administering medication, including delegated nursing tasks. Caregiver A stated s/he was responsible for	N 416		

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 _____	C 07/21/2026

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 416	Continued From page 1	N 416		

passing medications including eye drops, taking blood sugars, and administering insulin. When asked if s/he was delegated by a registered nurse, Caregiver A stated s/he reviewed the information on delegation of those tasks with Registered Nurse (RN) B, but RN B did not require him/her to demonstrate each delegated task. Surveyor asked Caregiver A for clarification and Caregiver A informed Surveyor s/he was required to complete one medication pass with RN B prior to getting signed off. Caregiver A indicated that administration of one oral medication would count.

On 07/21/2026 at approximately 1:26 PM, Surveyor observed Caregiver C administer one drop of Refresh into Resident 1's left eye.

Surveyor asked Caregiver C if there were any other delegated tasks s/he was responsible for. Caregiver C informed Surveyor s/he was also responsible for blood sugar checks and administering insulin. Surveyor asked Caregiver C if s/he was delegated by a registered nurse to complete the tasks identified. Caregiver C stated at the time of delegation there were not a lot of delegated tasks prescribed, and informed Surveyor s/he was trained by Caregiver D to do eye drops, take blood sugars and inject insulin. Caregiver C informed Surveyor Caregiver D was not a registered nurse. Caregiver C stated RN B offered more training but did not observe him/her completing the tasks per the delegation requirements outlined in N6.03(3).

Surveyor reviewed Caregiver A's employee record. Caregiver A had a hire date of 11/13/2023. The record contained a document with the title, "Medication Administration Competency Observation/Delegation" that was

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 _____	C 07/21/2026

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 416	Continued From page 2 initialed and signed by Caregiver A and RN B. Surveyor reviewed Caregiver C's employee record. Caregiver C had a hire date of 02/17/2025. The record contained a document with the title, "New Hire Checklist for Orientation Med passer," which included nurse delegated tasks including blood sugar checks, insulin/sliding scale insulin, and eye drops. The checklist was initialed by Caregiver C and Caregiver D and signed off by RN B on 01/05/2026. Caregiver C's record contained a document with the title, "Medication Administration Competency Observation/Delegation," but delegated tasks were not initialed and left blank. The document had RN B's initials next to a section that included the following instructions: "-Wash or sanitize hands before med pass and between residents -Assured correct resident by verifying with photo or identified with other staff. -Informed resident that they were administering medications to them. -Mar reviewed for parameters or special instructions prior to giving meds. -Med cart locked and Mar concealed when cart is unattended. -Ensure resident takes med and stay with them until med is gone. -Medications given in scheduled time frame (1 hour before or after)." The document was signed by Caregiver D on 01/12/2026. RN B's signature was written below Caregiver D's signature, but no date was listed to document when RN B signed the incomplete document. The provider did not ensure staff were delegated	N 416		

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 _____	C 07/21/2026

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 416	Continued From page 3 tasks by a licensed nurse pursuant to s. N 6.03(3).	N 416		