STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014128	A. BUILDING: _____ B. WING _____	R-C 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TERRACE RHINELANDER II	1450 W PHILLIPS STREET RHINELANDER, WI 54501

(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 08/21/2024, Surveyor conducted a verification visit and complaint (x2) investigation at Country Terrace Rhinelander II. Data collection continued through 09/04/2024. The deficiencies identified in statement of deficiency (SOD) 2V1M11 were corrected. The complaints (x2) were substantiated. Three deficiencies were identified. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 8	{N 000}		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall	N 158		

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

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N 158	Continued From page 1 maintain documentation of any investigation. This Rule is not met as evidenced by: Based on interview and record review, the provider did not investigate and document an allegation of neglect after it was reported on 07/07/2024. Findings include: On 07/10/2024, the Department received complaints alleging a caregiver left the facility while working an overnight (NOC) shift on 07/06/2024 and staff who were not medication trained were working alone at the facility. The facility is licensed to serve up to 15 residents in the client groups physically disabled, irreversible dementia/Alzheimer's disease, advanced aged and terminally ill. On 08/21/2024 at approximately 11:53 AM, Surveyor interviewed Resident 1. Surveyor asked Resident 1 if s/he had any concerns. Resident 1 reported, "I sit up late at night sometimes; I pushed the buzzer to get a snack and no one came. I walked around the building and looked outside. No one was here. If something would have happened, I would not know what to do. Luckily, no one was buzzing for help." Surveyor asked Resident 1 if s/he remembered when this occurred and which staff person left the building. Resident 1 stated that on at least two separate occasions in July 2024, Caregiver E was working alone and left the facility for several hours. Resident 1 could recall Caregiver E leaving the building during the early morning hours on 07/07/2024. Resident 1 reported that Resident 1 informed Caregiver D about the incident and on	N 158		

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N 158	Continued From page 2	N 158		

at least one occasion, Resident 1 called Former Director (FD) B to report Caregiver E for leaving the building.

On 08/21/2024 at approximately 1:35 PM, Surveyor interviewed Assistant Director (AD) C. AD C stated that Caregiver E left the building on two separate occasions while working overnight shifts alone (11:00 PM - 7:00 AM) in July 2024. Surveyor asked AD C when Caregiver E left the building and for how long. AD C reported that Caregiver E left the facility on two separate occasions between 07/06/2024 and 07/11/2024. The first time Caregiver E left the building was during the early morning hours of an overnight shift from 11:00 p.m. on 07/06/2024 to 7:00 a.m. on 07/07/2024, and Caregiver E was gone for over 2 hours. AD C reported that the second time Caregiver E left the building, AD C was unsure of how long and unsure of the exact date.

On 08/21/2024 at approximately 4:40 PM, Surveyor interviewed Director A. Director A reported that s/he was hired on 08/16/2024. Director A indicated that FD B was terminated a few weeks prior to Director A being hired. Director A stated that FD B was aware of Caregiver D walking out of the building and abandoning the residents on at least two separate occasions in July 2024. Director A indicated that s/he does not believe an investigation was conducted by FD B. Director A informed Surveyor that Director A would check to see if FD B started an investigation into Caregiver E abandoning the residents.

Surveyor reviewed Caregiver E's record. Caregiver E was hired on 10/09/2023. Caregiver E was terminated on 07/12/2024. According to the provider's July 2024 work schedule, Caregiver

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E worked the NOC shift alone on 07/01/2024, 07/02/2024, 07/04/2024, 07/06/2024, 07/08/2024, 07/09/2024, 07/10/2024 and 07/11/2024.

On 08/22/2024 at approximately 4:15 PM, Surveyor interviewed Caregiver D via telephone. Caregiver D reported that Caregiver E left the building for over 2 hours while working a NOC shift on 07/06/2024 to 07/07/2024. Caregiver D indicated that Resident 1 informed Caregiver D that Caregiver E left the building for several hours during the early morning on 07/07/2024, and Resident 1 locked the doors and Caregiver E had to "pound" on the door to get back into the building. Caregiver D reported, "[Resident 1] told me on 07/07/2024 and I told [FD B] immediately about Caregiver E leaving the building during his/her overnight shift on 07/06/2024."

On 08/23/2024 at approximately 8:15 AM, Surveyor interviewed Director A via telephone. Director A stated that FD B did not conduct an investigation regarding Caregiver E leaving the facility on two separate occasions in July 2024. Director A reported that Regional Nurse F started the investigation yesterday, 08/22/2024.

On 08/23/2024, Surveyor received an e-mail from the Office of Caregiver Quality (OCQ), confirming the facility submitted a Misconduct Incident Report (MIR). Per the MIR, in regards to a "Brief Description of Alleged Incident," the provider noted, "Abandonment by [Caregiver E] caregiver. [S/He] initially stated [s/he] did not leave."

On 08/24/2024 at approximately 8:49 PM, Surveyor received an e-mail from Caregiver D. Caregiver D noted that on at least two occasions Caregiver E left the building while working alone in July 2024. Each time, there were 10 residents

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N 158	Continued From page 4 in the building when Caregiver E left the facility. Caregiver D provided Surveyor with a copy of Caregiver D's statement to FD B on 07/07/2024. Caregiver D's statement read, in part, "[Resident 1] pressed [his/her] call button at 12:30 a.m. to ask for a snack and waited at the counter until 1:00 a.m. [S/He] then walked around the inside of the facility trying to find the NOC worker, [Caregiver E]. [S/He] then went outside and looked to see if [his/her] car was still in the parking lot to which [s/he] realized that there wasn't an employee there anymore. [S/He] locked both main doors and stated [s/he] was very scared due to the fact that [s/he] wouldn't know what to do if another resident got hurt. [Caregiver E] came back after 2:00 a.m. and pounded on the door waiting to be let in. [S/He] let [him/her] in and asked [him/her] where [s/he] went. [S/He] (Caregiver E) stated, 'I had to go do some stuff.' This incident occurred on 07/06/2024. Director notified on 07/07/2024." The provider did not investigate and document an allegation of neglect after a caregiver left 10 residents alone for several hours on 07/07/2024.	N 158		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property.	N 348		

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N 348	Continued From page 5 This Rule is not met as evidenced by: Based on interview and record review, the provider did not keep 10 residents free from neglect on 07/07/2024. Findings include: On 07/10/2024, the Department received a complaint alleging a caregiver left the facility while working an overnight (NOC) shift alone on 07/06/2024. The facility is licensed to serve up to 15 residents in the client groups physically disabled, irreversible dementia/Alzheimer's disease, advanced aged, and terminally ill. On 08/21/2024 at approximately 11:53 AM, Surveyor interviewed Resident 1. Surveyor asked Resident 1 if s/he had any concerns. Resident 1 reported, "I sit up late at night sometimes; I pushed the buzzer to get a snack and no one came. I walked around the building and looked outside. No one was here. If something would have happened, I would not know what to do. Luckily, no one was buzzing for help." Surveyor asked Resident 1 if s/he remembered when this occurred and which staff person left the building. Resident 1 stated that on at least two separate occasions in July 2024, Caregiver E was working alone and left the facility for several hours. Resident 1 could recall Caregiver E leaving the building during the early morning hours on 07/07/2024. Resident 1 reported that Resident 1 informed Caregiver D about the incident and on at least one occasion, Resident 1 called Former Director (FD) B to report Caregiver E for leaving the building.	N 348		

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N 348	Continued From page 6 On 08/21/2024 at approximately 1:35 PM, Surveyor interviewed Assistant Director (AD) C. AD C stated that Caregiver E left the building on two separate occasions while working overnight shifts alone (11:00 PM - 7:00 AM) in July 2024. Surveyor asked AD C when Caregiver E left the building and for how long. AD C reported that Caregiver E left the facility on two separate occasions between 07/06/2024 and 07/11/2024. The first time Caregiver E left the building was during the early morning hours during an overnight shift from 11:00 p.m. on 07/06/2024 to 7:00 a.m. on 07/07/2024, and Caregiver E was gone for over 2 hours. AD C reported that the second time Caregiver E left the building, AD C was unsure of how long and unsure of the exact date. On 08/21/2024 at approximately 4:40 PM, Surveyor interviewed Director A. Director A reported that s/he was hired on 08/16/2024. Director A indicated that FD B was terminated a few weeks prior to Director A being hired. Director A stated that FD B was aware of Caregiver D walking out of the building and abandoning the residents on at least two separate occasions in July 2024. Director A indicated that s/he did not believe an investigation was conducted by FD B. Surveyor reviewed Caregiver E's record. Caregiver E was hired on 10/09/2023. Caregiver E was terminated on 07/12/2024. According to the facility's July 2024 work schedule, Caregiver E worked the NOC shift alone on 07/01/2024, 07/02/2024, 07/04/2024, 07/06/2024, 07/08/2024, 07/09/2024, 07/10/2024 and 07/11/2024. On 08/22/2024 at approximately 4:15 PM, Surveyor interviewed Caregiver D via telephone. Caregiver D reported that Caregiver E left the	N 348		

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building for over 2 hours while working an overnight shift on 07/06/2024 to 07/07/2024. Caregiver D indicated Resident 1 informed Caregiver D that Caregiver E left the building for several hours during the early morning on 07/07/2024, and Resident 1 locked the doors and Caregiver E had to "pound" on the door to get back into the building. Caregiver D reported, "[Resident 1] told me on 07/07/2024 and I told [FD B] immediately about Caregiver E leaving the building during his/her overnight shift on 07/06/2024."

On 08/23/2024, Surveyor received an email from the Office of Caregiver Quality (OCQ), confirming the facility submitted a Misconduct Incident Report (MIR). Per the MIR, in regard to a "Brief Description of Alleged Incident," the provider noted, "Abandonment by [Caregiver E] caregiver. [S/He] initially stated [s/he] did not leave."

On 08/24/2024 at approximately 8:49 PM, Surveyor received an email from Caregiver D. Caregiver D noted that on at least two occasions, Caregiver E left the building while working alone in July 2024. Each time, there were 10 residents in the building when Caregiver E left the facility. Caregiver D provided Surveyor with a copy of Caregiver D's statement to FD B on 07/07/2024. Caregiver D's statement read, in part, "[Resident 1] pressed [his/her] call button at 12:30 a.m. to ask for a snack and waited at the counter until 1:00 a.m. [S/He] then walked around the inside of the facility trying to find the NOC worker, [Caregiver E]. [S/He] then went outside and looked to see if [his/her] car was still in the parking lot to which [s/he] realized that there wasn't an employee there anymore. [S/He] locked both main doors and stated [s/he] was very scared due to the fact that [s/he] wouldn't know

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N 348	Continued From page 8 what to do if another resident got hurt. [Caregiver E] came back after 2:00 a.m. and pounded on the door waiting to be let in. [S/He] let [him/her] in and asked [him/her] where [s/he] went. [S/He] (Caregiver E) stated, 'I had to go do some stuff.' This incident occurred on 07/06/2024 (during an overnight shift). Director notified on 07/07/2024." On 07/07/2024, the provider did not ensure 10 residents were free from neglect when a caregiver left the residents alone for several hours.	N 348		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more.	N 397		

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N 397	Continued From page 9 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure at least one qualified resident care staff was present in the community based residential facility (CBRF), when one or more residents were present in the CBRF. Findings include: Wisconsin Administrative Code defines a "Qualified resident care staff" as an employee who has successfully completed all of the applicable training and orientation under subch. IV. On 07/10/2024, the Department received a complaint alleging a caregiver who was not medication trained was working alone at the facility. The facility is licensed to serve up to 15 residents in the client groups physically disabled, irreversible dementia/Alzheimer's disease, advanced aged and terminally ill. On 08/21/2024, Surveyor reviewed the July 2024 work schedule. Caregiver G worked multiple overnight shifts alone in July 2024. On 08/21/2024, Surveyor reviewed Caregiver G's record. Caregiver G was hired on 09/09/2023. Caregiver G's record did not contain information about completing department approved medication administration training. On 09/04/2024 at approximately 4:30 PM, Surveyor interviewed Director A via telephone. Director A confirmed Caregiver G was not medication trained and was in the process of	N 397		

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N 397	Continued From page 10 completing medication training. Surveyor reviewed the July 2024 work schedule with Director A. Director A confirmed that Caregiver G worked several shifts alone in July 2024. Surveyor asked Director A for Caregiver G's hire date. Director A reported that Director A was not at the facility and was unsure of Caregiver G's hire date and told Surveyor to contact the facility and speak to Caregiver D. On 09/04/2024 at approximately 4:37 PM, Surveyor interviewed Caregiver D via telephone. Caregiver D indicated that Caregiver G's hire date was 09/09/2023. Caregiver D confirmed that Caregiver G was not medication certified and was in the process of becoming medication certified. Caregiver D reported that Caregiver G started working "NOC" shifts" at the beginning of April 2024 and routinely worked alone. The provider did not ensure a qualified staff was present when residents were present, during several overnight (NOC) shifts in July 2024.	N 397		